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Crossing the Line: Experiences of the Formerly Homeless Living Past Homelessness

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CROSSING THE LINE:

EXPERIENCES OF THE FORMERLY HOMELESS

LIVING PAST HOMELESSNESS

BY

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Abstract

This grounded theory study explored the experiences of formerly homeless individuals and families who have moved from homelessness into stable housing. This was an ethnographic study and involved the researcher staying in an east coast shelter where some of the formerly homeless participants had become staff members and reside. Data analysis was informed by dimensional analysis. Moving out of homelessness was the studies perspective. Findings of the study revealed the following dimensions that related the formerly homeless's experiences: (a) reacting to circumstances, or how they became homeless; (b) surviving as homeless, or how they lived while homeless ; (c) crossing the line, or what moved them to get out of the homeless life; (d) living past homelessness; and, (e)giving back. Findings of this study have implications for: (a) public policy making; (b) program development for homeless shelters;(c) health clinic staff that serve the homeless population; and, (d) future nursing research.

DEDICATION

To the homeless shelter staff who patiently and generously continue to work with the homeless; giving them a chance to "regain themselves." To all who care enough to pursue humane and dignified treatment for the homeless, and the chronically, mentally ill.

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Introduction

In the United States tonight, there will be 350,000 to 3,000,000 people spending the night sleeping on the streets, in parks, door-stoops and alleyways (Federal Task Force on Homelessness; 1992 ; US Conference of Mayors, 1998). Homelessness is a condition experienced by individuals and families who lack a stable residence and are literally sleeping on the streets, housed in single room occupancy hotels, or are staying in temporary, emergency shelters. Year after year, this significant social problem is a concern that receives attention from the media, government, popular and professional arenas. Homelessness is seemingly a timeless concern that perpetually plagues society, but not since the "Great Depression" have we seen these numbers of homeless. The problem of homelessness constantly sparks discourse among politicians, homeless advocates, scholars, religious leaders, and health care professionals.

Research efforts and scholarly work on homelessness have focused largely on describing the phenomenon. A large body of literature exists that identifies factors associated with homelessness such as substance abuse, mental illness, poverty, and gentrification of neighborhoods (Bassuk, 1993a; Bassuk, 1993b; Dear & Wolch, 1987; Jencks, 1994). This knowledge helps shelter staff and other professionals to work with homeless individuals and families living in shelters. In addition to work with the homeless, this knowledge base can inform policy makers and professionals who may have a direct effect on preventing homelessness. Despite this important work on homelessness, there is little known about the conditions that enable homeless individuals and families to move

from the state of homelessness into stable housing.

Purpose of the Study

This study explored how individuals move out of homelessness. More specifically, this study sought to find out about the process of moving out of homelessness and included factors that aided homeless persons in this transition. This study was guided by the following lines of inquiry:

1. Under what conditions do homeless individuals move from being homeless into stable housing?
2. What people, services and circumstances made it possible for homeless individuals transition into stable housing?
3. Were there any specific periods that services were crucial to provide for the transition to occur?
4. What do formerly homeless individuals have to offer shelter staff and other professionals regarding the process of moving from being homeless into stable housing?

In summary, the study aim was to explore the problem of homelessness and included the perspective of the formerly homeless who had moved into stable housing.

Research Method

Since there is little known about the conditions that enable homeless individuals to move into stable housing, the qualitative, exploratory method of grounded theory was selected. The procedures of grounded theory ultimately provide an in-depth understanding of the social and psychological processes of a phenomenon and the conditions under

which the phenomenon occurs (Strauss & Corbin, 1990, 1994). During the data analysis, a working theory emerged that explained the processes under study: moving out of homelessness. The data analyses was also informed by the procedures of Schatzman's (1991) dimensional analyses. Dimensional analysis offers an additional approach to the grounding of data by considering the context, conditions, action/process, and consequences related to moving out of homelessness.

Significance of the study

Historically, nursing has always played a role in providing health care to vulnerable populations. Since the beginning of organized nursing in the United States, leaders like Lillian Wald championed the causes that aided those living in poverty who lacked access to health care systems. Wald also challenged nurses to become involved in current significant social problems and, more specifically, to be politically active in promoting changes that would improve the quality of life for all individuals. By establishing the Henry Street settlement, the roots of the visiting nurse services, Wald set an important nursing precedent by providing care to all Americans, not just to those who could pay for the services. The work of Wald and her colleagues determined a challenging course for future generations of nurses and encompassed very distinct facets of nursing practice. First, they provided nursing services to all humans in need of nursing care. Lillian Wald responded to the need of the immigrants in Manhattan's lower east side by living among the people and directly serving those in need. By her example, Wald challenged future nurses to provide services to all people in need of care regardless of their ability to pay for services or their ability to access existing health care systems. Secondly, Wald envisioned that nurses

would play active social and political roles in public movements that would change social policy and structures detrimental to human happiness. Wald championed several humanitarian causes such as improving the welfare of children by founding the Federal Children's Bureau and school nursing. In addition, she was an ardent supporter of peace who believed that war wrought poverty and hatred. This passion led Wald to found the American Union Against Militarism which was later instrumental in averting war with Mexico in 1916 (Coss, 1989).

Nearly a century has passed since Wald and her colleagues began their important work. Today, many of the obstacles and barriers faced by Wald to provide care to those in need remain the same. Trying to establish health care programs seems a never ending struggle. That we, in this wealthy nation, are denying health care access to so many says little about this country's social and moral development since the time Lillian Wald began her work (Bassuk, 1993b). Given the changing structure of health care in America, nursing must assume a more active role ensuring care for those members of vulnerable populations like the homeless. Like Wald and her colleagues, nurses today must go to the homeless and determine how nursing can become involved to improve their health and to end their suffering.

This study adds new information to the existing body of knowledge on homelessness by enhancing knowledge of the conditions that enable individuals to move out of homelessness. This important step was needed to complete the body of research work on homelessness. The real events that ended the cycle of homelessness for formerly homeless individuals and families in this study can be used to inform nurses, shelter staff and other

professionals who work with the homeless. Based on knowledge of these events, effective intervention strategies can be developed that are geared towards ending homelessness.

Summary

In summary, homelessness affects up to three million individuals and families each year. Although homelessness has been studied extensively by a variety of disciplines, the bulk of research and scholarly work done with the homeless is descriptive in nature. Conditions associated with being homeless include substance abuse, mental illness, violence, gentrification of neighborhoods, and social stigma (Bassuk, 1993b; Hatton, 1997; Hatton, Bennett, Gaffrey & Kleffel, 1999). There is little known about those conditions that enable homeless individuals to move into stable housing. The purpose of this study was to investigate the experiences of formerly homeless individuals and shelter staff to determine which conditions facilitated an end to homelessness.

Chapter II

Review of the Literature

Introduction

Homelessness is a phenomenon that is mediated by social, economic and psychologic factors. In order to provide insight into the impact of "homelessness" on homeless individuals and society, Erving Goffman's conceptualization of "stigma" will be utilized here as a lens to view the phenomenon. Additionally, social, economical, and psychological factors associated with homelessness as reviewed in the literature will be discussed. Since the focus of this study is moving out of homelessness into stable housing, the research reviewed will be critiqued in light of the following question: How does this current literature contribute to understanding how the homeless move towards living in stable housing? Significant findings, as well as gaps in the literature, are examined as they relate to the purpose of this study.

Goffman's *Stigma:* A Theoretical Framework for Understanding Homelessness

Images of Homelessness

To conjure up the image of a homeless person is not difficult. Even if one has never seen a homeless individual personally, the television and news media reports on the plight of "the homeless" has provided vivid imagery of the existence of homeless individuals and families. From hundreds living in the sewer and subway tunnels beneath New York City, to individuals living under highway bridges in Atlanta, the subconscious of every American has been imprinted with an image of homelessness. One might envision a homeless woman carrying her life possessions in multiple bags, pushing a shopping cart along an alley, and

collecting cans and bottles from the garbage. She appears disheveled in her layers of dirty clothing, discolored stocking cap, and worn tennis shoes. She goes about her work of sifting garbage. Her weathered face and toothless chatter give her an aged appearance. Another image of homelessness is that of a drunken man passed out in a downtown door-stoop in the early morning hours. Recalling an image of homelessness is not difficult.

These images constructed by writer and reader, what the images mean to the homeless, and the way the homeless interact with society are the focus of the first portion of the literature review. Conceptualization of Erving Goffman's "stigma" will provide a framework for understanding homelessness. The lens of Goffman's "stigma" also provides insight into the complexity of the difficult task of moving out of homelessness and becoming part of "normal" society.

Normal Society

Society not only establishes the attributes considered natural, ordinary or normal for individuals, but also ascribes those attributes that are not normal for individuals in society. These attributes are considered handicaps, shortcomings or failings and can reduce the status of an individual in society from "normal to bad, weak, tainted and to be discounted" (Goffman, 1963, p. 3). Goffman distinguishes between the following three types of stigma: (a) physical deformity as in dwarfism; (b) character blemishes such as weak will, dishonesty and unnatural passions, traits inferred from a variety of conditions like unemployment, mental illness, addiction and alcoholism; and, (c) tribal stigmas that are passed on generationally including race, religion and nationality (1963). The homeless are stigmatized primarily by character blemishes. They may also possess physical deformity as

seen in many homeless disabled veterans. In addition, tribal stigmas are seen in the homeless migrant farm worker of Mexican descent.

Typical Housing in the United States

In the United States, the typical dwelling place of societal members includes renting or owning a residence such as a house, apartment, or trailer. The residence provides a place for a number of daily living functions including sleeping, eating, elimination, and bathing. In addition, intimate personal activities such as relaxation and entertainment are engaged in the residence. The typical home serves to provide a sense of security, safety, and belonging to its occupants.

Homeless Variances and the Reaction of the Normals

The key attribute that separates the homeless from the "normal" members of society is that they lack a residence or place to sleep on a consistent basis. Consequently, they are seen sleeping and conducting various daily living tasks that are normally concealed in the privacy of a home in public places, and in view of other members of society. To the normal society member, some of the tasks the homeless perform publically are particularly disturbing such as eating from garbage cans, begging for money, and urinating or defecating in public view. To some society members, just the sight of a homeless person occupying a park bench for the day and not working for a living is enough to cause revulsion towards the individual. These reactions of the normal society members towards the undesired and different behavior of the homeless serve to determine the fate of the homeless.

Goffman would describe the attitudes and actions of normals who view the homeless as

less than human. This viewpoint allows the normals to discriminate against the homeless and to ultimately reduce the life chances for the homeless (Goffman, 1963). The normals construct a stigma-theory of homelessness that explains the failings, shortcomings and inadequacies of the homeless.

Creating a Stigma theory on Homelessness: They don't Want to Work

To illustrate the above point, consider the normal's attitudes on work and the homeless. There are those who would say of a group of homeless people huddled around a burning trash can, "Those people are there because they just don't want to work!" This statement illustrates how normals might arrive at a stigma theory of why the homeless exist. By making simple observations and without any kind of verbal interaction, they determine on the basis of the appearance and actions of the homeless that they are homeless by choice since they do not want to work. The theory also alleviates them from taking any responsibility for the situation or steps to help the homeless since they are there of their own choosing!

The Difficulties of Working While Homeless

Elliot Liebow wrote extensively on the difficulties homeless women had with work (1993). He argued that the normal's discrimination against the stigmatized-homeless prevents homeless women from succeeding in becoming employed. Consider the problem of having no telephone or address as Liebow describes below:

> Having no phone is often reason enough to discourage prospective employers and agencies from wanting to hire you. It is not simply that communication is difficult, but rather that the person who confesses to having no telephone of one's own, or

> even access to one, is suspect. From the employer or agency point of view, such a person is probably a bad risk. He or she might even be homeless (1993, pp. 52-53).

Appearance presents another obstacle in the homeless person's job hunt. With limited access to bathing facilities and clothing appropriate to wear on an interview, few homeless succeed in securing and maintaining employment. Liebow points out that homeless women who are able to secure employment have difficulty maintaining personal appearance, with organization, and with self discipline (1993). The following describes a homeless working woman's wardrobe routine:

> Grace. . . has the advantage of being able to use her automobile as a clothes closet. She hangs her blouses, jackets and skirts on a crossbar. Underwear and accessories are piled neatly in a tattered suitcase on the front seat. Each item is tagged and coded so that she can pull out a matching outfit with relative ease (Liebow, 1993, p. 55).

"Passing" for normal may be critical since the consequences of disclosing homelessness to an employer may mean the loss of a job (Goffman, 1963).

Passing for Normal While Homeless

Sleeping on the streets or in homeless shelters, and trying to maintain a normal existence by keeping up relations at work as if all is normal, causes anxiety for passing (Goffman, 1963). As Goffman describes, passing requires that stigmatized individuals work along side the normals as if they do not have a condition that is different or stigmatizing. For some homeless individuals, passing may lead to some kind of transition into a normal existence. However, not all will be able to pass and their attempts at

working may not succeed. Passing as normal takes mental energy, or self assurance, in order for homeless people to carry the secret of homelessness and pass as normal (Goffman, 1963).

Failing to Pass as Normal: Depression, Despair and Bitterness

Not only will some formerly homeless not be able to maintain passing as normal, but there are those homeless who simply cannot present as normal. Consider this comment by a homeless woman on why it is so difficult for homeless women to work:

> The most serious reason for homeless people not working has to do with the fact that the mind will not function the way you want it to. You can't think through the questions and problems that come up in a job. You cannot think clearly, cannot hold an intelligent conversation, your mind wanders, you have difficulty following directions, difficulty remembering, and an attitude of despair, depression, and eventually bitterness sets in (Liebow, 1993, pp. 56-57).

For some, the reality of moving out of homelessness does not exist. Their hope for subsistence lies in the charity of the normals. For those with mental illness, substance abuse problems and depression, going back to work while homeless is more than they are able to cope with. Clearly, Liebow's research with homeless women provides data to suggest that the women who can, are making an attempt to enter the workforce.

Stigma as an Explanatory Conceptualization of Homelessness

Goffman's stigma conceptualization provides some of the explanation for the difficulties the homeless endure while trying to get back to a stable, working condition (1963). Working can be a stressful situation for most Americans without all of the

difficulties the homeless endure. While the concept of passing provides a glimpse at how some of the homeless may enter the world of normals, there is much more involved in making the transition from homeless to normal.

Affordable housing, access to health care, education, and job training are other important elements of the transition. For many homeless, recovery from mental illness, personal violence, substance abuse, and alcoholism are key components. The following discussion examines some of these important aspects of homelessness.

Economic Factors Contributing to Homelessness

The economic factors associated with homelessness may be personal in nature, such as recently becoming unemployed. Economic factors may also be representative of larger social problems as seen in the lack of available low rent housing. Along with the economic conditions, social factors like public attitudes towards homelessness create the environment for the homeless experience.

Personal-economic factors that contribute to homelessness include an individual's ability to produce income and the loss of established income precipitated by unemployment or divorce (Interagency Council on the Homeless, 1991). Individual ability to produce income sufficient to maintain a stable residence is influenced by level of education, skills and training. In the United States, jobs for unskilled industrial workers are limited, and minimum wage service jobs are generally not enough to support a family (Plant-Jackson, & McSwane, 1992). Many newly homeless individuals have recently lost their job(s), and are unable to maintain a residence (Brickner, Keen, Conanan, Elvy, & Savarese, 1985). For many women who are divorced and supporting children, ex-spouses

fail to pay child support which enhances financial hardships (Bassuk, 1993b). In addition, job segregation, harassment in the workplace and gender based discrimination against women still operate to maintain women's incomes below those of male counterparts (Bassuk, 1993b). Any of these personal-economic factors may precede the experience of homelessness.

Social-economic factors are also associated with homelessness. According to the Interagency Council on the Homeless, the recession of the 1980's was responsible for an increase in percentages of people living below poverty level from approximately 26 million to 35.1 million people (1991). At the same time, there was a decrease in the availability of low cost housing units (Bassuk, 1993a; Velsor-Friedrich, 1993). Less than half of the proposed six-million low-income housing units scheduled to be developed under President Johnson's administration were constructed (Dear & Wolch, 1987). Gentrification of poor neighborhoods and ghetto areas in central-cities drove rents out of the range for residents of these areas (Dear & Wolch, 1987; Jencks, 1994; Velsor-Friedrich, 1993). The progressive decline in affordable housing available to the poor, and the increasing number of impoverished people secondary to current welfare reform provide the social context of homelessness (Dear & Wolch, 1987).

Of those families living below the poverty level who are at high risk for becoming homeless, at least one-third are headed by single females (Bassuk, 1993b; Wilson & Neckerman, 1986). Single mothers who are heads of families are competing for the same resources as married couples with the potential for two sources of family income. These women are subject to societal inequalities built into our social structure that limit their

ability to generate income sufficient to support a family (Bassuk, 1993b). In one study, homeless working women who had children were trying to support their families on wages of as low as three to four dollars per hour (Bauman, 1993). According to Wilson and Neckerman (1986), these single mothers, relying on social welfare systems as their sole means of financial support, are likely to become persistently poor.

Social Factors Contributing to Homelessness

As indicated in Goffman's conceptualization of stigma, applied here to homelessness, negative stereotypes of the homeless prevail. These stereotypes of homelessness and mental illness have an impact on public support of programs and policies designed to benefit these groups (Buckner, Bassuk & Zima, 1993). Public opinion surveys indicate that public concern for the welfare of homeless individuals does exist (Lee, Lewis & Jones, 1992). However, despite verbalizing interest and concern, funding for programs that would improve conditions for the homeless-- such as job training, low-cost housing development, and increased welfare spending-- all consistently fail to receive public support (Toro, Trickett, Wall & Salem, 1991).

Legitimacy of Homelessness

This paradox is in part due to what Stern (1984) would call a lack of legitimacy for the problem of homelessness. Legitimacy indicates that a problem is recognized by the public and that a paradigm explaining the nature of the problem exists and suggests solutions to the problem (Stern, 1984). Most Americans recognize that homeless individuals freezing to death on a street corner is a problem. However, when asked if they are responsible for the problem, they may have difficulty claiming ownership of the problem of homelessness.

Since homelessness is not a problem they own, participating in the solution is difficult--particularly at the pocketbook level. Thus, public attitudes towards ownership of homelessness prevent the legitimization of homelessness as a problem. Without legitimization, solutions to the problem cannot be enacted and the problem of homelessness is perpetuated (Stern, 1984). This is important as Stern notes that once a social problem recedes from public notice, it becomes normalized and part of the routine order of society (1984, p. 293).

Deinstitutionalization of the Mentally Ill

The deinstitutionalization of the mentally ill has played an important role in homelessness. Initially, deinstitutionalization started in states as an attempt to reduce the severe overcrowding in state psychiatric hospitals. The goal of deinstitutionalization was to facilitate a more community based system of care for the population of mentally disordered offenders, developmentally disabled, mentally ill, and substance abusers (Dear & Wolch, 1987; Jencks, 1994). For example, in California, the population of the state hospital was reduced from 37,000 residents in 1959 to less than 6,000 residents by 1977 (Dear & Wolch, 1987).

The funds that usually were directed to the institutions were shifted to local communities who could then provide the former inpatients with outpatient treatment. Unfortunately, many of the programs never materialized, or funding was eventually cut to the scarce programs that did develop (Dear & Wolch, 1987; Jencks, 1994). The formerly institutionalized individuals may have been wrongly assigned to settings that lacked the support they needed to meet their needs. As Jencks (1994) notes, some of the mentally ill

who are homeless today would have been hospitalized under the old system of the 1950's. Under the current system of care for the mentally ill, they are frequently homeless, often in the criminal justice system for vagrancy and petty offenses, and comprise a large segment of the nation's nursing home population (Dear & Wolch, 1987).

Social Recognition of the Homeless

In addition to homelessness being a problem that is stigmatizing and lacks legitimacy, the actual numbers of the homeless make it difficult to provide services and secure funding. In *The homeless* (1994), Jencks describes the difficulties of counting the homeless population. According to Jencks, the number of 3,000,000 homeless is an overestimated count by homeless advocates, and reports of 350,000 homeless are underestimated counts by government agencies (1994, p. 2-20). Jencks estimated a count of the visible homeless at 400,000 during an average week for the year 1988 (1994, p. 16). While Jencks count is low and based on 1988 figures, these kinds of figures are used to secure federal and state funding for shelters and other programs that help the homeless.

In addition to challenging previous counts of homeless persons, Jencks discusses causes of the increased population. He argues that crack cocaine is a major contributor to the increasing number of homeless (1994,). Jencks offers numerous suggestions for partial solutions to homelessness including a budget of $18 million for the government to subsidize housing for the homeless (1994, p. 112).

Current sociological research which focuses on describing and classifying the homeless uses the characteristics of homeless individuals and families for classification (Shinn & Weitzman, 1990). One recent study examined the differences between 900 white and

nonwhite homeless men and women (North & Smith, 1994). In this study, the nonwhite participants were found to have more problems related to external causes such as the failing welfare system and lower incomes for men. In contrast, the white participants had more internal related problems such as substance abuse and mental illness (North & Smith, 1994). Extrapolating from these findings, one could conclude that the nonwhite group may need more assistance in terms of low rent housing and job skills enhancement, whereas the white group may benefit more from drug or alcohol rehabilitation prior to placement in low rent housing.

Psychological Factors Contributing to Homelessness

The psychological factors associated with homelessness are located within the homeless individual, such as a history of mental illness, or substance abuse. Although these factors are discussed separately, they do not occur in isolation--one from another-- rather, they form an intricate weave that is the fabric of homelessness. Psychological factors influencing homelessness include mental illness, substance abuse and history of personal violence.

Mental Illness

Mental illness includes an array of disorders that affect cognition, thought processes, and mood. Some forms of mental illness such as schizophrenia, major depression, and bipolar disorder may interfere with an individual's ability to generate a means of financial support and to access housing or shelter (Buckner, Bassuk & Zima, 1993). The reported prevalence of mental illness among homeless populations is highly variable, ranging from 30% to 80% in the homeless populations sampled (Fischer, 1991; North & Smith, 1992;

Breakey, Fischer & Kramer, 1989). Variance in the frequency of reported mental illness has been attributed to a lack of standardized, comprehensive, psychiatric evaluation in this group (Buckner et al., 1993).

In addition, mental illness may be unreported in shelters that do not allow residents with psychiatric conditions in their facilities (Buckner et al., 1993; Hatton, 1997). In a qualitative study on self-care among homeless women, Hatton identified "shame" as a feature of homeless women's' experiences that may influence their decision to report psychiatric problems as reflected in this woman's comment, "I can't tell anybody that" (p. 35, 1997). The actual incidence of mental illness in the homeless population may be higher than current methods of investigation reflect.

Current research is focusing on the increased incidence of mental illness in the homeless population. An example of this work is from the Harvard Medical School where they evaluated 218 sheltered homeless adults for levels of distress and suicidal thinking (Schutt, Meschede & Rierdan, 1994). The homeless adults in this study were found to have much higher levels of distress and suicidal thinking than measures of the same traits in the general population (Schutt et al, 1994). Findings from studies such as this support the development of interventions in shelters that give consideration to the mental health of homeless.

Substance Abuse

Substance abuse is reported as occurring at rates of 20% to 30% of the homeless population (Breakey, et al., 1989; Nestadt, Romanoski, Ross, Royal, & Stine, 1989; Buckner et al., 1993; Fisher, 1991; Jencks, 1994). Along with reports of mental illness in

this population, substance abuse reports lack comprehensive evaluation methods and actual rates of substance abuse may be higher. Drug and/ or alcohol abuse may compound problems for men and women who have psychiatric disorders. In this condition, known as a dual diagnosis, the individual has both a diagnosed psychiatric disorder and drug or alcohol addiction disorder. According to the Federal Task Force on Homelessness and Severe Mental Illness, half of the population with severe mental illness also suffers from a substance abuse problem (1992). The use of drugs and alcohol by residents is forbidden in most homeless shelters and transitional housing. This group becomes even more vulnerable as they are less able to secure safe shelter when intoxicated.

In a study of 581 homeless or drug-abusing minority women, Nyamathi (1991) found that homeless and drug-abusing minority women have greater somatic complaints and emotional distress but less social support than other populations. In a larger study with 978 homeless and drug-addicted minority women, Nyamathi and Flaskerud (1992) utilized the Community Based Inventory of Current Concerns and found that the women's greatest concerns were in their ability to function in the personal, social and religious domains.

These studies are some of the largest involving homeless and drug-addicted minority populations. The information gleaned from these studies is helpful in understanding the problems seen in drug addicted women in transitional shelters. These women would be vulnerable for future homeless experiences. The study does not separate homeless women from those living in transitional shelters. Considerations taken from these studies may include studying the efficacy of programs that would increase available social support and enhance the homeless's individuals level of functioning in the personal and social domains

Personal Violence

Histories of childhood physical and sexual abuse, as well as experiences of personal violence as an adult, have been identified as being prevalent in homeless individuals (Goodman, 1991; Hatton, 1997; Weitaman, Knickman, & Shinn, 1992). In a study of homeless and housed mothers on public assistance, Goodman found that 89% of the total sample experienced some form of physical or sexual abuse either during childhood or as an adult (1991). Frequently, the underlying theme of stories of homelessness is physical and/or sexual abuse (Browne, 1993). In Hatton's study with homeless women, one participant illustrates this point. When asked to describe her health as a child one woman remarked that she couldn't remember much from that time since her father was alcoholic and beat her and her mother(1997).

Personal violence histories are associated with mental illness and substance abuse (Browne, 1993). It is not surprising that qualitative research has indicated that the three psychological factors identified here as antecedents to homelessness are frequently present in the life stories of the homeless. A homeless individual may have none, or all of these psychological factors influencing her/his condition of being homeless.

Environment and Homelessness

The environment is an integral component of understanding how to help those living on the streets. In one innovative ecological approach to evaluating health risks of the elderly homeless, Reilly (1994) used the concepts of high risk area, space time geography and disease ecology in her study of 74 elderly homeless individuals. Reilly identified a number of factors that placed the homeless elderly at risk for health problems including:

> (a) closure of the shelter during daytime hours which forces shelter residents to relocate, (b) severe weather conditions and related exposure health hazards, (c) alcohol use outside of a place where the elderly can access sleeping quarters, and (d) traffic patterns at rush hour particularly in the evening when elderly homeless are traveling to the night-time shelter (p. 310).

Reilly suggests that her research findings have direct nursing implications for those working with the homeless by altering environmental risk factors and educating the homeless individuals about high risk times and areas (1994). While this study helps focus on the current health and safety of the homeless individual, more needs to be documented about the environment and the homeless. This study points out some clear areas of concern for nursing. However, more needs to be documented about the environment and the homeless in order to identify other groups at risk for danger while homeless.

In summary, the following factors were identified in this review of literature that are associated with homelessness: personal and social-economic factors; social factors; the environment, and psychologic factors. Noteworthy in this review of literature is the heterogeneous nature of the homeless population. The homeless are diverse in their family composition, gender, culture and array of associated conditions and problems such as alcoholism, history of personal violence and mental illness that may precede or accompany their homeless experience.

Conclusion

Stigma as conceptualized by Erving Goffman provides a lens to view society's understanding of the homeless and how the homeless relate to the larger society. The

"normals" of society view the homeless as less than human, and this viewpoint promotes barriers that prohibit the homeless from succeeding in their life experience. The homeless may respond to their stigma by passing as normal in order to maintain relationships and gain employment. Some homeless will never be able to overcome the barriers of the normals by passing. Given this stigmatization, it is truly amazing that some do transition into normal lives.

What is known about homelessness are the conditions that predispose individuals and families to homelessness including economic, social and psychological factors. In addition, research has provided descriptive characteristics and identified problems specific to the homeless that assist those working with this population. What is not known about homelessness is specific interventions that will facilitate transition to stable housing situations for homeless individuals and their families. Research that identifies effective interventions is urgently needed in order to provide practical solutions to the problem of homelessness. More needs to be discovered about this transition process from those who have done so successfully.

Chapter III

Methodology

Grounded theory was selected as the method for developing a theory of the process of moving out of homelessness. The ultimate goal of grounded theory is to construct a working and dynamic theory from the study data regarding the phenomenon under study. Grounded theory is a method which seeks to discover the derived meaning, contextual conditions and the interactional processes that surround a phenomenon from the participant's perspective (Strauss & Corbin, 1990, 1994). This study incorporates data from two seperate field studies, the first conducted in a west coast city, and the second in an east coast city. The data collection portion of the field studies were guided by the natural science methods described by Schatzman and Strauss (1973). The collection of each of these data sets will be described separately in this chapter. Schatzman's (1991) dimensional analyses was selected as the method for data analysis.

Data Collection

West Coast City

The west coast city shelter data was collected over a two year period by a nursing research team in 1994 and 1995 (Hatton, Bennett, Gaffrey, & Kleffel, in review). The focus of this field study was to find out about the services these area shelters provided and to determine how the shelter staff helped the clients with their health care needs. Following human subjects' approval, homeless shelters were identified in a United Way Directory as providing services to homeless women and children (Appendix A). All of the shelters listed as providing these services were contacted by phone by a member of the

research team. Ten west coast area homeless shelters agreed to have a member of the research team come to the shelter and interview the staff regarding their experience in working with homeless women and children. Over the course of the interviews, some of the shelter staff identified themselves as being formerly homeless. They related some of their experience of moving out of homelessness.

One or more members of the research team went to each of the shelters. Typically the shelter staff spent one to two hours answering questions from the research team and provided the team with a tour of the facilities. Informed consent was obtained from each of the study participants prior to the interviews (Appendix B). Using an interview guide, qualitative interviews were conducted with the shelter staff (Appendix C). The interviews were audio taped and some notes were taken during the interview process. Following the interviews and shelter tours, each interview team made observational notes describing the shelter and impressions of the shelter, the staff, and the clients present. In addition, theoretical notes were made that derived meaning from the observations noted (Schatzman & Strauss, 1973). This would often take the form of a discussion among the research group over coffee following the interviews. In keeping with grounded theory tradition, the notes frequently involved comparing findings in one interview as it related to previous interviews or constant comparative analyses (Strauss & Corbin, 1990, 1994). Interviews were transcribed verbatim and data analyses and collection took place simultaneously, thus keeping the emerging theory grounded in the data.

While observing the different types of shelter settings utilized by the homeless and while listening to the stories of the formerly homeless shelter staff, the researchers

identified a lack of information explaining how to help the homeless. This information included the stories of the formerly homeless and how their experiences enhance current understanding of homelessness, as well as how to help the homeless to become productive members of society. This interest in information regarding the formerly homeless led this researcher to become acquainted with a formerly homeless man who managed an east coast homeless shelter. This research continued to evolve inclusive of the west coast shelter work, and as an extension of the west coast shelter work by adding the perspective of the formerly homeless.

From the west coast shelter study, the ten shelters were described and contrasted. The stories of the two women who had identified themselves as formerly homeless were also analyzed from the perspective of their experiences of moving out of homelessness.

East Coast City

The east coast city data were collected by this researcher during the summer of 1994 primarily in a 1500 bed homeless shelter. Entry was gained into this setting by contacting the shelter manager by phone and sharing this researcher's interest in finding out about how people move out of homelessness into stable housing. The shelter manager knew of several "formerly homeless" individuals who he felt would be willing to share their experiences. The shelter manager also invited this researcher to come to the shelter and stay in order to conduct the interviews in the east coast city. Human subjects approval was obtained and arrangements made for travel to an east coast city (Appendix D). This researcher stayed in the east coast city shelter and collected data that included participant observation, and nine semi-structured interviews at the shelter and at locations outside the

shelter with formerly homeless individuals (Schatzman & Strauss, 1973).

Prior to the interviews, informed consent was obtained from each of the study participants (Appendix E). Using an interview guide, qualitative interviews were conducted with formerly homeless individuals as well as with shelter staff (Appendix F). Careful and thorough notes were taken during each interview. Following the interviews, observational notes were made that included a description of the setting, of the participant, and often of the feelings expressed by the participant that might not be captured on the transcripts (Schatzman & Strauss, 1973). In this study, time did not allow transcription of each interview for analysis prior to subsequent interviews since all interviews were conducted during the week long east coast trip. To address emerging themes, the researcher reviewed and analyzed each interview and observational note. Theoretical notes were made that identified emerging themes and differences in the experiences of the formerly homeless individuals (Schatzman & Strauss, 1973). These observations, consisting of nine sets of interview notes, and the personal experiences of this researcher while staying at the shelter were kept in a journal that comprised a 150 page book. The book was extremely helpful in the analysis of study data and was an additional source of data. A brief section in chapter IV highlights the study notes made in the journal.

All total, 11 formerly homeless interviews and 11 homeless shelters were included in this data analysis. Five of the formerly homeless participants were women and six were men. The age of the participants ranged from twenty-six to sixty-two years old. The formerly homeless had been living off the streets for as few as two years, and as long as thirty years. Three of the formerly homeless participants had more than one homeless

experience.

Data Analysis

Schatzman's (1991) method of dimensional analysis was selected for analyzing the study data. Dimensional analysis has philosophical underpinnings in symbolic interactionism (Kools, McCarthy, Durham & Robrecht, 1996). The interpretive process in symbolic interactionism, whereby individuals derive meaning from ongoing interaction with the environment and others, is termed "natural analysis" (Blumer, 1969). Schatzman asserts that dimensional analysis enables the researcher to discover people's interpretation and meanings of a phenomenon within their social world (Robrecht, 1996). According to Schatzman (1991), dimensionality is a cognitive attribute individuals use to derive meaning through interpretation of a situation or a phenomenon. These attributes of a phenomenon are referred to as dimensions.

Dimensional Analysis

As with many types of qualitative methods, data analysis and collection occur simultaneously in dimensional analysis. There are three distinct phases of the data analysis including designation, differentiation and integration (Kools, McCarthy, Durham, & Robrecht, 1996; Schatzman 1991). Each of these phases of data analysis will be described separately.

Designation Phase

During designation, the goal of analysis is to identify dimensions-- known as dimensionalizing. Dimensions are identified, named, labeled, and attributes of the dimensions are described. The question to be asked by the researcher during this phase is

"What all is going on here?" (Schatzman, 1991). This process enables the researcher to develop a vocabulary that describes the data (Schatzman, 1991; Kools, et al., 1996). Schatzman (1991) stresses the importance of obtaining a "critical mass" of dimensions that describe the phenomenon. After the "critical mass" of dimensions have been described and identified, the researcher will then proceed to the next phase of dimensional analysis--differentiation.

Differentiation

The second phase of data analysis begins after the "critical mass" of dimensions and their descriptive properties has been obtained (Schatzman, 1991). At this point, the critical mass of dimensions begin to provide some explanation for the phenomenon under study. The researcher now utilizes a tool to facilitate explanation called the "explanatory matrix" (Kools, et al., 1996). The explanatory matrix aids the researcher to move beyond describing the phenomenon to explaining the phenomenon. The explanatory matrix aided the researcher in moving beyond a description of the phenomenon to an explanation of it. The explanatory matrix "further differentiates the innate characteristics of identified dimensions into various conceptual components such as context, conditions, process (actions/interactions), or consequences" (Kools, et al., 1996, p. 318). The dimensions that facilitate, block, or shape action or interaction as viewed by the perspective are designated as "conditions". The dimensions that describe outcomes of actions are designated as "consequences". Dimensions that indicate the intended actions impelled by the prevailing conditions are identified as the "process". Finally, the dimensions that suggest boundaries to the situation or environment and give rise to the circumstances are termed "context".

termed "context".

During this designation phase, the researcher identifies the central dimension that provides the most salient explanation for the phenomenon under study. This central dimension is selected as the perspective as it gives the greatest explanation for the relationship among all the other dimensions (Schatzman, 1991). In this study, *crossing the line* was the dimension that explained how people move out of homelessness. It also served to explain that in this vulnerable population, the individuals and families may cross the line back to the streets and homelessness. The central dimension determines the organization of the explanation of the phenomenon. Crossing the line was a pivotal point in the lives of the formerly homeless from which they could live past homelessness.

Integration Phase

The final phase of the data analysis is integration. Integration of the data included clarifying the phenomenon under study by theoretical sampling and data saturation, thus ensuring that all dimensions are represented in the explanatory matrix. The researcher can then confirm that the configuration (perspective) and the relationships between the dimensions are truly representative of the phenomenon (Schatzman, 1991). The completed explanatory matrix provided a narrative of the phenomenon under study. The formerly homeless remained vulnerable to future episodes of homelessness. *Bouncing back: living past homelessness* and *giving back* provided a description of those activities and conditions that help the formerly homeless to be able to maintain stable housing.

Human Subjects Considerations

As described in the data collection section of this chapter, human subjects approval for

both studies was obtained from the University of San Diego Committee on the Protection of Human Subjects (Appendix D & Appendix E). In addition, study participants signed an informed consent document and allowed themselves to be interviewed for the studies. All study participants were willing to participate in the studies and were informed that they could drop out of the study at any time.

Potential Risks

Potential risks identified in the study included: (a) confidentiality, (b) privacy, (c) painful feeling associated with sharing the experience, (d) need for additional services identified over the course of the interview, and (e) fatigue resulting from the length of the interview. The following steps were taken to minimize risk to study participants.

Confidentiality was insured by separating any identifying data from the interview tapes and transcripts and storing this information in a locked storage unit. After interview tapes were completely transcribed, they were also stored in a locked storage unit. The use of selected quotes for the purpose of illustrating dimensions described in the data analysis was thoughtfully considered in light of maintaining confidentiality. Any quotes that could potentially identify study participants were eliminated from consideration for written publication. Privacy of the interview was easily maintained in the west coast study as most of the study participants had private office space in which to conduct the interview. Privacy was more of a challenge in the east coast interviews. Frequently, the interviewer took the study participant to a restaurant in order to find a quiet space, and one interview was conducted in a pickup truck.. Differentiation is based on coastal location of the cities involved in the study. In addition, pseudonyms were used for the names of the people

discussed in the description of the shelter. Specifically, Greg Harold and Dr. Green were substituted for participants' names in order to protect their confidentiality.

In the west coast study, no expression of painful feelings was related by the study participants over the course of the interviews. Arrangements for local counseling was available through the health center at the east coast shelter for participants who experienced any painful feelings or memories related to the interview process. However, none of the participants requested referral for counseling. In addition, the interviewer acknowledged the depth of feeling communicated by the participants at the time of the interview.

Chapter IV

Findings: The Shelters

The study findings in this investigation came from the following sources: (a) participant observation at one large east coast shelter, denoted as Shelter A; (b) participant observation at several west coast shelters, discussed as west coast shelters; (c) the investigator's experiences while staying at a large west coast homeless shelter, and over the course of conducting interviews at ten west coast shelters; (d) interviews with staff at several west coast shelters; and (e) interviews with formerly homeless individuals from both the west coast and the east coast. Findings from the shelters and participant observation are discussed here in chapter IV. These provide the contextual backdrop in which individuals and families are able to move out of homelessness. Findings from interviews with formerly homeless participants are presented in Chapter V. There, a substantive theory is described that accounts for how individuals and families move out of homelessness.

The West Coast Shelters

In the west coast shelter study, ten shelters were visited by a team of researchers. Staff at each of the shelters participated in the interviews. Following the interviews, the researchers were often given a complete tour of the facilities. Some of the shelter staff identified themselves as formerly homeless individuals. The shelters varied with respect to the following properties: (a) size and type of residence, (b) sources of funding, (c) shelter staff, (d) length of stay, (e) health services offered, (f) rules, and (e) programs available to residents. Each of these properties will be described as follows. All study findings reported

in this west coast shelter discussion represent the collective work of Hatton, Bennett, Gaffrey and Kleffel (1999).

Shelter Size and Type of Residence

The shelters varied greatly in the number of residents that were able to stay at the shelter. The smaller shelters had a limited capacity of beds and could only house twenty or thirty clients. The largest shelter was able to house as many as 1000 residents during the winter months. Some of the shelters were flexible and would try to accommodate extra numbers of homeless by adding mats to the floors in the dining room or other common areas in the shelter. In addition to varying in size, the shelters varied greatly in general appearance. Some resembled institutions in appearance with large dining facilities and dormitory style beds. Others simply consisted of a rural residential home where three or four families stayed in the same house. Some of the houses were for battered women and were known as "safe houses" where the women and children stayed without their identity being released.

Shelter Staff

The staff working in the shelters differed with respect to professional training and backgrounds. Some of the staff were professional social workers, whereas others had no professional training but were themselves formerly homeless. These staff felt this experience helped them relate to the residents. Still other staff had training in different areas such as human resources and psychology. The staff generally reported working long hours for little pay and were in it not for the money, but because they cared about the homeless. They had many responsibilities and their roles may have included: (a) counseling

the residents, (b) interviewing potential residents, (c) preparing and serving food, (d) helping residents relocate in other shelters or types of housing, (e) educating the residents about parenting and hygiene, (f) assisting the residents to access health care, and (g) assisting the residents with finding employment.

Length of Stay

The shelters also varied in terms of length of stay for clients. In some, a resident could only stay a few days–as short as three to five days in an emergency bed. Some of the shelters referred to themselves as transitional and the residents could stay for as long as three months or even two years. Residents in transitional shelters ultimately moved into other forms of more permanent housing. There was one shelter that provided long term "permanent housing" for the chronically mentally ill.

Shelter Funding

The shelters all had multiple and different sources of funding. Some received government funds for various programs offered. This was particularly evident in the shelters that housed battered women and children and was made possible by surcharges on marriage licences at the state level. Other shelters were run entirely on funding provided by religious organizations. In one of these shelters, women who were eligible to receive state assistance such as welfare, had to turn down the state assistance in order to enter the shelter. Other shelters were largely funded by private donations.

Health Services Offered: *Extra Work* of Shelter Staff

As stated previously, one of the shelters provided permanent housing for the chronically mentally ill. The staff reported substance abuse and physical and mental health

problems as health related concerns experienced by residents staying in these shelters. Some of the shelters did not allow residents with substance abuse and mental illness. One large transitional shelter had an elaborate health care program on the site. At this facility, medical services were staffed by nurses, physicians and dentist volunteers. In another shelter, a psychiatric nurse conducted interviews with potential clients. Two other shelters had volunteer nurses that provided services to residents or clients several hours a week. Some of the shelters had no health services available to them. One shelter had student nurses in community health nursing rotating through it as a part of their education experience. When asked about how the staff manage health problems of the clients, this shelter staff describes the role of the students and their professor as follows.

> Right now we handle it totally differently because we've got Florence [pseudonym] and her nurses here. Every week they're in the home and they're available. If someone got a funny this or a questionable that, there's our direct link.

However, when the university students are not available, the staff have to manage the health problems using their own resources as she describes here.

> If someone comes into the house that's obviously got something wrong, you know, if we can see it whether they can or not. If we notice a funny rash, or how you can tell with some people that something's wrong. As case managers, we tell [sic] them do you have a doctor, or are you seeing a doctor, you know, do you have any form of payment. . . . There's certain places that we are aware of that we have in our resource guide that they can go for certain things without [state funded] insurance. . . . There's not too many places that will see you except on an

emergency basis.

As this case manager describes, the emergency room is the primary source of health care utilized by the staff and clients to meet the needs of the homeless women and children.

> I don't know how other case managers feel. You know, none of us, it's not required to have any medical background. So, the way I feel is if it's after 5:00 o'clock, we'll go to the emergency room. . . . Any fall, basically any temperature, any sniffle, they went to the emergency room. . . . It's easier for the women to wait until after hours too, because when you have [state funded] insurance or you have to go to a clinic, you might sit there all day long. In the emergency room, you might sit there all night, but then you might luck out and sit there only a half hour. Sometimes it's just easier to wait for the emergency room.

This shelter is managing their clients' health care via the emergency room in the absence of available community health nursing students and on site health care.

Other shelters related much difficulty in getting the women with children to use appropriate health care channels such as community clinics. One staff member related the difficulty of sending a woman, along with her many children, on a bus to have one child treated for an ear infection. She waited an entire day to get treatment. In some cases, the women would wait and still not receive appropriate care their children. This was frustrating for the mother, uncomfortable for her children and hard for the staff who tried to assist the families to learn how to appropriately utilize health care services.

All of the staff viewed health care needs of the residents as *extra work* that exceeded their routine duties as homeless shelter staff. Although they were in a position to identify

potential health problems in their residents, they received no training to learn how to manage these problems. Most of the staff relied on their own personal and family experiences to guide them in directing how to advise the residents on health problems.

In addition to the health needs of the residents, the staff were unaware that they may be exposed to conditions like tuberculosis and should be screened for it. One woman depicts the lack of knowledge and/ or concern by the local public health nursing community. When asked if the staff were screened for tuberculosis, she responded as follows, "No, not here at the office. Our learning center staff all have to go through that. But that's through the state, or whatever their requirements are. . . . Are TB tests done at public health for nothing?" So even when state funded programs recognize the need for tuberculosis screening for those working with this population, local public health agencies have failed to follow through with the shelter staff in testing for this condition.

Rules

The shelters in this study had a range of rules or regulations that ultimately guided their operations on a day to day basis. A lot of the rules had to do with keeping order in their shelters. There were no shelters in this study that allowed substance abusers (either alcohol or drugs) as residents. One shelter staff states, "we have to ensure a sober and clean living environment for our women and children. We have to ensure that." In addition to prohibiting drug and alcohol use, some of the shelters did not allow residents to stay if they had untreated psychiatric conditions. Since many of the shelters housed children, they directed many of their rules towards ensuring the safety of the children in the shelter. The residents were expected to keep their living areas clean and perform other

chores to facilitate a communal living environment. If they were not able to perform their responsibilities, they may have to suffer consequences as described by this shelter staff worker:

> I guess what we do is work on a red dot system. I'm not sure that's the best, but it's really the best that we've been able to come up with. If they violate a rule, generally we'll give them a verbal warning. A reminder that you need to do your chore, and this is what the chore involves and then. . . sometimes they just don't want to do that and I guess they don't believe that we're really going to give them the red dot. If they get three red dots, then they could be asked to leave.

Not all of the rules were chore or community oriented. If the staff felt the residents needed a mental health evaluation, for example, they may make the resident's stay contingent on getting a psychiatric evaluation. As one staff member put it, "You need to have an evaluation or leave." In some of the shelters offering substance abuse programs, residents are routinely tested for drugs and one shelter staff member explains.

> We randomly drug test our clients and a dirty test isn't necessarily going to get them thrown out of the house. This is life. You spent 20 years using drugs, you don't stop in two or three days. You won't get more than one dirty test, I'll tell you that. If someone tests positive, they have to get into rehabilitation.

While the shelter staff was serious about maintaining the communal living rules appropriate for the setting, they would also bend the rules in a humanitarian way as described here. "A rule is a rule, but circumstances vary always, and it's 10:00 at night on a Friday night. They're [staff] not going to want to ask a mother and her little child to go

out on the streets."

Programs Available to Residents

Clearly, the larger shelters with more funding had more programs available to their residents. These programs included recovery from: (a) substance abuse, (b) education, (c) job training, (d) parenting classes, (e) counseling for abused women, and (f) bible classes for some religious affiliated shelters. Again, these services were dependent on funding sources as discussed previously. The smaller shelters had a difficult time accessing funds for large scale programs. The larger shelters were able to raise more funds and develop a broader range of programs to offer to their residents.

Summary

The west coast homeless shelters were as diverse in nature as is the homeless population they serve. From small shelters with relatively few programs and services to offer, to large centers with adequate health care and programs to facilitate the homeless individuals and families moving into stable housing, all seem to fill a niche in the community for the homeless. However, by learning that some of the shelter staff had themselves been through the experience of homelessness, it seemed obvious that another story that had yet to be told about homelessness. The additional stories would include the experiences of the formerly homeless and what they had to offer in explaining how to get out of homelessness.

Having just completed the interviews with the shelter staff, this ethnographer was referred to a formerly homeless man who managed a large facility on the east coast. The following ethnographic description and subsequent interviews obtained while staying at

the shelter flowed easily from our previous work with the shelter staff (Hatton et al, in review, 1999).

The East Coast Shelter: Shelter A

In Chapter 2, lack of affordable housing, economics, stigma, and deinstitutionalization of the mentally ill were identified as factors contributing to homelessness. These factors provide an explanation of the greater societal context, or, a macro view of homelessness. The west coast shelters visited provided a more in-depth look at homeless shelters in a large west coast city. The shelter variances were described earlier. In addition, some of the staff at the shelters identified themselves as formerly homeless. This became the incentive to take a more detailed look at life in the shelters, and the experiences of the formerly homeless in the west coast shelters.

The study findings presented regarding the east coast shelter, shelter A, provide a micro view, or, an intimate and personal context in which some of the east coast participants were able to move out of homelessness. The following account details the study setting in which many of the participants resided and made new lives for themselves at shelter A. Included in this account are the sights, sounds and other perceptions of this ethnographer as experienced over a one week period while staying at shelter A.

Background of Shelter A

Shelter A is a large three story building located just 1.5 miles from the center of a large east coast city. The building was previously a federal education building that had been abandoned and boarded up. In 1980's, Greg Harold and a group of homeless individuals recognized that the building could be converted into a shelter to house homeless

individuals. Greg Harold was an advocate for the homeless and had a charismatic nature that attracted Hollywood stars and influenced politicians. He was able to generate interest in the plight of the homeless. He felt that every human deserved to be housed in a dignified way regardless of personal problems or social disfigurement. He was distressed by the number of homeless alcoholics that died in the cold weather because of homeless shelter rules that prohibited their acceptance into facilities because of drinking. Harold negotiated with government officials in the 1980's to obtain a facility to use for homeless housing.

The current Shelter A building was claimed by Harold as a site for homeless housing . Along with other homeless individuals, Harold and his cohort proceeded to "de-board" the abandoned government building and move into this shelter. Although the government officials eventually agreed to give Harold and his group the building, they were unwilling to provide needed funds to renovate the building and make it habitable. Harold went on a hunger fast in front of the city capital. Initially, government officials refused to assist Harold and his group. On day 51 of the fast, Harold was taken to a local hospital near death. Finally, a high government official granted the funds needed by Harold and the homeless. The money for building renovation did not come until the late 1980's. In 1986, Harold and his group received $7,000,000.00 of federal funds to renovate the building. Additionally, money came from private sources to aid Harold and his group in constructing a state of the art homeless center.

Physical Layout

Physical Plant

At first sight, shelter A is a looming complex that occupies an entire city block standing

three stories high. The slate-gray exterior is cold and foreboding as are many of the government buildings in this large east coast city. Many individuals are milling about the exterior of the building, mostly African-American reflecting the composition of this center city population. There is one main entrance to the building. Upon entering the building, a staircase leads up to a communication center and then to the rest of the floors where residents and staff live. The building is fairly clean with linoleum floors and light painted hallways, the odor is musty and the lighting is dingy. From the entryway, loud voices, "boom boxes" playing rap music, and occasional shouting can be heard. There are 1450 residents at Shelter A including staff, residents and interns learning how to work in homeless shelters. The shelter, open for 24 hours, allows the staff and residents to work odd-shift jobs, including swing and late shifts. There are no restrictions regarding length of stay at shelter A, and some residents choose shelter A as their permanent, stable housing. Sixty-five percent of the residents at shelter A are working in the community.

The front desk area serves as a security point for the staff floor and the women's floor. A buzzer allows access to these areas. The rest of the floors are accessible by the main stairway. Each of the floors is designated for a certain population of residents. The men's floors are divided into three units. A separate women's floor houses women and infirm women. Another floor houses a drug and alcohol recovery unit. There are an additional 32 beds available for infirm men. Each floor has its own laundry facility, television room and dining space. One meal a day is served here which is supper. Exceptions are made for diabetics who eat three meals a day.

The beds are available on a first come, first serve basis. Residents volunteer to do the

chores on the floors and no one is forced or assigned to do tasks. There are no guests allowed with active tuberculosis. In addition, some individuals have been banned from the building for fighting. Additional rules in the community include no smoking in bed and no physical violence against others. Some clients drink in bed which is allowed. Illicit drug use is not allowed in the facility.

Men's Floors

The top floor houses the general population of homeless men and has 400 beds. Any homeless man can stay on this floor. The working men's floor houses 375 men. These are primarily the working poor who have minimum wage or part time jobs. These men cannot afford housing in this east coast city. Because some of them will eventually move into transitional housing, they are encouraged to save money for future housing costs. Racks and racks of bunk beds cover the floor along with short lockers that hold the belongings of each resident. There are no barriers or partitions for privacy while dressing. Noise carries across the entire space. On 1 south, 175 elderly and/ or disabled men reside. Men in wheel chairs live in this area as well as those who are developmentally disabled. The beds on this floor are less crowded, allowing for wheel chair access. Unlike the other floors, only about half of the beds on 1 south are bunk beds.

Women's Floor

Women stay on 1 north, where residents have more privacy, including fewer bunks and privacy curtains so that clothing can be changed unobserved. Each group of lockers and beds includes six bunks and corresponding lockers for each resident. A total of 300 women can be accommodated on this floor. Some of the beds have personal quilts or

blankets. Several of the lockers have pictures of children on the front. In the women's section there is a lot of ambient noise. Several radios, or boom boxes, blare and there is a lot of tension between residents which is expressed verbally. "You xxxxing bitch", is a frequent exclamation shouted out. The female infirmary, which includes five beds, is also located on 1 south.

Drug and Alcohol Recovery

On 2 north, there is a drug and alcohol recovery unit, a locked unit that houses up to 300 men and women. There are three distinct phases of recovery for the residents of 2 north. Phase I involves thirty days of structured living in a locked unit. Residents are not allowed off the floor until their detoxification time is completed. During this period, residents attend Narcotics Anonymous (NA) and Alcoholics Anonymous meetings (AA) as well as group counseling. Phase II residents move to the first floor and continue to live in a structured manner that includes AA and NA meetings and classes such as art, computer science, reading, and meditation. Group counseling is still an integral part of their program. At 60 days of sobriety, residents qualify for phase III. During this time the residents stay on the floor, get a job, and after a year, move to a transitional home. At the end of the program there is no pressure on the participants to leave. In fact, one participant has stayed four years, is sober, and is working. The program directors boast an 80% success rate for residents over the years their program has been in operation. The program operates at a low cost of 30 cents a day per participant .

The drug and alcohol recovery unit is run by two counselors, its only staff. Meal preparation, cleaning, and other activities necessary to maintain the program are done by

residents. Program directors attribute the high success rate to: low cost to residents, participants helping other community members, and participants do not work in the first 90 days which allows total immersion in the program. Entrance into the program is not easy. Future participants must collect thirty days of AA or NA meeting attendance as a signed record and then wait in a long overnight line outside the building each month for acceptance. Despite the program's high success rate and the low cost, the director's efforts to duplicate the program in other cities has been stifled by politicians who reportedly would rather pay for additional jail space than embark on this work of changing lives.

Health Care at Shelter A

In 1986, Greg Harold asked Dr. Green to start a clinic at shelter A.. Harold had already obtained some funding for building renovation, but had not raised enough money to build a clinic. Dr. Green looked at the building site and felt it would be a good place for university nursing students, as well as a clinical practice site for university faculty. With strong support from the university, Dr. Green was also able to get a major foundation grant to fund clinic development. Consequently, Dr. Green, Shelter A, and an east coast university collaborated to develop a health care center that fits the needs of not only the homeless in the shelter, but reaches out to the rest of the homeless community as well.

Services available at the clinic cover a variety of health and psychosocial needs. The clinic is staffed by registered nurses, nurse practitioners, physicians (including psychiatrists), dentists, and social workers. The clinic infirmary is able to house up to 32 men and five women who are too sick to stay on the regular wards, yet not sick enough to

require hospitalization. These are the only beds in the city available for sick, homeless people. Student nurses work in both the infirmary and the clinic. Self-care for the clients is emphasized strongly in the clinic and infirmary. For example, all medications taken by infirm clients are self administered, but staff provide instruction or assistance as needed. Also, a priority at the shelter A clinic is teaching which includes both health care and the appropriate use of the health care system. Dr. Green also emphasizes a "do no harm" operating philosophy. This includes ensuring the population stays free of tuberculosis by way of testing each individual that stays at the shelter. In addition to health care, social services are extensive at the clinic and help residents to connect with appropriate government and privately funded social service programs. One example is a separate social service who worker helps homeless vets to access their service related benefits.

Although health problems seen at the clinic and infirmary reflect those found in the general population, chronic conditions are not as well controlled. For example there are uncontrolled diabetic and hypertensive clients. Sexually transmitted diseases are prevalent, including chlamydia, gonorrhea, syphilis, and acquired immunodeficiency syndrome (AIDS). Skin conditions and infestations like lice, scabies, and cellulitis are common. Other routine health problems include colds, flu, and traumatic injuries. People with pneumonia are reported to be sicker and the illness course is prolonged due to lack of access to adequate health care. Residents afflicted with end stage AIDS are currently transferred to a nearby hospice facility. Shelter A is working to develop in house hospice beds for these individuals who develop family-like relations with fellow residents and staff. The director of shelter A believes that they will live longer and be happier if friends and

family can visit them during this time of their life.

The health care center extends services to the greater metropolitan area as they are able. They have offered immunization programs for children by mobile van. An innovative program in the summer involves a cooling center where a Shelter A van will pick up homeless individuals on extremely hot days and bring them to Shelter A. Here they are given fluids and observed for signs of hyperthermia. Clinic services are available for any local individuals and families who need assistance with health care. Everyday, an average of 75 people from the streets are seen in the clinic in addition to shelter residents. Thus, health care center and services offered are well utilized by the homeless.

Education at Shelter A

Education opportunities are abundant at Shelter A. The education building, separate from the main Shelter A building, is next door. Here, classes allow homeless individuals to complete their general education degree. In addition, a variety of other programs are available which include computer training, art classes, and even meditation classes. These programs, like the health care system, are well utilized by the shelter residents.

In the main shelter A building there are also opportunities for education. A chef's training program was started there by a formerly homeless chef. This program not only serves as the shelter's center for creating meals for its 1450 residents, but also has trained many chefs that have been successfully placed in jobs in the community. Again, this facility rivals any local large restaurant facility in modern equipment. Much of the food is donated to the shelter. Another program available is called Jobs for Homeless People. This program places interested residents in temporary or permanent jobs where they can learn

on-the-job skills. Many of the participants become permanently employed as a result of this program.

There is an extensive library in the main building where thousands of books are available for use by shelter residents. The library contains several tables and areas to sit and read or to use for quiet time. This was in fact the only place in the building where this researcher found it quiet enough to collect her own thoughts.

Additional Programs and Services

Along with the above mentioned services, residents of Shelter A have available to them programs designed to assist them with more permanent housing. Residents may be assigned a case manager if they choose. Case managers will assist residents with obtaining food stamps and other available government funded services. They will also help the veterans access programs designed to meet their special needs. Again, these programs are well utilized by the residents, but participants tend to be residents who have been there for a few months or longer.

Mail services are available not just for shelter A residents, but also for some 600 additional homeless individuals who need a mailing address. Many of the people that move on from shelter A continue to use it as their addresses. Additionally, clothing service is available for residents and other homeless individuals and families. The homeless can access shelves and shelves and racks and racks of clothing.

In general, the services are very comprehensive and help homeless people transition back to living in stable housing. With this help, the formerly homeless become productive members of society. When this ethnographer shared with the director how impressed she

was with the facility, he stated "Some places limit their services, but when another person is suffering, you can't do enough for them. That is what we're about."

Summary

The shelter A residents have every opportunity to access services and programs that would enable them to move out of homelessness and to become productive members of society. Since 60% of the Shelter A population works in low paying jobs and city housing is cost prohibitive for them, many use the shelter as their permanent residence. The health care facilities at shelter A are far advanced when compared to available services at the west coast shelters visited. The west coast shelters lacked both a comprehensive approach to meet the needs of the shelter residents, and the insight to reach out to the needs of the greater community. The rules and regulations so evident in the west coast shelter were noticeably absent in shelter A. However, the primary focus in the west coast shelters was with adults rather than with homeless families. The presence of children in shelters necessitates a more structured environment for the families to safely stay.

A Summary of Personal Notes While Staying at Shelter A

Since this portion of the results deals with this ethnographer's personal feelings, experiences, and notes, the formality of using the third person writing style will be dropped so as not to distract from the true intimate nature of the experiences at shelter A. The ideal study for an ethnographer (with roots closely linked to the art of anthropology), is one which allows entrance into the environment, the lives, and the world of those people and places of interest to the researcher. This was such a study. By graciously allowing me to stay at shelter A, the shelter manager allowed me to enter the world that the homeless

experience as they make the transition from life on the streets to living in stable housing. I felt privileged to stay for a brief period with these homeless and formerly homeless individuals.

Upon my arrival at shelter A, I realized that I was clearly an outsider. I was a single Caucasian American amongst 1450 primarily African American homeless men and women. At one point a homeless man who had been evicted from the shelter approached me and informed me that I didn't belong there. I knew he was right. I didn't belong there. However, for the time that I stayed there, I intended to blend in with the residents and, as much as possible, to experience their world. The second day at the shelter, the staff held a meeting to discuss if it would be acceptable for me to stay in the shelter and to talk with formerly homeless individuals. There was much discussion and debate about my presence. They were very concerned about my motives for staying and "conducting research." As I explained my interest in being there, I was able to share with them some of the study findings from the west coast shelters. They were not only receptive to what I had to share, but also seemed interested in how things were done on the west coast. Ultimately, they held a vote and by democratic process I was allowed to stay and conduct my study.

Immediately following the meeting, we broke up and spent the rest of that day picking up trash around the building. I readily joined in the cleanup effort, and soon found that some of the formerly homeless men were friendly and eager to share their experiences with me. They seemed to accept my efforts at joining their group, and I felt comfortable talking with the staff and some of the homeless residents. The shelter manager assigned one man to show me around some of the building. He then took me to see some of the things that

he felt were particularly important to the history of the building. This building was huge. Its halls were lined with art work, much of which was done by shelter residents, and some of the pictures were simply haunting. Depictions of people reaching out for help conveyed a sense of despair that some of the homeless must have felt as they tried to survive homelessness.

Perhaps because of the lack of wall divisions on the men's and women's floors, noise was everywhere. I often found it difficult to sit and collect my thoughts as I'd write in my journal or reflect on an interview. Some of the noise consisted of angry voices of residents arguing, and some of the noise emanated from numerous radios that constantly blared different types of music. At one point, I was sitting in a living room area and the TV was blaring cartoons so loud that I couldn't hear the person I was trying to have a conversation with. The noise level made sleeping impossible for me, but the other residents and staff seemed to be adjusted to it. I rarely slept more than two or three hours at night. Between the noise and sleeplessness, I found it difficult to think and focus on my work. I also found myself getting angry with the people playing the loud music. I could easily see how arguments would be a common occurrence as there was very little personal space, and the space I tried to create for myself was constantly intruded on by unwanted and uninterrupted sounds.

Since there was primarily one large meal a day, dinner was a community event. I ate on the floor with the shelter staff. Meals consisted of food cooked in the kitchen and food donated by bakeries and stores. The food was acceptable and it was also a great time for conversation with the staff. Here, they related their personal struggles, their successes, and

their frustration working with the residents. Many of the staff ate dessert first, followed by some of the main course. Cleanup was a group effort and everyone, including myself, helped with dishes. During the dishwashing, the shelter staff asked me questions about my personal and professional life. I made every attempt to be as open about myself as I expected them to be when sharing their stories with me. With the men, I found it easy to establish rapport, to laugh, and to share stories. With the women, I had a more difficult time having easy conversation. By sharing meals, chores, and stories, I felt and observed a tremendous sense of community among the staff and residents. A sense of family existed as staff and residents shared their daily experiences, both good and bad, with each other. There was often hugging for comfort and crying together. They also were able to laugh heartily and to share happy moments.

While attending staff and resident meetings, I discovered that the formerly homeless had a tremendous sense of purpose and belonging. For some, this was their home and their family. They thought, organized, and acted on new ways to raise monies and to ensure the survival of the shelter. They discussed political decisions that were being made that might affect their sources of funding. This was a surprise to me. Their awareness of events that might change the course of the shelter's existence was much higher than the level of political awareness I had observed in the west coast shelters. This may have been a lack of awareness on my part as a researcher in the previous study. Indeed, I was terrifically impressed with the staff's efforts to ensure that the shelter remained funded. In addition to being linked by their common experiences, these formerly homeless were also bound to the common purpose of ensuring the shelter's survival.

While staying at the shelter I also had contact with formerly homeless individuals elsewhere in the city. Sometimes, when I returned from the interviews, the staff would wonder where I'd been. I would then share some non-revealing information from my interviews, such as common struggles they had experienced when moving out of homelessness. In a fashion, I used these discussions to validate the theoretical notes I was formulating in my journal.

The time I spent at the shelter went quickly. It seemed like I had just gotten into a routine and then it was time to leave. On the last day I took photographs of some of the people I interviewed, and pictures of the building itself. The people wanted me to depict them working. They wanted to be seen in their "cleaned up condition;" some were in a suit and tie. That was the impression they wanted to leave me with, and the impression they wanted me to take to others to see. They were working, useful, had a sense of purpose, and were proud to show that to me and to whomever I chose to share my findings with. As I left, one of the men was singing to me and saying that he missed me already. That was a tremendous compliment for a researcher. As stated previously, I was privileged to stay at the shelter.

As a researcher, for a brief period, I experienced the conditions the homeless live in while attempting to move out of homelessness. In the following data analysis, I have related the experiences of the formerly homeless with an enhanced sense of depth and meaning.

Chapter V

Findings: The Experiences of the Formerly Homeless

Moving out of Homelessness: Crossing the Line

In chapter 4, the findings of the shelters were discussed. This revealed the context for moving out of homelessness. backdrop in which some participants would begin their move out of homelessness. This chapter continues the data analysis of findings in which the study participants moved out of homelessness. The following dimensions were the most salient for moving out of homelessness: (a) reacting to circumstances, (b) surviving, (c) crossing the line, (d) bouncing back- living past homelessness, and (e) giving back. Each of these dimensions will be described here in a chronological fashion as they related to the formerly homeless participants experiences. This does not mean that these dimensions are fixed and stable. In fact, some participants moved back into homelessness. This chronological presentation of the salient dimensions presents an organized discussion of the dimensions and their properties. In reading this discussion, it is critical to keep in mind both the macro, or greater societal context of homelessness, as well as the micro, or intimate contextual backdrop. The following substantive theory describes how individuals and families move out of homelessness.

Reacting to Circumstances

Becoming Homeless Abruptly

Although the formerly homeless each had their own stories about homelessness, becoming homeless was a matter of "reacting to circumstances". Some of the participants became homeless abruptly as did these women who left battering relationships. "I was

battered. I ran away. I left the apartment at 1:00 AM and rode the subways and stuff. I had one child," and, "My daughter was six years old and my son was 15 months, and I was unemployed but decided that because of a domestic conflict that I needed to leave." Another man simply states "Well, it's easy. All you have to do is become unemployed, then you become homeless. That's very easy." Another participant became homeless after a fire destroyed the family home, "We were reunited as a family but still homeless when a paternal aunt built a room onto her house which gave her enough space to have the six of us reunited in her home." For these individuals and families, circumstances allowed little time, if any, to make a plan for alternate living arrangements. For the battered women, their concern was a matter of danger for themselves and for the safety of their children.

Gradual Deterioration of Living Conditions

Other participants described becoming homeless as a gradual deterioration of their living arrangements. The following history related by a formerly homeless woman who spent two years on the streets of an east coast city illustrates this:

> It was numerous things. I had left home. I ran away from home. . . when I decide to move out I was sharing a room, an apartment room with a girlfriend. The lease was in her name. So, when she got tired, she didn't want to be bothered, you know, I had to leave, whether or not I had just paid my rent or not. So, like I was going from friends' house to friends' house, from this person's house to that person's house, from one man to another man, and eventually I wound up in the streets and too ashamed to go back home.

A man, whose father died, was unable to return to work. He eventually ran out of

unemployment funds and was unable to keep his apartment. He reacted to the circumstances initially by trying to continue fitting in with family and friends:

> I wanted to see my best friend so I went to this picnic and I know, well I thought that my clothes were somewhat clean. I realized by being at the picnic and people were in like more of a summer outfit than I was and my clothes were like really dingy and when I got there I realized that I was like dingy, didn't have any kind of a haircut and you know I realized no matter how much I did to it, it still looked unkept and I think that's when I kind of like said, well I'll just stay away from them people.

Another woman recounts her story of how homelessness happened as follows:

> It didn't really occur to me that I really didn't have a place to live or I really didn't have any place to stay. . .the things that led me into the homeless experience, I think it wasn't planned out, it just sort of happened.

These participants seemed to have less of a sense of urgency to their circumstances. Their gradual decline into homelessness even allowed them time to develop rationalizations for their situations, "I'm alright, I'm just taking my time to do what I want to do right now. I can handle this, I don't need all those comforts."

Regardless of how the participants ended up homeless, they reflected on events leading up to becoming homeless as circumstances that they reacted to such as: lack of housing, losing a job, avoiding a battering, eviction from housing, and the effects of drug and alcohol use. The individuals and families reacted to circumstances that left them homeless. The next important feature of their experiences was to survive as homeless.

Surviving

Although the focus of this research is not the experience of "being homeless", as the formerly homeless individuals related their stories about being homeless, it became clear that describing some of the events that made life on the streets difficult needed to be described.

Positive Features of Homelessness

Some of the early experiences of living on the streets had positive features. There was a decided relief for some that they no longer had to work or attend to prior responsibilities, as this man relates:

> When my father died I didn't go back to work for about two weeks because I was supposed to go back to work a week later and I just called up and told them I wasn't coming in. I really don't want to go back to work at all, I don't want to face people. . . .

As time went on and he attempted to re-enter the work force, he sent resumes and tried to go for interviews, but was unable to successfully hunt for a job:

> I was trying to get a job and I remember going there cause I thought, "Now this I can do, this I fit in". I went to the building and I didn't like the building, in my mind it just said "perfect" and I would just turn around. . . . I didn't want to go through that interview process of selling myself, just give me the job, don't ask me no questions about me. I don't think I could have sold myself then cause I didn't want to be bothered.

Losing his job, being evicted from his apartment, having his car repossessed, and being

unable to gain employment, he found relief and a sense of freedom, "I'm just doing this because this is what I want to do you know I'm free now, I don't have to worry about this or worry about that."

Avoiding Harmful Relations

For some of the formerly homeless, freedom and relief came from gaining distance from bad family relations as this woman describes, "At that time I decided my family didn't exist, and that was a good thing for me to not have to worry about that or to try and to just separate myself from that was good." Certainly for the women leaving battering relations, getting away from destructive relations was a positive step. This formerly homeless and single parent moved from house to house of willing friends and family after leaving a battering situation. She describes her difficult but positive move, "I was always moving to a progressively better situation, but I needed to move three times within a nine month period." Some even felt a strong kinship with other homeless individuals that was better than previous family relations as this formerly homeless woman describes, "Yeah, I felt more comfortable with those people than I ever did with my family, and I don't even know who these people were." So, becoming homeless was often a welcome relief from difficult or dangerous family relations.

Avoiding Legal Difficulties

Finally, homelessness may have provided an escape for unfinished legal circumstances or a means of avoiding arrest. One formerly homeless woman describes her precarious position as follows.

> I stayed at the. . . shelter. So, I stayed there and I started working for them there,

> cooking in the kitchen, and we would get paid for that, and I still didn't do right cause they wanted me to save money and I didn't. I was into drugs and alcohol. Eventually, the job faded out and I ended up with no money. When I was over there, police came running around arresting people and kept watching the house, so I was just walking the streets.

Another formerly homeless individual states, " I had a DUI that I never took care of so there was a warrant out for my arrest." In these circumstances, the positives of avoiding the law eventually gave way to fear of being caught and arrested. This formerly homeless woman and her child lived in fear of arrest while hiding in the subway, "I can remember riding all night back and forth hiding from subway police so I wouldn't get caught and put in jail or something like that."

Surviving as a Struggle

Despite any positive effects of being homeless, eventually this group of formerly homeless individuals found that living on the streets was a difficult struggle. Physical condition gave way to unbearable fatigue for many of the formerly homeless. "I got so tired of walking the streets," stated one woman. " I would just drag myself to the library and act like I was reading something and lay my head down," stated a formerly homeless man. Another woman states, "I was very tired and my fatigue level was very high." In addition to fatigue, weather conditions played a role in the struggle to survive for some as this formerly homeless man describes:

> I already had anxieties and it just grew and then I guess it got so unbearable, it was so cold. This was in March and it was cold and the way I used to sleep on this grate

> was I would sit up. . . and then lay down for a little while, and it was a constant trying to stay warm in the middle of this wide open space, just constantly trying to stay warm.

Surviving in the colder weather was more difficult, and when combined with fatigue, some of the formerly homeless were forced into seeking some form of shelter.

Crossing the Line

Despite the circumstances of becoming homeless, all of these formerly homeless individuals and families eventually crossed the line of homelessness and unsafe living conditions and sought assistance of some form. The type of assistance may have been in the form of a homeless shelter, government assistance, or subsidies of friends and family. These experiences are illustrated in the following cases.

Homeless Shelters

For some, seeking help from shelters was chosen as a means of survival. One formerly homeless woman speaking of going to the shelter stated:

> This was kind of crossing a line for me 'cause I realized at some level, although I don't think consciously that I needed to do something different if I was going to survive. . . I was really fatigued when I went to the shelter, and I needed some physical rest.

One formerly homeless man resisted moving to a shelter. Both he and his wife were homeless. After a few nights staying at the local bus station overnight, his wife decided to go to the local homeless shelter. Although he would go and visit her at the shelter, he felt strongly against moving to the shelter himself. He related his fears about going to a shelter:

> I don't need no one to watch out for me, I just don't want to be in there and people got lice, they got this, this, and this. I stayed on the streets because people on the streets would say certain things and then when I would go eat in soup kitchens, I would hear certain things.

Later, he gave in to the cold and fatigue:

> When I went to visit my wife one day it was cold, it had been a real miserable night and I hadn't seen her in a while and she was upset and she looked at me and said, "You look tired, why don't you just lay down?"And her uncle he was there and he said, "Look I'm running the men's floor, I'll just get you a bed and you can just lay down on the bed and if you want to go back you can go back" So, I laid down and when I got up there was a shower and I took a shower and I had a meal.

A formerly homeless woman who had been walking the streets also relented to the fatigue of surviving on the streets and crossed the line to get assistance in a shelter. She said, "Well, I got tired of sleeping in the streets, sleeping from place to place so I came down here [the shelter] and got a bed." Another homeless man sought shelter rapidly after becoming homeless due to the cold weather, "It was about 20 degrees out and I had to go somewhere." As this woman describes, after an agonizing decision to enter the shelter, she found the time she needed to determine what to do for herself:

> I don't know what would have happened to me if I hadn't had that little reprieve so that I could have a minute to think about what the hell I needed to do and it gave that, even though I wasn't there for a long period of time. But, there was some things I didn't have to worry about-- where I was going to sleep or what I was

> going to eat that night-- and I had a little time to think about what I need to do. I got enough rest to where I could stop and look and think I probably needed to get a job or something or some way to support myself.

For these formerly homeless, finally entering a shelter provided the rest, warmth, and food they needed, and an opportunity to begin to figure out "where to go from here."

Government Assistance

For other formerly homeless participants, crossing the line of being homeless meant getting help from government programs. One formerly homeless woman with a child attempted to get public assistance as she describes her story:

> Yeah, see I was a teen-aged mother here and I had children. . . I was trying to get public assistance and that's how I got off [the streets]. . . . But, I had to keep going back and. . . going back and they had to send letters everywhere in the world and I was still out there with really no place. Finally this friend of mine got me into a--it was like a hotel where welfare mothers stayed. We shared the kitchen and everything else.

Her story reflects how difficult government programs may be to access for homeless women with children on the street.

Family and Friends Assisting

Still, other formerly homeless women with children needed the help of family and friends to get restarted after leaving a battering situation. "I had support from my father and from my family. The support system really carried me." One woman's child helped her to cross the line as she describes here. "Daddy is mean, we need to go, let's move." Many of the

formerly homeless reported that friends or family influenced them to go into shelters as this woman describes:

> I was just walking the streets and so a girlfriend of mine that was staying down here, we were very good friends, and she wasn't into drugs or anything, but when she saw me she would give me some money and then she told me I had to stop doing that. If I wanted some help I had to come down here [to the shelter].

Another woman's aunt had a room addition built onto her house to aid them following the destruction of the family home by fire.

Despite having different circumstances that led them to homelessness and different means of surviving, all the formerly homeless crossed a line to a different and new way of living. Some lived in shelters, some moved into government funded housing, and some had the help of friends and family to start new ways of living. Having crossed the line, they started a new experience, they were moving out of homelessness.

Bouncing Back--Living Past Homelessness

The formerly homeless varied in terms of how they lived once they crossed the line and moved off the streets. Some of the formerly homeless lived temporarily in shelters and then moved into other forms of housing. Others stayed in shelters that had no time restriction and the shelter actually became their stable housing. Some participants, who had government, friends/ or family that subsidized their living situations, stayed in these temporary arrangements for a length of time and then moved into their own housing. In addition to variance among the ways the formerly homeless lived, their experiences differed with regard to situations that would impact their ability to secure work and stable housing. Some

participants revealed struggles with substance abuse and depression that affected their ability to "bounce back" from homelessness.

Stable Housing and Work

Finding stable housing and work were the most urgent problems facing the formerly homeless. Some participants entered shelters that had limited stays, sometimes as short as 72 hours. These brief stays made it more difficult to find stable residence to find a job in a short period of time. This formerly homeless woman's stay was not only brief, but limited in the hours she could actually be at the shelter:

> I had a meal and I wasn't sleeping by myself in a bed, but there was a bed. You had to leave right after breakfast in the morning and then you had to be gone until later in the evening like around 4:00 or 5:00.

During her limited stay at the shelter, although this woman was able to find a minimum wage job, she ended up sleeping back out on the streets:

> The other things I looked at was trying to find some kind of organized place to stay rather than a shelter-- cause at the end of that time I ended up going back to sleep in the streets, even though I had, well I didn't get a paycheck for a while for one. But, even though you're making a minimum wage, particularly in the downtown area, it's really not enough money to get a place to stay.

Some of the formerly homeless ended up working in the shelter and going on staff. These "staff" residents at the shelter had a private residence in the top floor of the building and were paid a "small stipend." In exchange, they worked thirty hours a week in a variety of staff positions that at Shelter A. There aren't many staff positions that come available. Some

of the staff choose Shelter A as their stable residence. The following formerly homeless woman lived and worked at the shelter for years:

> On one floor I stayed this woman had, she was working, and she had sores all up and down her arms, I started to complain because you're not supposed to be even working down there with sores, especially with sores. I could not have her get away without the gloves. So, she got angry and she said "Well if you want to run this kitchen come on in here," and I said, "Sure." So I started out like that. I just ran the kitchen. . . and then I got a room downstairs. She [a staff member] put me on probation. I didn't go upstairs for almost a year and a half. So, I was on probation and eventually I made it on staff. I've been on staff for years.

This woman credits being able to live and work in the shelter to keeping her alive. "I know if I hadn't been here, if I hadn't gotten any help in here I don't think I'd be alive right now." This woman, who is HIV positive, has made this shelter her permanent residence. "I don't know how long I'm going to be around or whatever. I don't know how long I'm going to be here. I mean, nobody knows." Another man related his experience going "on staff" by saying, "I volunteered for maintenance, you know, keeper of the building. I became a staff member. I have no complaints about the shelter. I don't mind giving back for my room, for staying there." For some formerly homeless accustomed to living and working in the shelter, moving outside of the shelter would be difficult. One formerly homeless man on staff stated, ". . . every now and then you go, I want the house, but do I want the headaches?" Some formerly homeless stressed that the combination of high housing costs and low wages affect their ability to secure housing as this woman describes. "Some people

don't pay much. You know, the rent is like $400 to $500 for a one bedroom, and then you got to pay utilities. So even if you're out there working . . . I'd have to eat off my $18"

Other participants, who had utilized government subsidies or had assistance from friends/ or family struggled to find permanent housing. It took nine months for this participant to find an apartment for herself and her children. During this time her main concern was as stated as follows:

> Really finding a place, an adequate place. Needless to say one room for three people, a mother and two children, was not adequate and finding a job so that I could take care of myself and the kids as a single parent. Those were the concerns: getting work and finding adequate place and making sure the children were cared for so that they were not too adversely effected by the break-up.

Drug and Alcohol Problems

Some of the formerly homeless struggled with drug and alcohol problems in order to stay off the streets as this woman describes:

> I was just using this place at first for a place to sleep-- this was in the early part of '90. At that time we could drink in the building. I forced myself to stay in. I stayed in for six months, I didn't go outside. I wanted to stay away from-- the only places I knew to go were places to get high, so I stopped smoking crack. When I stopped smoking crack it would increase my alcohol. Every time I got a craving for it, I would have a drink. I'm getting a little bit better with alcohol, I still drink a little bit.

Another formerly homeless man who was homeless for18 months related his success in stopping alcohol. The alcohol use resulted in getting him fired from his job and ultimately

led to his homelessness. "I got caught drinking on the job one morning and that's how I lost my job, drinking, missing work and so forth and the boss just got tired of it. . . . I'm sobered up and ready to get into the work force."

Depression

Some participants reported suffering depression as part of their experience of moving out of homelessness, and in some formerly homeless, depression continues to be a struggle. One woman who has suffered from depression throughout her experience states, " Sometimes when I get real depressed, I just don't care no more, I sit and drink." Another formerly homeless woman claims to still suffer depression about her homeless experience even thirty years after the event:

> Oh, I've had a lot of depression, shame too, but mostly depression. I know some of it comes from having been raped and battered by my stepfather as a teen, and also my husband beating me. I also worry about my daughter and how being homeless affected her-- I think she is overly religious so she doesn't have to look at her own life hardships. But I still get depressed about it. You know the African American culture doesn't favor psychotherapy as an intervention-- you should get over it. So, I never really got any help for the depression.

One formerly homeless man relates how his depression played a role in his experience:

> I didn't think I suffered from depression when I became homeless, you know I didn't see it. [My father], he was suffering from cancer for about six years, and the doctor at the time had given him about six months to a year to live. When he died, I was numb, like I didn't actually hear that it happened and as we went through the funeral

> process, the pain, and all that and still I was numb and I think I came out of it numb. I remember knowing the biggest problem was going back to work.

He still describes feeling depressed over the death of his father, but now, as formerly homeless, he is able to do his work and has stable housing.

As related in the above experiences, personal struggles such as depression and substance abuse were are a part of bouncing back from homelessness. For some, these experiences are ongoing, lifelong struggles. However, it should be noted, as this participant points out, that these are not the only issues the formerly homeless faced:

> There are people that are alcoholics, have substance abuse problems, and they have a house and they're maintaining a house. It's something else that separates the people that are homeless. We can't make it in society.

Living Skills

For other formerly homeless individuals and families, additional living skills became an essential part of living them. Training and education needed to move out of homelessness took time. Some were able to access job skills training while staying at the shelter as this formerly homeless woman describes:

> I went through this place called XXX Manner, and so they were hiring nursing assistants and they had this in-house training and I had to go through orientation and I had to pass a couple of tests which I did and that's the first place I worked as a nurse's assistant.

Another formerly homeless woman, who was single and had children, was able to obtain a scholarship to attend college and eventually completed her Masters in Social Work. She

relied entirely on government subsidized housing during her education which took a number of years to complete. Currently, she runs her own successful social service agency that provides aid to families living in transition following homelessness. One formerly homeless man now describes working with homeless individuals as incorporating life skills as a part of living past homelessness:

> [What the homeless need is] I guess some type of life skill, training in school. It amazes me how many people don't know how to manage their money. I know people who. . . [when asked] what you going to do with your paycheck, and they say, "Well, I'm going to spend it on something", and you say well what about your rent? And they say, "Well, my rent is not due until such and such date and I'll get another check before then."

Another formerly homeless woman felt her ability to bounce back from homelessness was related to her level of education. While contrasting her own experience of leaving a battering situation with her mother, who stayed in a battering situation, she describes the difference as follows:

> The other reality is that educationally and in terms of potential earning power, I was in a better position than my mom who had less education. I had my master's degree and had great earning power. And I think about that now. A lot of what you go through is based on not having dollars to take care of yourself. A lot of folk who been homeless . . . were able to rise above it because they got the right job, [were] making the good money that they could eventually bounce back.

For the formerly homeless who related their experiences, learning job skills, having or

obtaining education, and learning other life skills such as managing money made it possible for them to live past homelessness.

Giving Back

Having lived past homelessness, some of the formerly homeless related the importance of "giving something back" Some of them felt very committed to the homeless and elected to spend the rest of their lives working with other homeless individuals and families. Others worked in volunteer capacities with the homeless or donated funds. Study participants also shared their wisdom and experience as they reflected on homelessness.

Many of the formerly homeless have dedicated their careers and lives to working with other homeless as this west coast shelter participant describes:

> I spent four years in the military working as a legal officer, but after that I jumped into a different field, human resources. And it was during that time that I became a homeless individual myself. So I learned of my place of employment through my homeless experience because I went there. I got food, I got toiletry items, things of that nature. . . . So, it's kind of neat that years later I'm able to work here. It's very realistic, and I can relate to these women.

Some formerly homeless contribute financially to support others moving out of homelessness. This formerly homeless woman, who runs a transitional shelter for homeless families, started a new program for her residents that was partially funded by previous clients. "I can say that $5,000.00 was given by formerly homeless people." As she describes, the return of investing in this population can be great:

> What I . . . tell them on terms of returns on investment, . . . [is that] in terms of

> homeless folk who are now working, that we have a million dollars in combined gross salaries and they're contributing to the tax base. . . . People can be lifted up and can be returned to the community as contributing tax payers.

In addition to giving money back to the programs that help them move out of homelessness, she states that some formerly homeless volunteers, " run groups, they do picnics, they do clean--ups of the same facilities that they stayed in."

Some formerly homeless staff at shelter A spent a good deal of time organizing politically to determine how programs could be developed to assist shelter residents. In addition, one staff member was running for political office to better represent the homeless and their needs. Based on their experiences, the formerly homeless developed some new approaches to helping homeless individuals and families to transition into stable housing. One social worker developed a specialized social service program to aid homeless families in transition that the government contracts with. With her program, she evaluates each family to determine what current needs they have for food, clothing, and other supplies such as diapers. She also assists them by "Developing interventions for each family to prevent further episodes of homelessness." She emphasizes that these programs have a positive impact not only for homeless families, but also for those people who give to support these programs, "And nobody needs to feel guilty about just putting services in place that pro-actively and positively empower people to regain control of their lives."

Reducing the Stigma of Homelessness

Working to reduce the stigmatizing effects of homelessness was important to this social worker who runs her own shelter. She relates her thoughts on the complexity of

homelessness which is compounded by the stigma of being homeless:

> I have a problem with somebody being labeled homeless as opposed to being labeled just a person who needs some help, because the reality is that most of the folk who are homeless are much more than just homeless. They are chronically unemployed. They have serious physical health issues and mental health issues and substance abuse and all of that stuff rolled in together which perpetuated a condition of dysfunction and poverty and yet, they get labeled homeless and stigmatized, and folk throw rocks at them and they don't want shelters in the neighborhood, its so very complex. But it is indeed stigmatizing.

For her, creating an image of the formerly homeless people who have successfully moved out of her shelter included advertising that presents them in a different light. She states, "I have a beautiful picture of a family with the children and the mom smiling who are happy because their needs are being met and they're not homeless anymore."

Solving Problems of the Homelessness

In addition to giving their time, money, and commitment to help other homeless individuals and families, the formerly homeless related ideas they felt were important to the homeless. Most felt that the homeless needed additional assistance with affordable housing and work. The following comments reflect these concerns. "Well, for one thing there wouldn't be as many homeless people if there were more affordable housing," and, "We need to increase our public housing numbers. There is just no public housing. There is a waiting list that is so long." Many advocated that the idea of "warehousing the homeless" was not a housing solution, "Just trying to make sure that people were in out of the

inclement weather and got the basics of a meal and a roof over their heads isn't enough."

The formerly homeless shared concerns about the homeless mentally ill who lack appropriate shelter. One man stated, "Society doesn't have enough places where people mentally ill can go." Another formerly homeless man expressed his thoughts on the mentally ill:

> I believe that the hospital, the mental hospital is turning out people when they're not ready to come out. That's when you see most of the people out on the streets. You know, they don't trust anybody no more, . . . [they] won't go to a shelter even in bad weather.

All of the formerly homeless expressed the sentiment that the homeless deserve some compassion and a chance at improving their lives. One formerly homeless woman shared her ideas on this:

> For one thing people ought not think of them as just dirty people just because you see one [dirty homeless person]. If everybody just stopped and just gave them a chance, maybe two out of ten, if you gave them a chance, their gonna mess up more. But that's not going to be the majority. Get them some clean clothes, hot bath, shave, or whatever and get them to warm up and give them a chance to feel like somebody. To go out and do something for themselves.

Another woman describes her experience with a young man who lived and worked in her shelter:

> What if we hadn't found Joe and had the opportunity for Joe to regain himself by offering substance abuse treatment in the shelter where he showed up just for a bed

for the night? He was a diamond in the rough, and how many are there?

One formerly homeless man stated his feelings about the treatment of the homeless very simply and said, "They should be treated like other human beings."

Finally, for some formerly homeless, their own experiences impact the way in which they feel the formerly homeless can best move past homelessness. One man stated strongly his purpose and ability to work effectively for the homeless based on his experience. "I believe I became homeless for a reason. You know, for me to learn what I learned, and for me to try to be a voice for homeless people and an advocate for them." A formerly homeless woman shared her sense of empathy. "Well, I have been through it so I know how you feel when you are afraid of what tomorrow will bring because you don't have a place and you don't have the resources to make that happen." Yet another formerly homeless shelter staff related his ideas as follows:

> We can't have clinical case managers. It's too negative cause remember most of us are formerly homeless and one of the biggest barriers we ever ran into was the case managers. We use what is called a strength method of case management. When you come in we build on what positives you have. We don't care what it is. Good health? Fine. That's a positive, let's build on that.

The formerly homeless feel they know more about what the homeless need than someone who has never been homeless.

Summary

In summary, moving out of homelessness was the perspective that explained the conditions, actions, and processes with the related consequences for those individuals and

families. Five dimensions were revealed as the most salient with regard to moving out of homelessness. The dimensions included: (a) reacting to circumstances, (b) surviving, (c) crossing the line (d) bouncing back-- living past homelessness, and (e) giving back. These dimensions are summarized briefly as follows.

Reacting to circumstances describes the events which lead individuals and families to become homeless. Some become homeless abruptly when they leave battering relationships, lose a job, or family housing is destroyed by fire. Others have a more gradual deterioration of living conditions that eventually results in homelessness. Long term depression and the debilitating effects of drug addiction are examples of this gradual deterioration. For these participants, reacting to circumstances resulted in homelessness.

Surviving homelessness describes the conditions and circumstances under which the homeless live. Some of the homeless live on the streets, literally sleeping in parks or on downtown streets. Other homeless individuals and families seek refuge by moving from house to house of friends or family. Still other homeless hide in the subway at night as a way to survive. There are positive aspects of homelessness. For some of the homeless, being out of dangerous relationships provides a sense of relief. Others are relieved not to have to face work responsibilities. However, difficulties of surviving homelessness, such as severe fatigue and cold weather, may make seeking shelter necessary.

Crossing the line is a definitive point where homeless individuals and families move into a new and different way of living. If harsh weather is unbearable, individuals are forced to seek shelter. For families moving from house to house, ultimately having to cross the line to get assistance is often needed for more stable housing. In this case, government assistance in the form of subsidized housing and welfare may be sought. Friends and families may also

provide financial assistance for them. Friends and family of the homeless who are living on the streets may also encourage them to enter shelters. Some of the homeless cross the line into shelter, and cross the line back to homelessness.

Bouncing back-- living past homelessness includes activities that the formerly homeless engage to help them maintain stable housing. Finding work and adequate housing are the key features of bouncing back. Some formerly homeless go "on staff" and live and work in the homeless shelters. For these individuals and families, the shelter is their stable housing. Other formerly homeless move into more traditional housing arrangements by getting their own houses or apartments. Some of them struggle with drug and alcohol addiction as a part of living past homelessness. Once sober, they are able to seek employment and to find housing. Other formerly homeless individuals need job training and education in order to secure employment. In these cases, training and education may take years. Occasionally, the formerly homeless have education and job skills prior to their homelessness that enables them to work and to secure stable housing more readily. Depression and substance abuse problems may continue to affect the formerly homeless.

Giving back is important for many formerly homeless. Some commit their lives and careers to helping others who are homeless. Others give donations and volunteer time at the shelters where they received help. Returning to the work force and paying taxes into the system is one way that formerly homeless give back. Still other formerly homeless go on to develop programs geared to help homeless individuals. The formerly homeless feel strongly that homeless people should be treated with compassion and given a chance to improve their lives.

As described above, moving out of homelessness is depicted in the following

integrative diagram. As mentioned, these dimensions are not fixed and stationary, but rather are markers in the lives of the formerly homeless. Lines in the diagram are not unidirectional. As does the rest of the population, the formerly homeless remain vulnerable to circumstances that may again lead to homelessness.

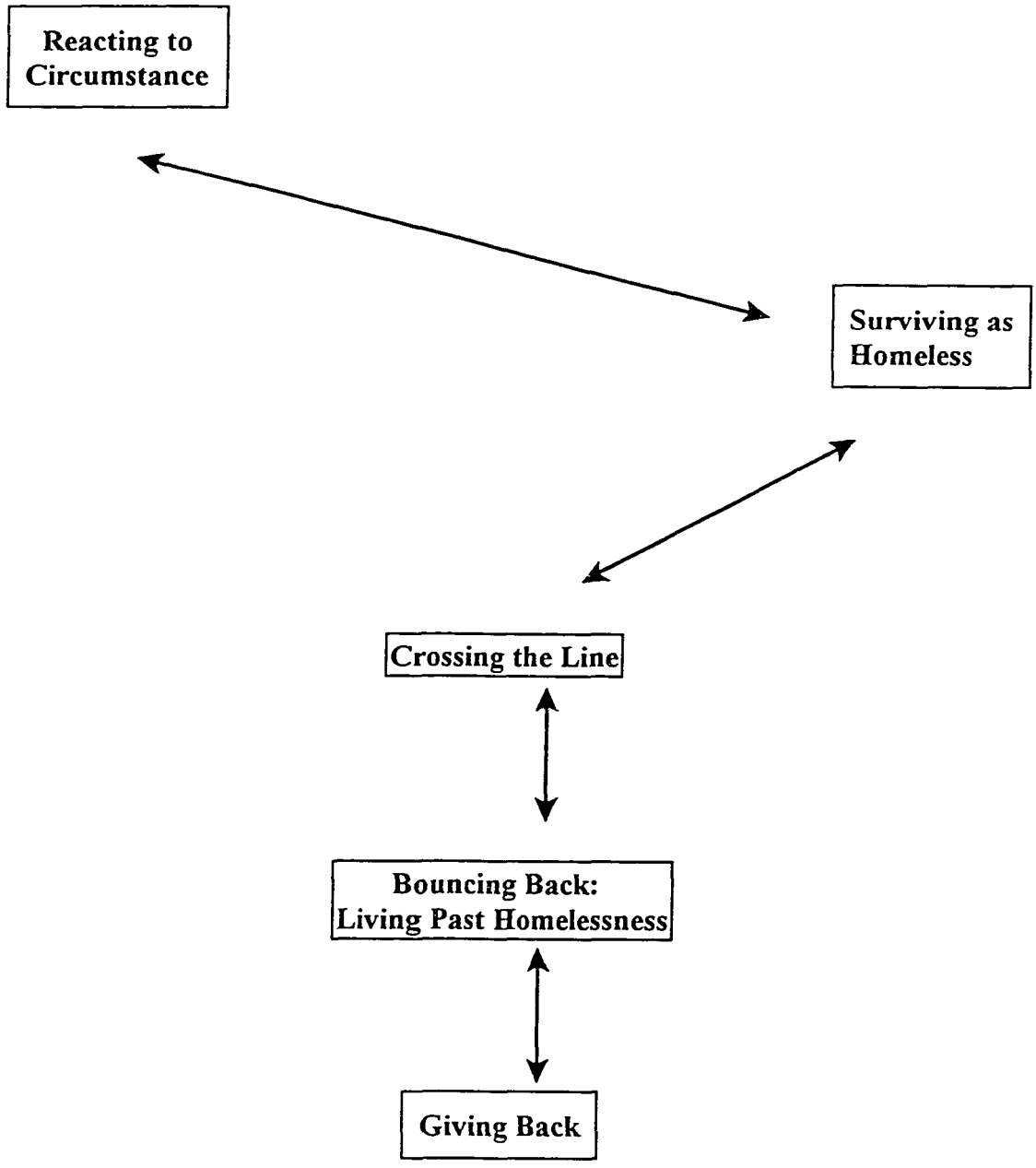

Figure 1. Integrative Diagram: Moving out of Homelessness

Chapter VI

Discussion of the Study

The purpose of this grounded theory study was to explore how individuals and families move out of homelessness. The findings of the study provide an account of what is involved for homeless people to move into stable housing. The strengths and weaknesses of the study are highlighted in this chapter. Theoretical findings, the relationship of the study findings to the literature, and implications for nursing research and practice are discussed in this chapter.

Strengths of the Study

The opportunity to stay in the east coast shelter gave this study an additional emphasis on the environment that was not readily apparent even after visiting 10 west coast homeless shelters on more than one occasion. Experiencing first hand the sounds, sights, noises, and other environmental stimuli homeless individuals staying in shelters gave this ethnographer a different sense about the homeless than what can be obtained by interviews alone. The experience of staying in the shelter also permitted this ethnographer access to formerly homeless individuals who may not have considered an interview. Because I shared their living space, helped them in cleaning up, picked up trash around the shelter, and shared meals with them, many participated in the interview process.

In addition to staying in the shelter, having visited many shelters gave this ethnographer a sense of how many shelters operate, develop programs for the homeless and fit in with the respective communities. Thus, giving this study a broad range of shelter experiences to draw from. This was particularly noticeable in looking at health care provision for the homeless. Interviewing the director of the east coast shelter provided an in depth account

of what it takes to deliver ideal health care for a homeless population from the ground up. Finding sources of funding for the clinic, and uniting a school with the project in a mutually beneficial way was an exciting nursing innovation that can be replicated in many cities. It also highlighted the need for strong, creative, and powerful nursing figures that are dwindling in this age of managed care.

The quality of some of the interviews was possible only because the formerly homeless participants and shelter staff made themselves available on more than one occasion for lengthy interviews. Thus, verification was establishing by checking out the accuracy of previous interview results in subsequent interviews.

Weaknesses of the Study

The limitations of this study were related to the study strengths. Were time permissible, staying in additional shelters may have provided more data to support the existing dimensions. A study in the mid west may have also added new information on shelters and the difficulties experienced by the homeless in these areas as they move out of homelessness. Because of a lack of a large funding source, and adequate time to conduct such a study, staying in one shelter proved both the financial and time constraints that this ethnographer could reasonably bear.

Study results would have been enhanced if more formerly homeless people leading highly successful lives would have participated. Although this ethnographer contacted some formerly homeless individuals who had high profile jobs, some were reluctant to share their experiences for fear of recognition by their peers. They were satisfied to give back to the homeless community in more anonymous ways through financial contributions to shelters. These formerly homeless would have added depth to the current study, but

given the stigma of being homeless, their reluctance to participate was understandable. Despite the study limitations, the formerly homeless who shared their experiences lent rich data to increase understanding of the process of moving out of homelessness.

Theoretical Findings

Moving out of Homelessness-- Crossing the Line

The perspective in this study was moving out of homelessness. Crossing the line was the most salient dimension that described how homeless individuals and families begin to move out of homelessness. The formerly homeless in this study referred to a point, or a time in their experiences where they were no longer able to live on the streets in inadequate or unsafe housing conditions. They crossed the line so they could ultimately access stable housing and move towards living productive lives. Some of the formerly homeless in this study had more than one homeless experience. Their lives illustrate how truly vulnerable this population is in terms of becoming homeless even after moving into stable housing.

In this study, the environment of "the homeless shelter" was described in an ethnographic fashion (Schatzman & Strauss, 1973). Homeless shelters on the west coast and a large shelter on the east coast were included in the analysis of data. The west coast shelters described here were also part of a previous study that focused on how homeless shelter staff managed the health care problems of homeless women and children (Hatton, et al., in review, 1999). Some of the west coast study participants identified themselves as formerly homeless individuals. This became the impetus for studying other formerly homeless individuals and more specifically, for focusing on how they were able to move out of homelessness.

In addition to environmental concerns regarding homelessness, formerly homeless individuals recounted their experiences of moving out of homelessness into stable housing. Some of the participants went "on staff" and ultimately resided and worked in the shelter, which became stable housing. Other formerly homeless participants moved out of homelessness without staying in homeless shelters. Some had help from friends and family who provided lodging or funds that enabled them to move into stable housing. Others utilized government funded programs to move into stable housing. The differences in these settings and their implications will be discussed and related to the literature as follows.

Relating the Formerly Homeless Experiences to the Current Literature

The study participants reflected a variety of conditions as described in the dimension reacting to circumstances that resulted in their experiences as homeless. This diversity reflects the scholarly work and research as discussed in chapter 2. First, the greater societal context in which homelessness occurs was a factor for these participants. Socioeconomic factors predisposing individuals and families to homelessness such as poverty and a lack of affordable housing are well documented (Bauman, 1993; Bassuk, 1993b; Brickner, Keen, Conanan, Elvy & Savarese, 1985; Dear & Wolch, 1987; Wilson & Neckerman, 1986). For the formerly homeless participants in this study, losing jobs, lacking adequate job skills, and lacking available and affordable housing contributed to their homelessness. Secondly, the impending danger posed by staying in a battering relationship made homelessness the only option for some of the formerly homeless women and children in this study. The plight of single mothers who are homeless has been documented both in homeless literature and in battering literature (Coffin-Romig, 1997; Goodman, 1991; Weitaman, et al., 1992). Although the battering literature describes the

women and children as needing shelter, the studies reviewed do not focus on homelessness in reference to the living conditions of these women and their children. However, the women in this study who had left battering relationships readily identified themselves as homeless. This discrepancy may be in part due to funding provided to battered women's shelters that is not available for individuals and families who are "just plain homeless" (Hatton, et al., in review, 1999).

The greater societal context in which homelessness occurs is supported by the findings of this study. Lack of affordable housing and employment were the key problems faced by these formerly homeless people, the stigma of "being homeless" played a role in the ability of the formerly homeless to cross the line from homelessness and to access the help of homeless shelters. As center city gentrification projects continue to decrease available housing for the working poor, individuals and families will continue to be forced into homelessness (Dear & Wolch, 1987; Jencks, 1994; U.S. Conference of Mayors, 1994). In this study, 60% of the east coast shelter were working poor. Many are working minimum wage paying jobs and are not able to pay rent in high rent city centers. This formerly homeless woman describes the dilemma. "Most of these homeless folk aren't applying for $50,000 a year jobs. They are applying for six and seven dollar an hour jobs, and where are you going to live with a family on that?" In addition to lack of employment and affordable housing, the number of homeless women with children is increasing secondary to welfare reform. One formerly homeless woman who runs a shelter addressed this concern as follows:

> The whole welfare system was faulty. But, now you got all these people coming off welfare and where you used to have 300 homeless families now you got 45,000

> that need to be in homes. . . . These people are poor and they need employment and heath and education and everything made available to them right where they are. I say that because families are the hardest population. It's easy to serve single men moving around by themselves.

Mental illness, including depression, in the homeless population is well documented (Buckner, et al,1993; Hatton, 1997, Hatton, et al, 1999). There were no formerly homeless interviewed in this study who reported mental illness with associated psychotic features such as schizophrenia and bipolar disorders. However, the west coast shelter staff reported dealing with homeless clients that had psychotic disorders. One west coast shelter did provide long term housing for the chronically mentally ill. This raises the question of what should this society do with the chronically mentally ill who are not able to sustain stable housing? As discussed previously, the deinstitutionalization of the mentally ill has played a role in increasing the numbers of homeless mentally ill individuals and hence, the high incidence of mental illness among the homeless (Breakey, et al., 1989; Buckner et al., 1993; Fischer, 1991; Hatton, 1997; North & Smith, 1992, The task force on homelessness and severe mental illness, 1992). What then is the solution to providing dignified housing to this population who were previously assisted with food, clothing, and shelter in addition to medical support? As one formerly homeless noted, the mentally ill on the streets are often to afraid to seek available space in homeless shelters.

Depression among the homeless is also well documented (Buckner, et al., 1993; Fisher, 1991). Findings of this study support previous work done in this area, but add another dimension by considering depression in the formerly homeless population. As reported by the formerly homeless, depression was present and persisted untreated even

years after establishing themselves in work and stable housing. This was surprising that these individuals had overcome so much to move out of homelessness and yet still suffer depression. It was very sad indeed. Clearly nursing must play a more active role in assessing these individuals and in facilitating treatment of clinical depression.

Relating the Formerly Homeless Experiences of Crossing the Line to an Existing Theoretical Model: The Nature of Comebacks

Although the participants in this study were not necessarily suffering any chronic illness, their experiences are conceptually not unlike those described by Corbin and Strauss (1998) in their grounded theory research with chronic illness sufferers. In their work they describe the "nature of comebacks". A comeback represents an uphill journey back to a satisfying, workable life within the boundaries imposed on them by any physical or possibly mental limitations (Corbin & Strauss, 1998, p. 174). In this study, the formerly homeless, were in some cases limited by physical conditions related to suffering from environmental factors, (like frigid weather) lack of food and known or unknown chronic illness conditions (like hypertension and AIDS). They also suffered from depression both while becoming homeless and well into living past homelessness. Corbin and Strauss (1998) indicate that the comeback journey involves the attempt to regain salient aspects of oneself that have been lost because of illness or injury (p. 174). While making a comeback, the experiences of these individuals depict trajectories that mark their illness course including: (a) comeback phases, (b) stable phases, (c) unstable phases, and (d) downward phases (Corbin & Strauss, 1988). The formerly homeless exhibit many of the characteristics that the chronically ill demonstrated. They have trajectories that mark their own comebacks from homelessness. For some of the formerly homeless, brief shelter stays

were not adequate to assist them into stable housing and so they experienced setbacks and had to return to living on the streets. Other formerly homeless had difficult struggles with substances that continue to make them vulnerable to future episodes of homelessness, or downward phases.

The ideas expressed in giving back depicts clearly how individuals and families faced with unfortunate and unwanted conditions want to regain what Corbin and Strauss (1998) refer to as salient aspects of their selves in order to live satisfying lives. One formerly woman described helping another homeless man by saying the following:

> You got a guy like John sitting out there and he is the person who keeps me engaged in this work, every time I look at him. He's one of the best employees I have ever had, and I always think about "What if we hadn't found John and given him an opportunity for John to regain himself by offering substance abuse treatment in the shelter where he showed up just for a bed for the night? He was a diamond in the rough. How many are there that nobody takes the time to search out a particular individual's space and experience? John starts college in September, John is in his own place, not because I made that happen. He made that happen because there were opportunities and he said "I don't want to be this way. I'm going to take advantage. I'm going to move." And he's moving.

Formerly homeless wanted other people to know was that given their adverse circumstances, and given the right environment, they are able to "rise above it" and become productive, tax paying members of society. They also wanted people to know that not all of them would bounce back. Those who are unstable or in a downward phase are deserving of a bed and a dignified way of living as this formerly homeless man states:

> I've never seen the other side of the streets until I became homeless you know. I saw but one world, just my little world. A person can do better. As far as I'm concerned a person doesn't have to sleep on the streets. There is enough places for everybody. There is enough food for everyone. But, I believe the hospital, the mental hospital, is turning out people when they're not ready to come out. That's when you see most of the people out on the streets. You know they don't trust anybody no more, won't go to a shelter even in bad weather.

Corbin and Strauss's model is helpful for understanding the chronic nature of the problem of homelessness, and how people moving out of homelessness need support during setbacks and downward phases. The stories of the formerly homeless reveal how moving out of homelessness has a trajectory. The homeless trajectory includes periods of progress towards stable housing and regaining a sense of self. However, the homeless may also face setbacks with limited shelter time, and the effects of substance abuse and depression.

Nursing Implications

Nurses are involved with the care of the homeless in many areas. First, nurses provide direct care to homeless individuals and families in a variety of health care settings including acute care hospitals, outpatient clinics, and homeless clinics such as the east coast shelter described in this study. Given the profession's access to the homeless, nursing must assume an active role in developing clinical practices that fit the needs of this population. Secondly, nurses continue to conduct research with this vulnerable population. Finally, nurse educators have a role in ensuring that future nurses at all levels of practice are aware of the special needs of the homeless population. The findings from

this study will be discussed with respect to each of these areas and to appropriate nursing interventions.

Providing Care to Homeless Individuals and Families

The shelters in this study that had on site health care facilities reported that health care programs were well utilized by the homeless populations they served. In addition, the east coast shelter reported that services provided to the homeless outside the shelter were also used by homeless individuals and families. The shelters with no access to health care facilities reported difficulty on many levels in getting care for homeless women and children as described in previous studies (Hatton 1997; Hatton, et al, in review, 1999). Some shelters utilize emergency rooms for health care needs that could be met in a primary health care setting. Others assist the homeless by providing access to health care systems established outside the shelter. Having on-site access to health care seems to be a more comprehensive, efficient way to deliver care to this population. However, only a limited number of large facilities are able to establish and maintain the funding needed to provide such comprehensive services.

Clearly, nursing must play an active role in helping homeless individuals and families to access health care on site, or by making an effort to reach the shelters where on site care is not possible. This kind of effort can only be established if current nursing policy supports caring for the homeless. Any agenda for a healthy population must have mechanisms that address the homeless. If nursing policy supports the homeless, then the appropriate support at the community level can be enacted. Community health nurses must have the appropriate funding and budgets to serve this population. These nurses can then familiarize themselves with the local shelters and provide care to individuals and

families in the smaller shelters who are currently utilizing emergency rooms as primary health care.

In the west coast shelters, public health nursing was not involved in assisting the shelters to identify potentially threatening communicable diseases that are a threat to the greater community with. According to study findings, neither the staff, nor the shelter residents were screened by public health nurses for tuberculosis. The shelters are often utilized by migrants from other countries, and they may carry tuberculosis- resistant strains of bacteria. Testing for the shelter staff and residents is clearly indicated (Hatton, et al., in review,1999). In contrast, the east coast shelter health care clinic tested all residents for tuberculosis within three days of admission to the shelter. Again, this is another area where individuals and families are immigrating to from other countries that may not routinely screen for this ailment. While not all homeless individuals are suffering from tuberculosis, screening to find tuberculosis in this population is a routine test that could easily be performed by nurses.

Previous studies have shown that health care is not a priority for homeless individuals and families (Bassuk et al, 1996; Hatton, 1997). This study's findings supports the notion that although the participants moving out of homelessness had health problems, these problems were not a primary concern for them. The priority of the participants in this study was clearly to become employed and to find affordable housing. This was particularly noticeable in those with mental health and substance abuse problems. Some of the study participants had become homeless as the result of depression and/ or substance abuse and never received any treatment for these health problems. Other participants reported dealing with substance abuse problems as a part or moving out of homelessness,

but some continued to struggle with substance abuse after moving into stable housing. These findings support previous studies that have documented the problems of depression and substance abuse in the homeless population (Bassuk, 1993; Breakey et al., 1989; Hatton, 1997 & Hatton, et al, in review, 1999). What stands out in this study is, that given an optimal environment and adequate time to work on substance abuse and related issues, the homeless are able to overcome some of these problems and move on to be productive members of society.

Health problems suffered by homeless persons have been described as being more acute and chronic when compared to individuals and families who are not homeless (Bassuk & Weinreb, 1993). The severity of health problems as reported by the east coast shelter health center was indeed severe. Specific conditions including diabetes and hypertension were not controlled due to non- treatment. Pneumonia was also described as being severe, especially in the winter months. These findings support the work of previous research.

Nursing Research

As described above, nursing must continue to develop new programs that will effectively aid the homeless population. Nursing research focusing on mental health and substance abuse in the homeless can be informed by the findings in this study. In the dimensions bouncing back: living past homelessness, and giving back, the formerly homeless contributed a number of ideas that helped them to get into stable housing. These contributions have direct implications for future nursing research. The following are the most salient findings that can assist nurses in this endeavor.

Nursing intervention studies can be informed by the formerly homeless. One

example is the difficulty some formerly homeless staff reported with case management. They suggest additional features of helping the homeless that can contribute to existing case management models. By their suggestion in giving back, the formerly homeless offered a different way to approach the homeless. This formerly homeless man describes his approach to the homeless below:

> We don't call it case management. We use what is called a strength method of case management where when you come in here and we go "What can you do?" And we build on what is positive.. . . It works for us. I don't think as a community we could do it any other way. We can't have case managers. Its to negative for us.

By being homeless themselves, they seem to be able to establish a rapport with the homeless and to find positives in the lives of the homeless. Nurses can incorporate these same methods in developing programs for the homeless by using formerly homeless consultants and peer mentors, along with the professional staff, to assist the homeless. Clearly, this has worked for shelters with battered women (Coffin-Romig, 1997). The peer mentoring approach would do well with other homeless populations just as it has worked in the east coast shelter. One formerly homeless shelter worker talked about her shelters as follows:

> We are transforming and demonstrating for the city how you can take a shelter which is more cost efficient to run then let's say transitional housing where the density is smaller and where you can just lay around for awhile. It costs the taxpayers money. You can do some of the same things for folk with the understanding, gentlemen, that you aren't just going to flop here year after year. You're getting your meals and everything. And now, okay, you got a handle on

> your sobriety, we got a job ready for you, and we want you to start paying child support. And you are a vital resource to the community in case nobody told you. So we have a heavy focus on family reunification where that is possible. In a lot of cases it's not, those bridges are burned. But you're going to take care of your child and that's required.

In their successful program, the residents are required to set aside money for savings, family support, and rent once they start working. The result of this is described here:

> We got people when they leave us, when they move to an apartment, who have three to four thousand dollars in savings . . . the focus was on having them learn some saving habits and to learn an economic self-sufficiency. How does that really takes place– by budgeting and learning those skills to be independent.

Based on the successes in this program run by the formerly homeless, emphasizing living skills such as money management is important when working with homeless individuals and families. These are simple skills to teach, but hard to learn. Nursing is as well equipped as any discipline to help these individuals learn to manage their money.

Another particularly significant finding in this study involved the east coast shelter, a "wet shelter," that allows drinking and even intoxicated individuals to stay as long as they present no physical danger to the rest of the population. The west coast shelters strictly enforced their rules and policies that prohibited drinking and intoxication in the shelters. No studies looked at the successes and differences in these types of shelters. Lines of inquiry could look at when it is appropriate to have substance abusing clients in sheltered settings and what factors would prohibit the presence of intoxicated clients. Clearly both are needed, but currently only one type is being implemented in the west coast shelter

settings studied.

In addition to program intervention studies, advanced practice nursing needs to embark on drug research with the depressed, homeless population. As described in this study, depression was an element of moving out of homelessness and living past homelessness. In this age, our profession is fully capable of treating those people suffering from depression. Now is time to move the next step– documenting and treating depression. Even in the formerly homeless, some attention needs to be paid to this group with regard to their mental status and depression.

Nursing Education

One of the most exciting interviews was with the nurse who started the clinic at the east coast shelter. She set an extraordinary example for all nursing educators by creatively uniting a nursing school with a homeless shelter to form a mutually beneficial health care center. For the homeless, state of the art health care is available both at the center and for the greater community of homeless individuals and families. The university has a practice site for clinical faculty and nursing students. By soliciting grant monies from a large foundation, the clinic will continue to thrive and meet the needs of this community. Also, some nursing schools are involved in providing outreach services to the homeless via community health programs (Hatton, 1997). In addition, clinical faculty and other community nurses volunteer their time at west coast homeless shelters in order to help meet health care needs (Hatton, et al., 1999) . However, the needs of the homeless can be addressed more directly if nursing educators commit to caring for the homeless population.

In the west coast study, many of the shelters were open to involvement by nursing

schools to assist them in identifying and managing health concerns (Hatton, et al., 1999). Of the 10 shelters in the study, only one was being visited regularly by nurses in a community health nursing program. In the same city, there exists an abundance of schools including associate, baccalaureate and graduate programs in nursing. These schools fight for practice sights in acute care hospitals and private practice settings, but ignore homeless shelters as practice sights for their nursing students (Hatton, et al., 1999).

Conclusion

The findings of this study indicate that homeless individuals, at some point, are able to cross the line and reach out for assistance that enables them to move out of homelessness and to lead productive lives. Some are able to utilize existing government programs to help them with the transition. Others stay in shelters or rely on the help of family and friends to move out of homelessness. Once they have moved into stable housing, the formerly homeless are able to live dignified lives. Some have much to offer other homeless individuals and families by sharing their experience of moving out of homelessness. Many have developed their own successful homeless programs. Not all formerly homeless individuals are able to work or live outside a sheltered environment. Those with physical and mental impairments that prohibit an independent lifestyle still deserve a dignified way of life. Few shelters were identified that any of these individuals could live in and be proud to call home. Most importantly, given a chance, there will always be those homeless individuals who are able to "rise above" homelessness. As nurses, there is much we can do to find and to help the next "diamond in the rough."

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Appendix A:

Human Subjects Proposal for West Coast Shelter Study

STAFF PERCEPTIONS OF HEALTH PROBLEMS AMONG HOMELESS WOMEN SHELTER RESIDENTS

PROPOSAL TO USD COMMITTEE ON THE PROTECTION OF HUMAN SUBJECTS

SEPTEMBER 17, 1993

DIANE C. HATTON, R.N., C.S., D.N.Sc.
ASSISTANT PROFESSOR
PHILIP Y. HAHN SCHOOL OF NURSING

STAFF PERCEPTIONS OF HEALTH PROBLEMS AMONG HOMELESS WOMEN SHELTER RESIDENTS

Background and Purpose of the Study

During the last decade, the demographic profile of the homeless population has changed. Joining the traditional homeless, comprised of predominantly single males, are the "new homeless" including families who are the fastest growing subgroup (Wright & Weber, 1987). Researchers estimate that women head 85% of these families, in which African Americans and Latinas are overrepresented (Institute of Medicine, 1988). Projections indicate, moreover, that in the near future the majority of the homeless in the United States will be single mothers with children (Vladeck, 1990).

Homeless women and children represent a vulnerable, underserved population. These individuals suffer from health problems of enormous complexity (Wright, 1990) and under utilize health care services (Adkin & Fields, 1992; Miller & Lin, 1988). The Office on Women's Health (1991) has argued for a commitment and comprehensive health plan for improving health services to homeless women. In order to facilitate such planning, research dealing with the health problems among members of this population is essential.

During the past 2 years, the investigator has conducted a field research study with homeless women and children in San Diego County. Data analysis from that study indicated that these women pushed health, both mental and physical, into the

background of their lives. Respondents frequently had difficulty articulating their health concerns and health needs. Moreover, they rendered mundane many ailments a clinician would deem serious. As for their self care, data analysis revealed four conditions as most salient: shame, fear, (lack of) information, and eligibility. As a consequence of these conditions, shelter residents often did not seek basic health maintenance for both mental and physical problems. This situation existed in spite of multiple supportive services provided by shelter staff.

This previous study among homeless women offered an understanding of health problems from the perspective of the shelter residents. The proposed study would explore these problems from the perspective of shelter staff. These latter individuals are often critical to the management of such problems among shelter residents. More specifically, the aims of the proposed research are:

1) to identify and describe health problems among homeless women and children from the perspective of shelter staff;
2) to describe and analyze how homeless women manage various ailments, both their own and their children's, from the perspective of shelter staff;
3) to describe and analyze staff actions with residents when dealing with health problems among shelter residents;
4) to compare and contrast the perspectives of staff with

the perspectives of residents from the previous study.

Significance of the Study

A review of the literature related to homeless women and children revealed no studies of staff perceptions of health and health problems among shelter residents. Yet, data analysis from the investigator's previous study indicated that shelter staff were critical to the management of health problems among residents. Thus, the proposed study would provide important data regarding staff ideas of health and its management for residents. Understandings of staff perceptions are essential for the future planning of community health nursing services for women and their children who reside in homeless shelters.

Research Method

The proposed study will utilize the qualitative field method of research known as grounded theory (Glaser & Strauss, 1967; Schatzman & Strauss, 1973; Strauss, 1987). Data gathering and analysis will proceed concomitantly in order that salient dimensions may be pinpointed and pursued before leaving the field. Two doctoral students who have indicated an interest in the homeless will work with the investigator during data gathering and analysis.

Subject population and research procedure. Using the United Way Directory, homeless shelters in San Diego County will be identified. The directors of shelters serving women and children

will be contacted by letter and then phoned in order to arrange a meeting time to discuss the study. The study will be explained to the directors and their participation requested. The convenience sample will consist of directors and other interested staff willing to participate in a semi-structured interview lasting 30-60 minutes.

Setting. The setting for the interview will be mutually determined by interviewer and staff member in order to allow for privacy. Interviews will be audiotape recorded and transcribed verbatim and will be flexible and open ended in order to explore facets of each interviewee's concerns. Topics which appear relevant to the purpose of the investigation will be explored (Becker & Geer, 1969) (See Appendix A for interview guide). Each respondent will be guaranteed anonymity and staff will be reminded that participation in the study will not affect their employment in the shelter and is voluntary. All subjects will be informed that they may withdraw from the study at any time.

Before interviewing, each participant will be given an explanation about the project and will be told that there are no known risks and that they may withdraw from the study at any time. The researcher will also explain that the findings of the study are completely confidential and that findings will be presented in such a manner that each subject's anonymity is maintained. Each subject will be asked to sign an informed consent document (Appendix B).

Sources of research material. Interviews with subjects will

provide the primary source of research data. In addition, participant observation field notes of the context of the interview will also provide data. The latter notes will include the subject's non verbal communication, where the interview was conducted, and general observations on the conduct of the interview itself. No personal records from shelters will be reviewed. Shelter residents will not be interviewed in this study.

Data management. After the dictations are transcribed, the investigator will erase all tapes. A numerical coding system used on written recordings of data will prevent the identification of specific respondents. Data will be maintained in a locked file, and in the reporting of data, the investigator will present findings in such a manner that anonymity and confidentiality of the subjects and their agency is maintained.

Potential risks and procedure for protecting against risks. Each interview will last approximately 30 minutes to 1 hour--a potential inconvenience for subjects. Subjects will be observed for signs and symptoms of fatigue as well as for cues signifying discomfort with the interview itself. Having done many such interviews in the past, the investigator has the skills to recognize these signs and will terminate the interview should they arise. The research assistants will be trained by Dr. Hatton to monitor these signs as well. In addition, both are master's prepared nurses who have considerable interviewing skills and have completed a research course.

Potential benefits. The investigator's experience in her previous research suggests that subjects experience satisfaction by talking with a researcher about various aspects of health and its management. Findings from this study will potentially contribute knowledge about the complexity of health problems among homeless women and children. In sum, the potential benefits of the study outweigh the risks to subjects.

Timeframe

The proposed study will be submitted to USD's Committee on the Protection of Human Subjects for their approval at the October meeting. After approval, a review of agencies in the county and contact with directors will be initiated. During November and the remainder of the academic year, shelter directors and staff will be contacted and arrangements made for interviews. Data analysis will proceed concomitantly with the process of data gathering during the academic year and will be done during summer 1994 as well. The final report of the proposed study will be completed September 15, 1994.

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Appendix B:

Informed Consent for West Coast Shelter Study

HATTON PROPOSAL

CONSENT TO ACT AS A RESEARCH INTERVIEWEE

STUDY OF STAFF PERCEPTIONS OF HEALTH PROBLEMS AMONG HOMELESS WOMEN SHELTER RESIDENTS

DIANE C. HATTON, R.N., C.S., D.N.Sc.
PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

I have been asked to be interviewed by Dr. Diane Hatton or her research assistant for a study of staff perceptions of health problems among homeless women shelter residents. Dr. Diane Hatton is from the University of San Diego and is conducting this study in order to find out how homeless women manage their own health and their children's health.

I understand that the interview will take from 30 minutes to 1 hour and will be conducted in a place convenient for me. If it is agreeable with me, the interview will be audiotape recorded. I also understand that at any time I may quit the study and that if I decide not to participate, it will in no way affect my employment at the shelter. I understand that I may ask questions before I sign this consent form and that later I can call Dr. Hatton at 260-4549 about any questions I have concerning the study.

I understand that the interviews will be coded and locked up and that all information is confidential.

I realize that there are few or little risks to myself other than possibly being uncomfortable with some of the questions. If there is any question I do not wish to answer, I do not have to do so. I understand that the benefits from the study will be, not to myself, but to those who deliver health care to homeless women and children and are trying to improve that.

I have received a copy of this form. There is no agreement, written or verbal, beyond that expressed in this form.

I, the undersigned, understand the above explanations and on that basis, I give consent to my voluntary participation in this research.

_____ _____
Signature of Subject Date

_____ _____
Location Date

_____ _____
Signature of Researcher Date

_____ _____
Signature of Witness Date

Appendix C:

Interview Guide for West Coast Shelter Study

HATTON PROPOSAL

Interview Guide for

Staff Perceptions of Health Problems among Homeless

Women Shelter Residents

1. Face data:
   - Gender
   - Work history
   - Educational background
   - Years working in this shelter; other shelters
   - General information about shelter
     - -# of clients
     - -# employees
     - -hours per day open
     - -distance to other agencies/services

2. Tell me about the typical clients you have.

3. Tell me what you think are the main health problems among women in your shelter.

4. Tell me what you think are the main health problems among the children in your shelter.

5. How do women take care of these health problems?
   --probe for problems of the women, themselves
   --probe for problems of the children

6. What do you, or other members of your staff, do for women and children who have health problems?

   --describe for me the last time you sent a resident to another agency or provider for a health problem

   --tell me what you do when a resident has a mental health problem.

7. Tell me about the financial availability of services for women and children.

8. Tell me about the acceptability of services for women and children.

9. If you could change health services for homeless women and children, what would you do?

10. Is there anything you would like to add? Is there anything you would like to ask me?

Appendix D:

Human Subjects Approval for East Coast Shelter Study

The Experiences of the Formerly Homeless

Proposal to the Committee on the Protection of Human Subjects

Susan M. Bennett

May 23, 1994

Running Head: Bennett Proposal

Background and Purpose of the Study

Homelessness is a complex social problem that affects the lives of millions of women, children and men daily in the United States (Federal Task Force on Homelessness, 1992). To date, much of the research in the area of homelessness focuses on that portion of the homeless population that is currently without a home, living in temporary housing and shelters (Breakey, Fischer, Kramer, Nestadt, Romanoski, Ross, Royal & Stein, 1989; Browne, 1993; Goodman, 1991; Hatton, 1993; & Weitaman, Knickman & Shinn, 1992). In a previous paper exploring *homelessness* as a concept, the review of literature revealed that little information is available on people who have had homelessness as part of their life experience, and were able to later sustain income or employment that would maintain a stable residence (Bennett, 1993). The purpose of this study is to explore the experiences of those individuals who at some time in their lives have had a homeless experience. Specifically this study will focus upon: 1) the impact of being formerly homeless on the daily lives of these individuals, and 2) events that facilitated these individuals moving into a stable residence.

Significance of the Study

The proposed study is significant for the following reasons. First, although the solutions to the complex problem of homelessness involve a multidisciplinary approach and intervention from a host of public and private sources,

practical, workable solutions to homelessness by those who have lived through the experience have not been systematically investigated and analyzed. This study proposed will give those formerly homeless a chance to offer solutions to homelessness by telling their lived experiences of moving out of homelessness.

Secondly, although some have hypothesized that the experience of homelessness may have long lasting effects on homeless individuals, (Buckner, Bassuk, & Zima, 1993), these hypotheses have not been systematically investigated. Providing nursing care for those formerly homeless individuals may be more comprehensive if more is known about the special needs and concerns of this group.

Research Method

The proposed study will utilize the qualitative method known as grounded theory (Glaser & Strauss, 1967; Strauss, 1987). The investigator will interview respondents using an open ended format (See Appendix A for interview guide). Consistent with grounded theory method, data gathering and analysis will occur concurrently in order to identify common themes that emerge from the interviews.

Subject population and research procedure. Approximately 15 semi-structured interviews with formerly homeless individuals will be done. The interviews will be audiotaped and transcribed verbatim. The interviews will be conducted in such a manner as to allow the subjects to explore areas that they feel are

relevant to their experiences as formerly homeless individuals. As the data collection proceeds, the interview guide questions may be changed, deleted or supplemented as themes emerge from the data. This will ensure that the themes discovered are actually "grounded" in the subjects experiences. Although the interviews will be open ended, they approximate length of each interview will be one to two hours. The interview will be conducted in a private setting and at a location convenient for the subject.

The study sample will be a snowball sample. With this sampling procedure, subjects who participate in the study suggest others like themselves who may be interested in participating in the study. For example, the first contact I made with a formerly homeless individual was while discussing this study with a colleague at a conference. In addition to wanting to participate as a subject, this person suggested two other individuals who were formerly homeless that may be interested in participating in the study. The potential participants are given means to contact the principle investigator. Only those formerly homeless individuals interested in participating in the study will be contacted by the investigator. In addition, contact with formerly homeless individuals may be made through colleagues that work with these individuals.

Where the research will be conducted. The research will be conducted in quiet, private locations convenient for the participants. Study subjects may select their home as the

interview site, or may suggest an alternative location. Initial subjects identified as potential study participants reside in Washington, D.C. and San Diego, Ca., and these locations will be the focus of the initial interviews in the proposed study.

Estimated duration of the study. The proposed study would begin July, 1, 1994, and would be completed by July 1995. The review of literature for the study has been completed, and the process of contacting formerly homeless individuals, interviewing the subjects, and data analysis will take place from July until June of 1995. The final report will be completed by July of 1995.

Potential risks and risk management procedures. The length of time the interviews take, one to two hours, proposes an inconvenience for the subjects. The subjects will be monitored for signs of fatigue and for any cues from the subject that they are uncomfortable with the interview process or questions. As an experienced interviewer, this investigator possesses skills necessary to recognize these cues and signs and will terminate the interview should they become evident. In addition, the subjects will be offered a rest period at one hour into the interview should the interview time exceed one hour in length. Permission in the form of written consent for the tapes and written transcripts will be secured before beginning the interviews (See Appendix B). Maintaining the subjects anonymity will be ensured through separating written consent forms from

tapes and transcripts which will be identified by a numbering system. The anonymity of the subjects will be further protected by presenting any written reports of the subjects experiences in such a manner that no individual could be identified by the material reported.

Potential benefits. Individually the subjects may benefit from participation in this study by feeling satisfied that they are contributing potential solutions to homelessness. Their personal successes in moving beyond homeless experiences gives them expertise in providing practical, workable solutions to the problems of homelessness. In addition, since there is little knowledge about what are the needs and concerns of formerly homeless individuals, they may benefit from knowing how the experience of homelessness has impacted the lives of other formerly homeless individuals like themselves. For this purpose. the study results will be summarized and offered to each of the subjects at the completion of data analysis.

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Appendix E:

Informed Consent for East Coast Shelter

Formerly Homeless Consent Form:
Consent To Act As A Research Interviewee

I have been asked by Susan Bennett, a Nursing Doctoral student from the University of San Diego, to be interviewed in a study which she is doing with people who have had homelessness as a part of their life experience. She is studying this in order to know more about the special needs and concerns of individuals who are formerly homeless, as well as looking at events that have made it possible for some homeless individuals to move into stable housing situations.

I understand the interview will take from one to two hours, will be audiotaped, and will be conducted in a place convenient for me. I also understand that at any time I may quit the study and that if I decide not to participate, I may stop at any point during the interview. I understand that I may also refuse to answer any question during the course of the interview. I understand that I may ask questions before I sign this consent form, and that I can call Susan Bennett at (619)223-7164 about any questions I have concerning the study.

I understand that the interviews will be coded and locked up in order to assure confidentiality. I understand that the results of the study will be reported in a way that will protect my anonymity.

I realize that there are few risks to myself other than fatigue during the interview and possibly being uncomfortable with some of the questions. I understand that the benefits from the study will not be to myself directly, but to homeless individuals and those working on trying to find solutions to problems for homeless people.

I have received a copy of this form. There is no agreement written or verbal, beyond that expressed in this form. I the undersigned understand the above explanations and on that basis, I give consent to my voluntary participation in this research.

_____

Signature of Subject Date

_____

Signature of Principle Researcher Location

_____

Witness Date

Appendix F:

Interview Guide for Formerly Homeless Study

Interview Guide for Formerly Homeless Study

1. Face Data:
   - Gender
   - Geographic History
   - Marital Status
   - Children

2. Tell me about your homeless experience.
   - What year
   - Length of time
   - Location
   - Precipitating factors
   - Where did you sleep
   - How did you meet basic needs like food, hygiene
   - Health problems during this time
   - Shelter experiences
   - Typical day

3. Tell me about people you felt were important during this time.
   - Friends
   - Family
   - Special people that were helpful or influential
   - Difficult people
   - Dangerous people

4. What factors/ events made it possible to move out of the homeless experience and sustain a source of income that maintains a stable residence.
   - Shelter
   - Employment
   - Spiritual influences
   - Recovery

5. How does the experience of being homeless impact your daily life now?
   - Activities related to working with other homeless
   - Problematic- ever worried others will know
   - Negative thoughts or dreams about the experience
   - Health related problems

6. Is there information that you would want others to know about what it was like when you were homeless
   How should the homeless be treated
   Suggestions for solutions to homelessness
   Programs you could suggest