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Acknowledging the Homeless who are not Mentally Ill in the Context of Medicalized Housing Assistance

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ACKNOWLEGING THE HOMELESS WHO ARE NOT MENTALLY ILL IN THE CONTEXT OF MEDICALIZED HOUSING ASSISTANCE

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Abstract

This thesis describes the homeless population in El Paso, Texas, and discusses data coming from an adaptation of Housing and Urban Development's (HUD) point-in-time (PIT) survey methodology. It improves on previous methods used in homeless counts while allowing social science students to participate in hands-on training. Surveys were collected in "traditional homeless spaces," using convenience sample methods as well as in non-traditional spaces where homeless Hispanics were believed to be more heavily represented. Additionally, snowball techniques were used to find and survey marginally-housed individuals. The number of homeless individuals surveyed exceeded that of the official El Paso PIT count of the homeless (676 *N*), which demonstrates the possibility of employing and further developing the methodologies used in future studies of the homeless population. We also measured varying degrees of mental illness among the homeless population, using novel methods that challenge current homeless census. The results of the study demonstrate a wide range of factors experienced by and affecting the homeless population in this border region.

Keywords: Point-in-Time, homeless subpopulations, marginally-housed

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UTEP's Point in Time

INRODUCTION

Conducting a homeless point-in-time census has proven to be a daunting task for reasons, such as: homeless individuals are difficult to locate given their untraditional use of space (Lee, A.Tyler and Wright 2010), an unknown number of homeless individuals change housing status from one night to the next in a precarious housing situation Rossi (1987) calls the "marginally" housed. Since gathering a sufficient number of street-dwelling homeless respondents has proven to be difficult, most previous research on homelessness has focused on those homeless individuals who are institutionalized either in hospitals, shelters, or some sort of housing program (Fischer et al. 1986, Folsom et al. 2005, Hopper et al. 1997, Shlay and Rossi 1992), or merely fit the description of a traditional homeless person, i.e. a disheveled male who acts bizarre (Lee, A.Tyler and Wright 2010). However, conducting research within an institutional setting gives substantial leeway to interpretation, considering the social context in which the research is conducted (Bachrach 1984, Huey, Fthenos and Hryniewicz 2012, Salkow and Fichter 2003, Snow, Baker and Anderson 1988, Snow, Anderson and Koegel 2002). This paper studies street homeless in El Paso, TX, and makes novel efforts to include the marginally housed population often neglected in prior research.

Information on those homeless who are already institutionalized provides information on those homeless within service settings. However, quantitative, academic research on street homelessness is rare but also necessary for understanding those homeless individuals who are not institutionalized. Additionally, the working homeless, or those homeless individuals who are employed, has rarely been studied, even though the number of working homeless could compose a substantial portion of the homeless population (Theodore 2000, Wasserman and Clair 2010). Efforts to conduct large scale quantitative analysis have produced mixed results.

A national homeless count was implemented for the first time in 1984 by the U.S. Department of Housing and Urban Development (HUD) to attempt to count all homeless individuals in the U.S. According to Jencks (1995). Another HUD PIT count, conducted in 1990, included anyone staying in bus stations, parks, or unusual spaces without even asking respondents any questions, so many considered it a halfhearted attempt (Jencks 1995). Currently, HUD requires major cities receiving funding for homeless programs to conduct two separate homeless PIT counts. The "shelter count" is conducted annually and counts those within the service industry, such as at shelters, soup kitchens, and halfway houses, while the second is a "street count" conducted every two years. The street count surveys those homeless people not accessing shelter services and is typically conducted using volunteers from the local community. The information gathered in HUD's PIT count is reported to Congress (Jackson 2007) and the U.S. Census Bureau for population estimates and utilized for public policy development in relation to homeless services, poverty, and urban planning.

Some previous studies on the ethnic composition of homeless populations have found that many local homeless populations are not proportionally representative of various racial and ethnic groups in the general population, and that Hispanics are underrepresented in many local homeless populations (Baker, 1996; Tan and Ryan, 2001). Baker (1996) calls this phenomenon the "Hispanic Homeless Paradox." Some have proposed that this underrepresentation may be due to methodological data collection biases rather than to actual underrepresentation, as Hispanic homeless people are more likely to sleep and live in places not traditionally considered to be "homeless spaces" such as shelters, and may be more likely to "double-up" with family members, sleeping on floors and couches (Conroy & Heer, 2003). These individuals are considered to be the "marginally-housed" homeless by Rossi (1987) and are included in the definition of homelessness by the HEARTH Act of 2008 (National Alliance to End Homelessness, 2009). However, these individuals are not counted in typical HUD PIT censuses.

Because Hispanics make up 80.7% of the general population of El Paso (cite), it is important that studies of homelessness in this region take into consideration the methodological concerns discussed in the literature, and attempt to capture this subpopulation, a daunting and historically ignored task. This study implemented an innovative snowball technique, utilizing a broad base of student researchers, to find individuals "doubling-up" or "couch-surfing" with friends or family. Also, day-labor and agricultural worker sites, as well as heavily Hispanic neighborhoods, were targeted by surveyors, as it was believed that these locations could contain a large homeless Hispanic population.

Methods

The data for this study were collected in a modified replication of HUD's PIT homeless count in El Paso, Texas, which was conducted by the El Paso Coalition for the Homeless. The same survey questions were used with the addition of two prerequisite questions in order to determine duplication and two questions concerning mental health (see Appendix A). The survey was given in both English and Spanish, so respondents were able to take the survey in the language of their choice. Surveyors were bilingual (Spanish and English) and those surveyors who were not bilingual were instructed to pair up with someone who was bilingual. The authors used the same questions as HUD in order to compare information between the street homeless and the marginally-housed homeless population, which means the questions themselves have the same limitations as HUD's PIT, as discussed later.

Undergraduate students enrolled in a Social Science Methods of Research course, offered in the Spring of 2013 by the Department of Sociology at the University of Texas at El Paso, were trained in scientific research and data collection techniques. After two and a half months of regular coursework, which is more training than HUD's PIT offers its volunteers, all data were collected on February 28, 2013 between 4:00 AM and 10:00 PM. About 83 volunteers collected quantitative data under the oversight and direction of the authors. Surveys were conducted in either English or Spanish, according to the abilities of the surveyor and the respondent (approximately 80% of surveyors were Hispanic and spoke Spanish.) We also instructed surveyors to approach people who they knew were marginally housed, that is, living temporarily with friends or family, sleeping on couches or the floor, or in other locations such as at their place of work. Many surveyors knew people in these situations and conducted surveys of them. Interviewers were assigned areas to survey the homeless population throughout the city, walking block-by-block in their designated areas. Interviewers were designated areas of the city to collect data as one way to avoid duplication, a method used by the El Paso Coalition for the Homeless during their PIT counts. Interviews took place on the streets, under bridges, in public parks, and included marginally-housed respondents living temporarily with friends or family.

However, this study included interviewing homeless people in heavily Hispanic and Spanish speaking neighborhoods and day labor/agricultural worker sites. Since HUD's PIT undercounts hidden populations, a separate method was also used to find homeless students and the marginally-housed. A purposive sampling strategy was designed to represent El Paso's population while oversampling the homeless and undocumented populations that often are undercounted, using a snowball technique. Data collectors, approximately 80% of whom were bi-lingual Hispanic, were encouraged to survey people they knew who met homeless criteria. The street survey data, data from day labor/agricultural workers, and data from volunteers from acquaintances who were marginally-housed were to be given their own variables in the database, then compiled in order to find a total number of homeless individuals. Those respondents who fit the description of homeless according to the HEARTH Act (Department of Housing and Urban Development 2011) as without a permanent place to stay were categorized as "homeless" in a constructed variable. The "homeless" variable was constructed to include those living in traditional homeless settings, such as parks, under bridges, and on the streets. Additionally, the "homeless" variable included those respondents living in marginally-housed settings, which were identified by those living in hotel rooms, with friends, or with family. Respondents who reported being students and living with parents were not included.

Before starting this survey, interviewers also asked two prerequisite questions to prevent duplication, "What city were you raised in?" and "What is the name of the street you grew up?" The city and street that the respondents reported were then input as a separate variable in the database. The authors felt the questions were ambiguous enough for the respondents to remain confidential, but specific enough to notice respondents who had responded to more than one survey after the data were input into the database.

In order to add to the literature on homelessness, this study compiled simple frequency distributions to conceptualize the prevalence of homeless subpopulations. Cross tabulations were run in order to delineate situations of homelessness by ethnicity to compare homeless, marginally-housed, Hispanic/non-Hispanic populations in El Paso, TX. The questionnaire used Pearson's Goodness with respective Chi-square analysis, because most of the questions asked in this survey were in the form of categorical (2 categories) binary "Yes/No" questions. Chi-squared can be observed per each cross tabulation, as labeled in their respective table." This is an exploratory study with no a-priori hypotheses, thus our first step was to use univariate analyses. Future studies should incorporate more complex analyses. Also, individuals who appeared homeless but who did not complete a survey were counted, and their appearance was recorded and compared as another measure decreasing the possibility of double-counting these individuals. As already stated, typical PIT censuses tend to undercount hidden populations including homeless Hispanics, homeless students, and the marginally-housed.

Results

In the course of this study, 678 individuals were surveyed, and an additional 65 homeless individuals were counted but not surveyed, for a total of 743 persons. The following results are derived from the 678 surveys conducted and are divided into sections addressing demographics, reasons and risk factors for homelessness, experiences of homelessness, and services needed but not received.

Our study found a much larger percentage of male (81.3%) than female (18.8%) homeless individuals, and a large percentage of respondents (40.9%) were over 50 years old. A majority of respondents (66.5%) reported themselves as being Hispanic, a percentage nonetheless lower than that of the general Hispanic population of El Paso (80.7%). Respondents were somewhat evenly divided between having been raised in the El Paso region (36.3%), other areas of the United States (29.2%), or abroad (34.5%). The majority of those raised abroad were raised in Mexico. However, a majority of respondents (61.3%) reported having lived in El Paso for over five years. Education levels also varied between those having a 6th grade education or less (22.0%), those who had completed high-school or had received a GED (34.8%), and those who had received a college or trade school education (20.6%) or were currently enrolled in a trade school or college (12.4%).

[Table 1 here]

Respondents reported a variety of primary causes for their being homeless, however, (45.2%) reported job-related primary factors, including loss of a job (20.7%) and an inability to get a job (21.6%). Also, 9.1% reported being employed but still unable to afford housing. A sizeable percentage (19.5%) reported being agricultural workers. When asked if being in foster care was a primary reason in causing their homelessness, almost no respondents felt having been in foster care was the primary reason. However, 18.5% did report having been in foster care at some point. A number of respondents reported having been discharged from various institutions in the last six months, including from a hospital (5.9%), a substance use treatment center (5.3%), a psychiatric facility (2.5%), or a correctional facility (9.7%). A sizeable percentage of respondents reported perceiving they had problems with alcohol or drugs (23.2%), or a current psychiatric or emotional problem (19.6%) (see these Authors forthcoming for more on mental health among the homeless). Additionally, 19.2% reported having a felony conviction on their record. Respondents indicated a variety of disabilities, including mental (6.3%) and physical (12.7%). Finally, 26.9% of respondents reported that they or their family members had served in the military, although only (7.8%) reported being currently registered with the VA.

[Table 2 here]

An individual who has been homeless for longer than one year, or who has been homeless four or more times in the last three years is considered by HUD to be "chronically homeless," a condition that is specifically targeted by several HUD programs (U.S. Department of Housing and Urban Development, 2007). A variable taking into account these two criteria was created, which allowed the categorization of respondents as chronically homeless. A large percentage of respondents (78.1%) fell into this category. The current sleeping situations of respondents varied between sleeping in a shelter (24.0%), being marginally housed (22.6%), or sleeping on the streets or in an unspecified situation (52.5%).

[Table 3 here]

Respondents reported a variety of services or assistance they needed but had not received. These needs included finding a job (41.1%), housing (27.0%), transportation (15.0%), medical care (15.2%), dental care (9.4%), mental health care (6.3%), substance use counseling (5.5%), childcare (4.9%), legal guidance (7.4%), and educational assistance (6.0%).

[Table 4 here]

Discussion

Hispanics are the fastest growing ethnic population in the United States, and their social experiences are of great interest for growing research (Pew Hispanic Center, 2008), including research on the Hispanic experience of homelessness. In a meta-analysis, Baker (1996) found that various ethnic and racial groups are not proportionally represented in the homeless population, and that Hispanics are proportionally underrepresented in homeless research and censuses. This is somewhat surprising, as poverty and the inability to afford housing is considered one of the most prevalent causes of homelessness (National Alliance to End Homelessness, 2013), and according to the U.S. Census Bureau (2013), the Hispanic rate of poverty is 23.2%, compared to an average rate in the U.S. of 14.3%. Thus Baker (1996) labeled this unexplained phenomena the "Hispanic Homeless Paradox."

However, based on analyses conducted on survey information of Mexican-born individuals in Los Angeles County, California, Conroy and Heer (2003) call into question the hypothesis that Hispanics are underrepresented in the homeless population, finding instead that they are more likely to be homeless. However, because they tend to live and sleep in non-traditional spaces such as in abandoned buildings or cars, instead of in homeless shelters, they are undercounted in censuses that conduct research in typical homeless locations (2003). Others, including the U.S. Department of Housing and Urban Development, believe that the "Hispanic cultural orientation" causes many Hispanics who might otherwise be living on the streets to be brought in to live temporarily with a friend or family member, even if that means sleeping on the floor, couch, or in overcrowded conditions (2008).

Although it could be argued that the omission of the marginally housed from typical homeless research is justified because the marginally housed do not necessitate assistance through government-funded emergency or long-term housing programs, the HEARTH Act, passed by Congress in 2008, includes the marginally-housed in its definition of homelessness (National Alliance to End Homelessness, 2009). We believe that the lack of representation of this population in both academic and governmental research has the effect of downplaying the scale of housing insecurity and its accompanying effects within the consciousness of the general population and policy makers and therefore limits the possibility of addressing this problem adequately.

In fact, previous research conducted by Tan & Ryan (2001) in El Paso, also using a point-in-time methodology, found that 70.7% of homeless respondents self-identified as Hispanic, which is also similar to the 76.6% of the general population of El Paso identified as Hispanic in the 2000 Census (U.S. Census Bureau, 2000). Tan & Ryan used methods from Burt (1996) in a point in time collaboration with HUD's Homeless Coalition, which is that same PIT count we are replicating in this study. Tan & Ryan's findings are different from HUD's 2014 findings, which means that HUD's findings have changed from years past. Tan & Ryan's (2001) findings are similar to ours even though the methods seem quite different, which suggests some subtle differences. It seems that the places surveyors go to find homeless on the streets, the types of individuals who are targeted for homeless surveys, and general beliefs about homelessness can vary greatly from one study to the next even if the methods are similar. Our findings surveyed individuals in marginally housed settings while finding similar proportions of Hispanic homeless individuals. It seems that the type of homelessness experienced by Hispanic individuals have changed from a traditional homelessness to a more marginal setting between 2000 and 2014.

We believe several important issues relating to research are addressed in our methodology. As already described and discussed, it attempted to address the "homeless Hispanic paradox." It also implemented a type of snowball technique to find marginally-housed individuals. This population is extremely difficult to find, and has been historically ignored in research. Because the marginally-housed are not necessarily connected through networks typically utilized as channels of research in a snowball methodology, perhaps the only way to find individuals in such a housing situation is through the personal knowledge and contacts to be made by the researcher. This also limits the actual "snowball" aspect of this method to one or two degrees of connection, and the number found is to some degree proportional to the surveyor pool utilized. We were able to find the number of marginally-housed individuals we did (at least 152) because of our large pool of surveyors who were embedded in the local community. We do not believe this to be an exhaustive count of the marginally-housed in the region, but an initial step in developing a database on this hidden population as well as an initial step in developing methodologies for researching it further among homeless research.

Finally, we believe our focus on student-based research had the dual effect of improving our PIT count and therefore our research in general while at the same time providing hands-on experience in social science research to students studying in this field.

As previously stated, typical PIT counts of local homeless populations combine the sum of those who claim to have slept on the street the night previous to the count and the sum of those reported by the local homeless services to have slept in shelters the night previous to the count. If a respondent surveyed on the street claims to have slept in a shelter the previous night, they are not counted, as they will be included in the shelter's report. This combined total is then used by local homeless services to apply for Federal financial grants through HUD's designated homeless assistance programs.

Additionally, previous PIT methodology used to study homelessness has not addressed the population of the marginally-housed, thus a large portion of homeless Hispanics, as well. Because we attempted to address these biases within our research, it would be beneficial to compare our results to the results of the PIT count conducted by the El Paso Coalition for the Homeless on January 24th, 2014, in order to analyze the success of this attempt. In this latest PIT count, the Coalition found 182 "unsheltered" persons, while emergency and transitional shelters and permanent supported housing services reported 1,188 persons, including "individuals" and "persons in families." The official total of homeless persons reported in El Paso was therefore 1,370 (PIT 2011).

Contrary to the Coalition's PIT count, our methodology focused solely on a street-level survey, and we did not request reports from shelters. However, if the 163 respondents who reported sleeping in a shelter the night previous to the survey are removed from the total of 678 respondents who completed the survey, and the 153 who reported being marginally-housed are also removed, 362 respondents are left--those who slept on the street or in an unspecified location. This is significantly higher than the 182 "unsheltered" persons reported by the Coalition. If, on the other hand, the Coalition's total of 1,188 sheltered individuals is added to the 362 respondents we found who reported being unsheltered, a total of 1,550 persons is reached. If it is added to our combined count of unsheltered and marginally-housed individuals, a total of 1,703 persons is reached. Although a more in-depth analysis would be needed in order to discover the true cause of this discrepancy, our initial hypothesis is that the methodology we utilized, including purposefully seeking out homeless Hispanics and using a large pool of surveyors who are well-connected to the community, allowed a more complete count than that conducted by the Coalition. We believe this to be a standard shortcoming of HUD PIT counts across the U.S. We appreciate the work of the Coalition, and do not wish to criticize it. We simply wish to spur further discussion on census methodologies, especially in light of the border location and large Hispanic population of El Paso, and the place of the marginally-housed in homelessness and housing-insecurity research.

International and internal migration plays an important yet understudied role in the composition of local homeless populations at any given point in time. A majority of respondents in our study, including Hispanics who had been raised abroad and non-Hispanics who had been raised in other regions of the United States, reported having been in El Paso for over five years. In fact, while over 40% of non-Hispanics reported having been in El Paso for over five years, 70% of Hispanics reported having been in El Paso for this length of time, a difference which seems to suggest that a larger percentage of the non-Hispanic homeless individuals in this region are transient, and that El Paso is attractive even to non-Hispanic U.S. citizens who are not originally from this area. Our research did not address the reasons homeless individuals stay for extended periods of time in the El Paso region, but could include the fact that being in the southwest, El Paso has relatively pleasant weather for those living on the street, especially in the winter (Authors forthcoming); that the local VA serving Ft. Bliss is relatively accessible to homeless veterans; or that local homeless services operate effectively. Some also suggest that Hispanic neighborhoods in El Paso provide accepting and helping environments for the homeless population, i.e. cheaper hotel rates, access to prescription needs, an informal economy that may be easier to access (Comar, 2011).

Chapter 2: Hispanic and non-Hispanic Homeless Populations in El Paso, Texas

INTRODUCTION

Some previous studies on the ethnic composition of homeless populations have found that many local homeless populations are not proportionally representative of various racial and ethnic groups in the general population, and that Hispanics are underrepresented in many local homeless populations (Baker, 1996; Tan and Ryan, 2001). Baker (1996) calls this phenomenon the "Hispanic Homeless Paradox." Some have proposed that this underrepresentation may be due to methodological data collection biases rather than to actual underrepresentation, as Hispanic homeless people are more likely to sleep and live in places not traditionally considered to be "homeless spaces" such as shelters, and may be more likely to "double-up" with family members, sleeping on floors and couches (Conroy & Heer, 2003). This study used an innovative snowball technique to find individuals "doubling-up" or "couch-surfing" with friends or family. These individuals are considered to be the "marginally-housed" homeless by Rossi, Wright, Fisher, and Willis (1987), and are included in the definition of homelessness by the HEARTH Act of 2008 (National Alliance to End Homelessness, 2009). However, these individuals are often not counted in typical Department of Housing and Urban Development (HUD) Point-in-Time (PIT) censuses. This study provides further insights into the prevalence of homelessness among Hispanic and non-Hispanic populations in El Paso, Texas, and discusses averaged differences in these populations' reasons for being homeless, experiences of homelessness, and services needed.

Methods

The data for this study was collected in a modified replication of the PIT count of the homeless required by HUD and conducted in El Paso, Texas by the El Paso Coalition for the Homeless every two years. The same survey questions were used, with the addition of two questions concerning mental health. Undergraduate students enrolled in a Methods of Research course offered by the Department of Sociology at the University of Texas at El Paso, were trained in proper research

and data collection techniques. They collected the data under the oversight and direction of the authors. All data was collected on February 28, 2013 between 4:00 AM and 10:00 PM. Students were designated areas of the city in which to collect data as one way to avoid duplication, a method used by the El Paso Coalition for the Homeless during their PIT counts. The PIT is conducted in one day in order to minimize the possibility of double-counting homeless individuals on the street, but it undercounts hidden populations including Hispanic homeless, homeless students, and the marginally-housed. Therefore, in order to find and survey these populations, data collectors, approximately 80% of whom were Hispanic, were encouraged to survey people they knew who met these criteria, using a snowball technique, in addition to interviewing homeless people in Spanish in heavily Hispanic neighborhoods, day labor and agricultural worker sites. For more information see Methods section above.

Results

Out of 676 individuals who answered the survey, 6 respondents did not indicate race or ethnicity and are therefore not included in the results presented in this paper. All of the following statistics have a p value <.05. Of the 670 left, 445 (66.4%) reported being Hispanic, and 225 (33.6%) reported being non-Hispanic. The following comparisons are divided into sections addressing demographics, reasons and risk factors for homelessness, experiences of homelessness, and services needed but not received. Each section compares Hispanic and non-Hispanic populations' responses.

Our study found no substantial difference in gender ratios between the Hispanic and non-Hispanic populations, with much larger percentages of males than females in both the Hispanic (79.9%) and non-Hispanic (84.6%) populations. Approximately 43.5% of both populations were over 50 years old. However, there are significant differences in several other demographics. Hispanics were significantly (p<.000) more likely to have been raised in the El Paso region (40.3%) or abroad (49.1%) than non-Hispanics, the majority of whom (68.0%) were raised in the U.S., but outside of the El Paso region. Hispanics and non-Hispanics also differed significantly

(p<.000) in the length of time they had lived in El Paso. Although the majority of both groups had lived in El Paso for over one year, homeless Hispanics (70%) were much more likely to have lived in El Paso for over five years than non-Hispanics (43.3%). Education levels also differed significantly (p<.000), with a larger percentage of Hispanics (27.6%) having a 6th grade education or less, than did non-Hispanics (10.2%), and more non-Hispanics (45.7%) having completed high school than Hispanics (29.9%). However, Hispanics (13.4%) were significantly (p<.007) more likely to be currently enrolled in a trade school or working on a degree than non-Hispanics (6.4%).

[Table 5 here]

Hispanics and non-Hispanics differed in their reported primary factor for being homeless, as well as in other risk factors. The following findings have a significance level of <.005. Over 40% of each population reported job-related primary factors with 21.8% of Hispanics reporting job loss and 19.8% reporting the inability to get a job, while 18.6% of non-Hispanics reported job loss and 25.6% reported the inability to get a job. Also, 11.3% of Hispanics and 5.1% of non-Hispanics reported being employed but still unable to afford housing. Although almost no respondents felt having been in foster care was the primary reason they were homeless, 19.6% of Hispanics and 16.4% of non-Hispanics reported having been in foster care at some point.

Hispanics (17.4%) and non-Hispanics (36.6%) differed significantly (p<.000) in reporting having been discharged from an institution such as a hospital, substance use treatment center, psychiatric facility, or prison in the last six months. Non-Hispanics (31.6%) were significantly more likely (p<.000) to report having problems with alcohol or drug use than Hispanics (19.1%). Additionally, non-Hispanics (33.7%) were significantly more likely (p<.000) to report a felony conviction than Hispanics (12.6%) and non-Hispanics (38.9%) were also significantly more likely (p<.000) to report being disabled than Hispanics (17.9%). The following findings have a significance level of <.005. When asked to indicate the type of disability, 11.6% of non-Hispanics

reported mental disability and 17.6% reported physical disabilities, while only 3.9% of Hispanics reported mental disabilities and 10.5% reported physical disabilities. In a different question, non-Hispanics (27.7%) were also significantly more likely ($p<.001$) than Hispanics (16.3%) to report concerns about current psychiatric or emotional problems (see these Authors Forthcoming for more on mental health among the homeless).

Significant differences ($p<.000$) were found between Hispanics (25.8%) and non-Hispanics (7.7%) who reported being agricultural workers. Significant variations ($p<.000$) were also found between Hispanics (19.1%) and non-Hispanics (43.3%) who reported that they or someone in their family had served in the U.S. military. Hispanics (5.1%) were also significantly less likely ($p<.001$) than non-Hispanics (12.8%) to report being registered with the VA.

[Table 6 here]

An individual who has been homeless for longer than one year, or who has been homeless four or more times in the last three years is considered by HUD to be "chronically homeless," a condition which is specifically targeted by several HUD programs (U.S. Department of Housing and Urban Development, 2007). A variable taking into account these two criteria was created, which allowed the categorization of respondents as chronically homeless or not. Those considered chronically homeless differed between ethnicities substantially ($p<.002$), although a large percentage of both Hispanics (75.5%) and non-Hispanics (84.0%) were categorized as chronically-homeless.

. Hispanics and non-Hispanics also varied significantly in their current sleeping situations. The following findings have a significance level of <.000. A similar number of Hispanics (24.0%) and non-Hispanics (24.7%) reported sleeping in a shelter, while Hispanics (27.2%) were more likely to be living in a marginal housing situation than non-Hispanics (12.1%). Non-Hispanics

(63.2%) were more likely than Hispanics (48.7%) to sleep on the street or in an unspecified situation.

[Table 7 here]

Non-Hispanics (34.1%) were more likely than Hispanics (27.0%) to report no income. Hispanics (40.8%) were much more likely than non-Hispanics (16.8%) to report earned income ($p<.000$). We categorized any earned income as either working day-labor jobs, panhandling, or other reports of income due to work, such as odd jobs. Any forms of social security income were not categorized for this measurement. Hispanics (44.3%) were significantly more likely ($p<.018$) than non-Hispanics (34.4%) to report needing assistance with finding a job. Both Hispanics (25.5%) and non-Hispanics (30.0%) reported needing assistance in finding a place to live. Hispanics (9.7%) were significantly less likely ($p<.000$) than non-Hispanics (27.1%) to report needing health care, and Hispanics (4.6%) were also significantly less likely ($p<.008$) than non-Hispanics (10.0%) to reported needing mental health care. Similarly, Hispanics (3.4%) were significantly less likely ($p<.001$) to report needing substance abuse counseling than non-Hispanics (10.0%).

[Table 8 here]

Discussion

It is difficult to accurately determine the size of marginally-housed, Hispanic homeless populations. Additionally, changes to U.S. policy relating to the definition of homelessness brought by the 2009 HEARTH Act (National Alliance to End Homelessness, 2009) has attempted clarify what homelessness is, providing some guidance for research on homelessness. Because of the complexities involved in homelessness research, we designed a modified Point-in-Time census methodology, which focused on capturing the marginally-housed, Hispanic homeless population

by canvassing heavily Hispanic neighborhoods as well as locations such as day-labor and agricultural-worker sites. The authors hypothesized that work sites may be heavily frequented by Hispanics. We also instructed surveyors to approach people who they knew were marginally-housed, that is, living temporarily with friends or family, sleeping on couches or the floor, or in other locations such as at their place of work. Many surveyors knew people in marginally-housed situations. Although our PIT found more Hispanics and non-Hispanics than previous counts, only 66.4% of respondents in our survey self-identified as Hispanic, a percentage lower than that found by Tan and Ryan in 1998, and not proportional to the 80.7% of El Paso residents who self-identified as Hispanic in the 2010 Census.

There are many factors possibly influencing the underrepresentation of Hispanic homeless in prior research, including the fact that a high percentage of non-Hispanic homeless individuals (71.6%) reported being raised outside of the El Paso region, while 72.3% reported having been in El Paso for longer than one year. It seems that there is some form of attractiveness for non-Hispanic homeless to El Paso, which could explain the increases in proportion of non-Hispanic homeless individuals in the region. Also, 27.2% of Hispanic homeless respondents reported being marginally-housed, compared to only 12.1% of non-Hispanics. Finding the marginally-housed is not possible using traditional HUD PIT censuses, as marginally-housed, homeless individuals may not be in locations such as on the streets or in shelters. Methods using a modified snowball technique such as ours are limited to one or two degrees of connection, instead of reaching higher degrees of connection possible in typical snowball samples, because the marginally-housed do not necessarily know each other. In other words, the number of marginally-housed individuals who can be surveyed is directly proportional to the number of surveyors used and their embeddedness in the local community. Because the authors utilized a large pool of student surveyors, they were able to survey at least 152 marginally-housed individuals. This large percentage demonstrates the large number of individuals in the El Paso region who live in such conditions but is not a definite count. Because the percentage of Hispanic and non-Hispanic marginally-housed individuals

differed significantly, these findings possibly lend a certain credibility to the hypothesis of a "Hispanic cultural orientation" limiting the number of Hispanics who live on the streets or in homeless shelters. Of course, it is important to note the large number of Hispanics who indeed are homeless. Also, many student surveyors reported having family members who live in the streets because of severed familial ties due to alcoholism, addiction, sexual orientation, poverty and other causes. Furthermore, given that the larger proportion of people in El Paso is Hispanic, one would expect a larger number of the marginally-housed to be Hispanic. By capturing even more of the marginally-housed population, the proportion of Hispanic homeless individuals in comparison to non-Hispanics logically increased. The marginally-housed population in general has largely gone unidentified and under-researched, due to the difficulties inherent in gathering data about it. We hope that this study will be an initial step towards developing useful methodologies to study this population, and in developing a sound set of data which can be the basis for important policy decisions in the future.

International and internal migration plays an important yet understudied role in the composition of local homeless populations at any given point in time. Most Hispanics, including those who had been raised abroad, reported having been in El Paso for over five years. In contrast, most non-Hispanics were raised in the United States, but not in the El Paso region. Over 40% of non-Hispanics reported having been in El Paso for over five years, which demonstrates that a larger percentage of non-Hispanic homeless individuals are transient. At the same time, El Paso seems attractive even to non-Hispanic individuals who are not originally from this area. This study did not address the causes of homeless individuals staying for extended periods of time in the El Paso region, but reasons could include that the southwest has relatively pleasant weather for those living on the street, especially in the winter (Authors forthcoming); that the local VA serving Ft. Bliss is relatively accessible to homeless veterans; the transnational mobility for those who routinely cross the border into Mexico provides for cheaper places to stay such as hotels; or that the local homeless

services operate effectively. Some also suggest that Hispanic neighborhoods in El Paso provide accepting and helping environments for the homeless population (Comar, 2011).

We also found significant differences in levels of education, as 45% of all non-Hispanics had completed high school, while only 30% of Hispanics had. It is possible that education level is related to the place individuals were raised, as for example, a high school education is difficult to complete in rural Mexico. We also found that more than twice as many Hispanics, 13.4% compared to 6.4% of non-Hispanics, are currently enrolled in some form of higher education, either working on a degree or enrolled in trade school. It is worth noting that the University of Texas at El Paso's Academic Advising Center administers the Foster, Homeless, Adopted Resources (FHAR) program, which provides advising, referrals, and mentorship to students falling into these categories, and which during the 2010-2011 academic year, assisted approximately 70 students (Acosta, 2010). Only 8.4% of Hispanics and 8.6% of non-Hispanics reported having a Bachelor's, graduate, or professional degree, and both the experience of homeless students and the long-term outcomes of education on mitigating homelessness would be important aspects for further research, considering the important role of higher education in long-term employment and earning outcomes (U.S. Census Bureau, 2002).

Our study found significant differences in the primary reason for being homeless reported by Hispanics and non-Hispanics. However, over half of all respondents reported unemployment or underemployment as their primary reason for homelessness, which follows national trends of a lack of affordable housing and a lack of employment opportunity as the most widespread causes of homelessness (National Coalition for the Homeless, 2009). Less than 10% of non-Hispanics reported being agricultural workers in our survey, while over 25% of Hispanics worked in agriculture, an occupation that provides seasonal employment and thus contribute to the inability to afford long term, adequate housing (El Paso Coalition for the Homeless, 2011). It is surprising that despite the border location of our research site, only 5.1% of Hispanics reported the lack of

regularized status or the violence in neighboring Ciudad Juarez, Mexico as their primary reason for homelessness.

Contrary to common conceptions about homeless people, only a minority reported a mental illness or substance abuse. Over 30% of non-Hispanics report having a felony record, while only approximately 12% of Hispanics reported such a record. The trend of low rates of criminal behavior and incarceration among Hispanic and other immigrant populations has been previously researched (Wadsworth, 2010). It is important to note that many who report disabilities, substance use, or a criminal record do not understand these factors to be the primary cause of their homelessness, and indeed, these factors could actually have been outcomes of homelessness instead of its cause.

Significant differences were also found between Hispanics and non-Hispanics in conditions of familial relationships that may contribute to homelessness. Among Hispanics, 9.2% reported family conflict and 3.4% report domestic abuse as the primary factor in their being homeless, while only 5.1% of non-Hispanics reported family conflict and 1.4% reported domestic abuse as the primary factor in their being homeless. Higher rates of Hispanics reporting familial reasons for homelessness were also found in previous research by Tan and Ryan in the El Paso region (2001), and they suggest that this may be due to the important, sustaining role, played by the family in Hispanic culture. If such a support is removed, it may be difficult to find alternative supports mitigating the risks of homelessness. Beyond this possible cultural difference, domestic violence is considered an important factor contributing to homelessness nation-wide (National Coalition for the Homeless, 2009).

It is widely acknowledged that a high percentage of young people age out of foster care and become homeless. However, even though 19.6% of Hispanics and 16.4% non-Hispanics reported having been in foster care at some point in their lives only 1.4% of non-Hispanics and no Hispanics reported that foster care was the primary factor in their being homeless. The numbers reported from various previous studies vary from 11% to 36% (HUD, 2012). Because familial

support typically facilitates a successful transition to adulthood, research has shown that those in foster care who retain relatively close connection to an adult family member are less likely to become homeless after aging out of the system (Dworsky & Courtney, 2009).

Some aspects of housing status, such as that of marginal housing, have already been discussed. It should be noted that almost identical percentages of Hispanics and non-Hispanics surveyed (24.0% and 24.7% respectively) reported currently sleeping in a shelter. In contrast, the 2011 Point-in-Time Census found that 64% of individuals in shelters were Hispanic (El Paso Coalition for the Homeless, 2011). The different reports between this survey and HUDs could be that the data presented in this paper does not include information provided by shelters, as the Coalition's did. However, it is reflected in those reporting sleeping on the street or in unspecified locations with 48.7% of Hispanics and 63.2% of non-Hispanics, because similar percentages reported being sheltered, and more Hispanics reported being marginally-housed than non-Hispanics,

There was a significant and important difference between respondents who reported "some form of earned income." Hispanics reported 40.8% and non-Hispanics reported 16.8% of "some form of income." While types and amounts of earnings were not part of our survey, the difference between Hispanic and non-Hispanics may be partially explained by the prevalence of day laborers and agricultural workers among Hispanic respondents. Day labor/agricultural work is an occupation that may be seasonal and unconducive to the ability to afford long-term, stable housing. In fact, we found that 9.1% of total respondents who reported being agricultural workers also reported being unable to afford housing. As noted by Tan and Ryan (2001), high percentages of employed yet homeless individuals, especially among the Hispanic population, may also partially be an outcome of low levels of education and therefore low-skilled and low-paying employment, which often does not provide enough to pay for housing. However, Theodore (2000) also showed high reports of working day labor among the homeless in the mid-West region of Chicago.

No significant differences were found between Hispanics and non-Hispanics in any other form of income, including forms of long-term and emergency government assistance, pensions or workman's compensation related to former employment, or familial assistance such as child or spousal support. It is important to note that few Hispanics or non-Hispanics reported receiving any of these forms of income, although a thorough examination of the reasons for this as well as of programs of assistance available to homeless individuals is beyond the scope of this paper.

As expected, large percentages of both Hispanic and non-Hispanic homeless individuals reported services needed but unavailable to them in the last twelve months. As previously discussed, the inability to procure adequate housing, either because of a lack of affordable housing or the lack of an adequate income is the foundational cause of homelessness. Although not significantly different, our study found high percentages of both Hispanics (25.5%) and non-Hispanics (30.0%) reported needing assistance in finding a place to live, as well as high percentages of Hispanics (44.3%) and non-Hispanics (34.4%) who reported needing assistance finding a job. Hispanics (14.4%) and non-Hispanics (15.4%) were also quite likely to report a need for transportation, the lack of which would logically interfere with the ability to search for and retain employment.

Our study found that Hispanics were significantly less likely to report unmet medical needs of various kinds than non-Hispanics, including health care (9.7% compared to 27.1%), dental care (7.4% compared to 13.9%), mental health care (4.6% compared to 10.0%), as well as substance uses counseling services (3.4% compared to 10.0%). Fewer Hispanics (8.3%) reported needing eye care than non-Hispanics (12.9%) as well. The fact that Hispanics have better health outcomes than many non-Hispanic whites, despite higher levels of poverty and other factors typically associated with negative health outcomes, is well documented in the literature, and is known as the "Hispanic Health Paradox" (Morales, et al., 2002). However, this phenomenon and its causative factors are not well understood and are still vigorously debated. Also, there is a relatively new and growing body of literature on the disparities of mental health outcomes between Hispanics

and non-Hispanics. According to the American Psychiatric Association, Hispanics use mental health services less than most non-Hispanics, and it appears that immigrant Hispanics use mental health services less than U.S. born Hispanics (2010). However, there is continued debate as to whether this disparity in care is simply due to Hispanic's inability or unwillingness to access the mental health care system (Blanco, et al., 2007) or to an actual lower prevalence of mental illnesses among the Hispanic population (Alegria, et al., 2008). While our results seem to support the Hispanic physical and mental health paradoxes, it is important to keep in mind that our survey questioned respondents' perceived needs, instead of actual health outcomes. It is possible that Hispanics, as described by the American Psychiatric Association (2010), are simply less likely to be worried about their symptoms or to understand their symptoms to be those of an actual mental disorder.

It would be logical to understand the experience of homelessness in the border region area may not be generalizable to other, non-border locations or Hispanic populations. For example, a large percent of our Hispanic respondents reported being raised outside of the United States. However, immigrants are now present in almost all areas of the United States, including urban and rural areas, so the results in this study are likely to be similar to those found in many other locations across the country—if not now, the near future. Homeless people are highly mobile and their place of residence may be seasonal and flexible, as the responses concerning the length of residence in El Paso demonstrate. Thus, it is important to study the internal migration of homeless people across the U.S. in future research.

While this study reveals several similar demographics, experiences, and services needed by both Hispanic and non-Hispanic homeless people in the El Paso region, it also reveals several important differences between Hispanics and non-Hispanics, including: where respondents were raised, their education levels, their housing status, and their perceived health needs. This study adds to the current discussions on the Hispanic social experience, including that of homelessness,

the Hispanic homeless and health paradoxes, and the largely hidden population of the marginally-housed.

Chapter 3: Homelessness in El Paso, Texas: UTEPs Point-In-Time Study on the Severity of Psychological Symptoms

INTRODUCTION

Although mental illness among the homeless has been studied before, meta-analyses and critical literature reviews question the methods and findings (Lee, Tyler and Wright 2010, Susser, Conover and Struening 1990). Others discuss the ambiguity intrinsic in attempting to operationalize mental illness (Horwitz 2002, Whooley 2014). Most prior research focuses on any general mental illness listed in the DSM. For the purposes of this paper respondents are categorized by symptomatology that HUD considers in providing housing to certain homeless individuals. Housing criteria lists severe mental illness (SMI) diagnoses in an effort to delineate housing eligibility for homeless individuals. Written documentation is necessary upon access to homeless housing social services under Housing and Urban Development's (HUD) Shelter Plus Care. Social services housing qualifications demand written documentation for SMI diagnoses included in (Jans, Stoddard and Kraus 2004) according to Smith (forthcoming). It is important to provide a more accurate count of those homeless with what the housing industry calls SMI diagnoses instead of what the mental health field considers SMI, because eligibility for mental health housing assistance hinges on homeless individuals being clinically diagnosable under Housing and Urban Development's (HUD) Shelter Plus Care (S+C), (Donovan 2012, Housing and Urban Development 2013). We improve upon prior homeless research methods by distinguishing between the quantities of homeless individuals with SMIs according to HUD in contrast to less severe mental illnesses that do not qualify for S+C funded housing.

Researchers have made great efforts to study the prevalence of mental illness among the homeless for decades. However, measuring how prevalent mental illness is among the homeless has not been measured as often as one might think. Although providing mental illness services to the homeless population became a hot political talking point during the 1980s, most prior research, to date, limits sampling to those homeless already institutionalized, focusing on program efficacy

(Folsom et al. 2005, Hopper 2003, Lehman et al. 1997). To our knowledge measuring the prevalence of mental illness among the overall homeless population has only been measured a few number of times in an academic study (Fazel et al. 2008, Johnson and Chamberlain 2011, Shlay and Rossi 1992, Snow et al. 1986). Although the limitations of these studies have been acknowledged (Susser, Conover and Struening 1990), the methods used among academic research are far superior to the point-in-time street count conducted by HUDs report to congress for policy reconsideration (Jackson 2007). HUD concedes, "Point-In-Time count methodologies vary [between cities] and are imperfect and as such the aggregated numbers do not represent a precise count of homeless people" (p.1, National Coalition to End Homelessness 2013). We improve upon HUDs Point in Time count using novel SMI measurement to compare the levels of severe mental illness among the homeless population in El Paso, Texas in two studies.

Prior research concerning the defining characteristics of what mental illness is on a theoretical level has proven to be problematic (Horwitz 2002, Scull 2007, Whooley 2010, Whooley 2014), especially in efforts to quantitatively measure how prevalent mental illness is among the homeless (Lee, A.Tyler and Wright 2010, Susser, Conover and Struening 1990). Measurement of mental illness is made especially difficult considering the historical changes among recent versions of the Diagnostic and Statistical Manuals of Mental Disorders (DSM) (American Psychiatric Association 1980, American Psychiatric Association 2000, American Psychiatric Association 2013). The lack of definitive categories for overlapping symptoms, ambiguity of design, and severity of patient's illness all present theoretical ambiguities in defining and categorizing mental illness in general (Aggarwal et al. 2013, Rounsaville et al. 2002), thus making it more difficult to study mental illness among the homeless. (Susser, Conover and Struening 1990) analyzed the infrequent use of methodologies in the measurement of mental illness among the homeless by saying:

> Uncertainty pervades existing survey data on the frequency of mental illness among the homeless. Reported diagnoses and assessments by means of scales are fraught with problems of interpretation. There is no measure that is comparable across all

> or even most surveys. Since samples of homeless persons differ in important respects from both patient samples on the one hand and from community samples on the other, methods and standards developed for patients and communities cannot be expected to work well for the homeless without modification. At this time it is essential to identify the sources of error and the limits to our knowledge, for the field to advance (p.410).

Difficulties on the measurement of mental illness have resulted in fewer studies on the matter since the 1980s and early 1990s. (Rossi 1987) raises another difficulty in generalizing the homeless population when he discuss the “marginally housed” population, defining them as "the precariously (or marginally) homed; persons with tenuous or very temporary claims to a more or less conventional dwelling or at least a stable housing situation" (p. 21). This population is not as recognizable as the traditional “street” homeless. Examples of the marginally housed include those people who stay on the coaches of extended family and friends, rotate staying with various friends or family, or someone who stays in a hotel one night but may sleep outside the next. The marginally housed are especially difficult to survey or even count, due to their absence in traditional spaces thought to be inhabited by the homeless, which makes quantitative research an easy target for not accounting for this population.

Likewise, the methods commonly used to study homelessness produce an overrepresentation of people with severe mental illness. Oftentimes over-counting is done explicitly to compensate for the mere possibility of undercounting homeless people with mental illness (Shlay and Rossi 1992, Snow et al. 1986, Snow, Baker and Anderson 1988, Wright 1988). The actual prevalence is often lower than often assumed (Sullivan, Burnam and Koegel 2000). Furthermore, some have observed that many homeless people with mental illness circulate through services as a means for shelter more than to aid their mental health needs (Hopper et al. 1997). In fact, shelters often overvalue a mental illness diagnoses. Lyon-Callo (2000) says:

> I uncovered and challenged an underlying hegemonic hypothesis of deviancy functioning within the local sheltering industry. I found that routine practices focus primary attention on developing techniques for detecting, diagnosing, and treating pathological disorders within individual homeless people. Detecting and

> diagnosing disorders begins the moment a homeless person first enters the shelter. The new shelter guest is quickly directed into the staff office for an intake interview. The intake interview serves several functions. On one level, it is simply an opportunity for the staff to compile basic statistical and demographic data while detailing the shelter rules and procedures. A case history, used to guide case management, is also started. Of paramount importance, though, is that the intake interview is the first opportunity for the staff and guest to diagnose the disorder(s) of the self that caused the person to be homeless… A caring staff member uses this opportunity to develop a sense of rapport with the new guest. Through this more informal discussion and from the homeless person's mannerisms and articulations, the staff member attempts to gather additional data on possible disorders within the person. If, for example, the staff member detects what he or she perceives to be possible mental illness or substance abuse, these observations are noted in the person's case folder and in the staff log. Other staff can thus be made aware of the diagnosis and look for possible supporting symptoms.

Also misleading surveys of homeless populations conducted during the 1980s and 1990s, such as those of Fischer & Breakey (1991) and Baum & Burnes (1993), found consistently high rates of addiction and mental health problems, particularly among single men. However, critics found that many conclusions of such studies were biased in their measurement of reported substance abuse and mental illness because they recorded lifetime experiences rather than focusing on current experiences (Snow et al. 1986, Snow and Anderson 1993, Snow, Anderson and Koegel 2002, Snow and Anderson 2006). Researchers also began considering if claims from the 1980s that homeless people were mentally ill were influenced by interactions between homeless people and intake workers or by funding and insurance demands instead of by empirical evidence (Braun and Cox 2005, Lyon-Callo 2000, Price 2013). Yet other research that may have a sound argument overall simply overlooks that being diagnosed is a prerequisite to be accepted into housing. As (Kertesz et al. 2009) says:

> According to a smaller analysis of eighty participants in Housing First programs [which prioritizes the most severe form of SMI among homeless individuals as a prerequisite], including some from New York's Pathways to Housing and two other programs (Pearson et al. 2007), 91 percent carried a major psychiatric diagnosis, and nearly all received federal disability benefits (506).

It seems that there is disconnect between researchers and the housing social service world. Many researchers do not know the intake process and the requirements surrounding subsidized housing. The authors of the quote above may ignore the fact that in order to qualify for many of these programs one must be homeless and SMI or addicted. Those not included in (Kertesz et al. 2009) had to be addicted in order to be admitted into the shelter. In fact (Martinez and Burt 2006) describe typical S+C qualifications:

> Individuals were eligible to receive housing at either residence if they were living on the street or in a shelter and had at least two of the following disabilities: substance use disorder, mental illness (axis I or axis II diagnosis), and HIV-AIDS. To qualify for residence in the Lyric, one of the disabilities had to be a diagnosis of an axis I mental illness. A small proportion of Canon Kip units (nine units, or 9 percent) were allocated to individuals with only one diagnosis. A clinician confirmed all diagnoses in writing, and a social worker certified homeless status.

It seems that research that samples among shelters or housing with mentally ill inhabitants are predetermined to find a prevalence of SMI.

It is important to draw attention to notable studies on mental illness among the homeless. Shlay & Rossi's (1992) annual review article discusses the large variation in the ways that mental illness was measured in different publications on the topic. They describe how much of earlier research focused attention on stereotypical subpopulations of homeless people who stay in specific types of shelters while simultaneously neglecting other populations. Their compilation of 60 studies found a 33% mean average of homeless people who reported mental illness, but a standard deviation of 23 demonstrated an inconsistency of methods used to measure this phenomenon. They acknowledge this by writing:

> Although these studies do not focus on any uniform set of measures, they collectively provide sufficient information across any single indicator to begin to identify central tendencies…The studies are quite diverse in methodology. Sixty percent are based on interviews with samples of shelter residents only…Our focus is on breadth rather than quality (p.134).

Shlay and Rossi (1992) also address the fact that research limitations included the degree to which mental illness was defined and measured, adding that:

> [A] wide variation in estimates of the prevalence of mental illness are shown because there is neither a universally accepted definition of mental illness nor a common method for measuring mental illness (p.137).

As policy makers, social service providers, and social scientists grappled with whether mental illness was causing homelessness (Baum and Burnes 1993, Scott 1993), questions as to the prevalence of mental illness among homeless people grew (Fazel et al. 2008, Fischer and Collins 2002, Koegel, Burnam and Baumohl 1996, Lamb 1984, Scott 1993, Snow et al. 1986, Snow and Anderson 1993, Susser, Conover and Struening 1990, Wright 1988). As Shlay & Rossi (1992) indicate, many studies sample from institutions where all of respondents are mentally ill. Such studies assumed a high prevalence of mental illness among the entire homeless population. Conrad (1992) calls the process of diagnosing those individuals who are not mentally ill an example of "medicalization," which "describes a process by which nonmedical problems become defined and treated as medical problems usually in terms of illnesses or disorders."

Many homeless people are medicalized for the first time in jail. Fitzpatrick & Myrstol (2011) and Gowan & Whetstone (2012) conclude that many homeless people are jailed not because they do anything illegal but because their mere presence in public spaces is troubling to onlookers. Incarceration, specifically for those jailed awaiting their sentencing, can reproduce the impression of homeless people as rabble-rousers (Elliott and Krivo 1991, Irwin 1985).

David Snow and colleagues (Snow et al. 1986, Snow, Baker and Anderson 1988, Snow and Anderson 1993, Snow, Anderson and Koegel 2002) are most notable among researchers who studied mental illness among the homeless. Their most notable contribution was Snow, et al.'s (1986) study that found that 9% of a street sample of 164 respondents met the criteria of having two distinct symptoms of mental illness. In an additional sample of homeless people receiving homeless services, they found that 16% of 747 respondents had a mental illness diagnosis. Of the

total 800 homeless respondents, (some were duplicated), 15% were categorized as mentally ill. Careful not to be criticized for overlooking any hidden mentally ill subpopulation among the homeless, their study included anyone who could possibly be mentally ill, even if they had not been formally diagnosed:

> We classified individuals within our [additional] field sample of 164 as mentally ill if they met at least two of the following three criteria: prior institutionalization; designation as mentally ill by other homeless individuals; and/or conduct that was so bizarre and situation-ally inappropriate that most observers would be likely to construe it as symptomatic of mental illness (p. 412).

Defining mental illness among the homeless population has proven to be problematic, but this difficulty has been remedied in recent research measuring mental illness among the non-homeless population (Hedden et al. 2012). For example, two studies on mental illness among the general populaltion, The National Survey on Drug Use and Health (NSDUH) (Mental Health Services Administration 2009) and the National Comorbidity Survey Replication (NCS-R) (Kessler et al. 2006) found the prevalence of any mental illness (AMI) disorder to be 19.9% and 24.8%, respectively, and the prevalence of SMI to be 4.8% and 5.8%, respectively (Hedden et al. 2012). So, we ask: Why not do this for the homeless population?

HUD implemented the first national count of homeless people in 1984. Currently, HUD requires major cities receiving funding for homeless programs to conduct two separate, homeless Point in Time (PIT) counts every two years. The first part counts homeless people within the service industry, such as at shelters, soup kitchens, and halfway houses. The second part counts homeless people not accessing shelter services, found in places such as on the streets, under bridges, and in homeless camps. The information gathered in HUD's PIT count is reported to Congress (Jackson 2007) and the U.S. Census Bureau for population estimates and public policy development in relation to homeless services, poverty, and urban planning.

The National Coalition for the Homeless, established in 1982, collaborates with local agencies to coordinate the PIT counts. The National Coalition for the Homeless (2013) acknowledges limitations involved saying that, "point-in-time count methodologies vary between cities and are imperfect, and as such, the aggregated numbers do not represent a precise count of homeless people" (p.3). Furthermore, the National Alliance to End Homelessness, an educational and policy-driven organization working to prevent and end homelessness, has changed its definition of homelessness every year since its establishment in 2002, leads support to ambiguity involved in defining homelessness (Lee, A.Tyler and Wright 2010). The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, passed by Congress in 2009, renewed and restructured the McKinney-Vento Homeless Assistance Act, originally passed in 1987, and officially defined a homeless person as "one without adequate place to sleep at night" (Department of Housing and Urban Development 2011).

Our PIT census, replicated HUD's PIT street count. There are many methodological challenges in a PIT street count, which can lead to inaccurate reporting and the continuation of stereotypical generalizations about the homeless. These discrepancies can include the following: 1) Each city has its own methodologies and sets of survey questions, thus limiting true comparisons across cities and leading to ambiguity in national homelessness statistics; 2) Volunteers conducting the count typically receive limited training, often under two hours, before surveying homeless people on the streets; 3) Volunteers are often instructed to record answers pertaining to mental health/illness and addiction based on their own perceptions (not the respondent's actual answer) even though volunteers do not possess the credentials or skills to conduct a proper mental health/illness assessment; and 4) The count is likely limited to those who fit the stereotypical appearance of a homeless person, disregarding any homeless person who does not fit this image.

Another noticeable limitation in the HUD PIT count, and prior homeless research, is the difficulty of defining and researching the homeless population. Ethnographic research is often devoted to trendy subpopulations whose attributes thereafter tend to be generalized to all homeless

people in the public imagination (Bourgois 2009). These stereotypes cause further limitations by creating the possibility that researchers, and HUD PIT volunteers, may only survey homeless people who stand out in a crowd because they fit the surveyor's perceptions of homelessness by appearing or behaving bizarrely (Lee, A. Tyler and Wright 2010).

The following surveys were conducted in light of issues in methods and ambiguities in mental health and homelessness definitions among prior homeless research. By differentiating and defining the various types and severities of mental illness and targeting a wider range of the homeless population, we provide clearer results regarding mental illness among the general homeless population. The methodologies presented below represent a step forward in describing the prevalence of serious mental illness among this vulnerable population, as well as the access to services attached to diagnoses of mental illness.

Methods

We analyze the levels of mental illness among homeless individuals according to eligibility for SMI homeless housing services. Our survey is based on a PIT census, which is similar to a typical HUD PIT census. Our amended PIT survey introduces two fill-in-the-blank questions to control for the incentive homeless respondents may have in their attempts to qualify for housing based on their potential mental illness. It is our belief that reading a list of symptoms to subjects from a questionnaire can serve to produce inaccurate answers from those looking to access housing.

Our survey was administered through face-to-face interviews, in either English or Spanish depending on the participant's preference. Interviewers were assigned areas to survey the homeless population throughout the city, walking block-by-block in their designated areas. Interviews took place on the streets, under bridges, in public parks, and included marginally housed respondents living temporarily with friends or family. Respondents included those homeless individuals who were observed in stereotypical homeless spaces along with targeted populations of often overlooked homeless individuals sleeping on couches, in hotels, or in their automobiles. In order

to include respondents from the marginally housed homeless subpopulation, surveyors also used snowball samples to include friends and acquaintances who were homeless because they are outside the purview of researchers working in traditionally homeless places.

Our dataset used criteria for measurement of severe mental illness (SMI) among the homeless social service world. According to and (Jans, Stoddard and Kraus 2004) SMI includes a list of the following diagnoses:

> The National Institute of Mental Health [NIMH] analyzed the Epidemiologic Catchment Area (ECA) data to determine the percentage of adults who have severe mental illness. (In some studies the term "severe and persistent mental illness" is used as an equivalent.) This definition is based on the specific psychiatric diagnoses as well as the duration and severity of the symptoms. People who, during the prior year, had disorders that are usually accompanied by psychotic symptoms (schizophrenia, and severe forms of bipolar disorder) were included in the severe mental illness category. In addition, people with other diagnoses (major depression, panic disorder, and obsessive-compulsive disorder) were included in the severe mental illness category only if there was evidence that the disorder had been disabling in the past year (p 8 – words in bold are emphasized by author).

Brennaman & Lobo (2011) also says:

> …diagnoses of schizophrenia, schizo-affective disorder, manic depressive [Bipolar] disorder, autism, severe forms of major depression, panic disorder, or obsessive compulsive disorder, because these disorders are so severe that they almost always lead to serious impairment if not treated (p. 55– words in bold are emphasized by author).

Manic Depressive disorder is now called Bipolar Disorder and severe depression and major depression were categorized to be synonymous with Major Depressive Episode according to DSM-IV (American Psychiatric Association 2000). Although categorizing SMI by the lists above disagrees with most mental health literature, the goal of this study is to categorize homeless SMI by eligibility for homeless housing social services.

Our PIT census was conducted on February 28, 2013. It consisted of the same survey questions the El Paso's PIT street count conducted on January 24th, 2013, with the addition of two follow-up, fill in the blank questions concerning symptoms and conditions of mental illness. While

HUD's PIT records if respondents report concerns of psychiatric or emotional problems, which are sometimes used to deduce SMI, the purpose of our survey was to discover if homeless people who report that they have mental health concerns also report SMI symptoms or diagnoses.

Undergraduate students enrolled in a Methods of Social Research class conducted this survey as a possible research project for the course. These students and volunteers from other classes were trained by the authors in ethics and proper surveying techniques for over a month before conducting the survey, and were given constant direction and oversight. The survey was conducted between 4:00 AM and 10:00 PM on February 28, 2013. As in other PIT censuses, the goal was to count and survey every homeless person possible. Surveyors did not enter any homeless service centers or shelters because it is customary to obtain those numbers from the service administrators to add to the street count. Surveyors wrote a short description of what homeless respondents were wearing so that any duplication of surveyed respondents could be tracked and eliminated during data analysis. With the same objective, respondents were asked to name the city and street where they grew up in order to avoid duplicates, yielding a total sample of 676 (N).

Our PIT census utilized the following modifications in order to address possible socialized incentives among the housing industry found in HUD's PIT. We wanted to avoid language that could be seen as suggesting the possibility of access to housing and services. Since this was a university-led survey independent from HUD and the City of El Paso, we were clear with the respondents that no immediate services or aid would result in participating in this research project. In addition to the typical question used by HUD in many cities to measure mental health, "Do you think you have any current psychiatric or emotional problems?" two follow-up, fill-in-the-blank questions were asked: "What disorder/condition do you experience?" and "Who diagnosed you?" Surveyors were instructed to record any symptoms, formal or informal, that the respondents described along with any symptoms or discrepancies between behavior and reported illness observed. Even if respondents answered "No" to having any emotional or psychiatric problems,

surveyors still asked if respondents had ever been diagnosed and recorded any symptoms described by respondents. Surveyors were also instructed to probe further for any indication of symptoms of mental health in general. Respondent's descriptions of symptoms, diagnoses, and concerns were recorded into a database verbatim. The responses were categorized according to two categories: 1) Those respondents who were diagnosed 2) those who were not diagnosed. They were then delineated further into more categories: those who reported two or more symptoms of an SMI diagnosis who could potentially be diagnosed, and those who reported two or more symptoms of a lesser diagnosis, who could potentially be diagnosed with a less severe diagnosis.

The following flow chart was used to help surveyors better assess respondents' mental health (see figure 1).

[Figure 1 here]

Included in our PIT census was HUD's question, "What type of services did you really need but you could not get in the last 12 months?" A possible answer for this question was "mental health services." If a respondent felt that they may be experiencing mental illness, surveyors were instructed to offer an on-site, good-faith mental health assessment by an expert and transportation to a formal diagnostician for proper assessment. No respondents requested this form of immediate assistance, and there were no adverse events or incidental findings that required an intervention during the course of conducting the surveys.

Those respondents who called themselves homeless and those living in marginally housed settings were categorized as "homeless" in a constructed variable. Those who reported symptoms and/or formal diagnoses or institutionalization for having a mental illness on any answer of the survey were included in the categorization of "diagnosed" in a constructed variable.

Those who were undiagnosed were grouped according to their symptoms as "Potential SMI" according to diagnostic categories of symptomology via the DSM-IV. We did not use the

DSM-V due to the harsh criticism it received for being ambiguous in delineating between diagnoses and their respective symptoms (Aggarwal et al. 2013, Rounsaville et al. 2002, Whooley 2014). The "Potential SMI" was to be counted along with the "Diagnosed SMI" category for a total number of SMI. The "Potential SMI" variable was constructed in order to categorize further whether the respondents fit the list of SMI in (Jans, Stoddard and Kraus 2004), meaning that their diagnoses was either on the list and categorized as "SMI" or not on the list. Those diagnoses not on (Jans, Stoddard and Kraus 2004) list of SMIs were not discarded completely. They were categorized as other mental illness (OMI) or mental illness of less severity, meaning that may be considered mental illness among mental health research but not the homeless housing social services industry. So, by recording data of diagnosed SMI respondents and undiagnosed respondents, we could clearly compile a number of diagnosed and undiagnosed SMI respondents together.

Two symptoms were necessary to be counted as possible OMI, such as reports of feeling tired along with depression. Again none of the reports of mood disorder cases would be considered SMI unless the duration of symptoms was longer than one year or they had suicidal ideation, which no respondents reported during the study.

Many respondents reported a mental health concern or experiencing a single symptom but did not warrant a possible diagnosis. Some reported a mental health concern then described a medical condition, such as "My leg hurts." The responses were recorder anyways for analysis and to illustrate that simply asking "Do you feel you have a mental or psychiatric problem?" is insufficient evidence to ascertain SMI status. Yet, this is the only question other than reported history of hospitalization or reason for homelessness collected by HUD Point in Time counts.

Those who reported only a single symptom of paranoid schizophrenia were categorized as only one symptom because a single symptom would not warrant a formal diagnosis per assessment tools such as the DIS or MINI assessments (Black et al. 2004, Robins L et al. 1981). If respondents described hearing voices or believing that someone was spying on them, followed by a description

of an actual person, i.e. a policeman, wife, or other homeless person, they were not coded as symptomatic of mental illness because they described a rational fear.

Results

Out of 676 (N) homeless respondents, 20.1% reported a mental health concern according to HUD PIT measures, answering "Yes" to the question, "Do you think you have any psychiatric or emotional problems?" Some respondents reported symptoms of a general mental illness but were not concerned with their psychological or emotional problems. A total of 22.5% reported symptoms of AMI. Surveyors reported only two cases where observable signs of mental illness conflicted with respondent reports.

When we considered those who reported a concern for psychiatric or emotional problems, findings show that a 61.82% were concerned about a mental illness of lesser severity. which would not qualify them for Shelter Plus Care housing since they could not be considered having SMI. Only 38.2% of those who report a psychiatric or emotional problem do so because they describe symptoms of SMI or are diagnosed SMI. Thus, of those who report a mental health concern according to HUD's PIT question, 61.8% do not report symptoms or diagnoses of SMI and would not qualify for housing services under S+C. As further analysis of the total respondents who answered "Yes" to a possible psychological or emotional problem, 4.07% reported a medical concern, a concern unrelated to mental health, or could not specify why they had a mental health concern. Out of all respondents, 6.3% reported a need for mental health services in the past 12 months but could not access services.

Out of the total respondents, 71% (480) were chronically homeless according to HUD's definition by reporting being homeless for over one year, or being homeless four or more times in the past three years. Of those who were chronically homeless, 7.01% reported symptoms or diagnoses of SMI. Among the non-chronically homeless, 2.52% reported symptoms or diagnosis of SMI.

Fig 2 is by author with data from Hedden et al. (2012), Shlay and Rossi (1992), and Snow et al. (1986). As Shlay & Rossi (1992) point out, many studies included in their 60-study meta-analysis counted various degrees of mental illness as SMI in their measurements and many studies measured from samples of 100% mentally ill respondents, which focus more on finding causes of mental illness among the homeless population. Therefore, their mean average of 33% has a standard deviation of 23 and the degree of mental illness is unclear, i.e. SMI vs. OMI.

[Figure 2 here]

Discussion

The results of the PIT Census were similar to prior research that studied any mental illness. However, compared to prior research on homelessness that does not measure severity, i.e. SMI and other mental illnesses, the results vary drastically. Those studies that measure SMI report lower rates of mental illness. Those studies that measure any mental illness show higher results. (see Fig 5). Like the aforementioned studies in Hedden et al. (2012) that sampled from the non-homeless population, we differentiated between SMI and any mental illness (AMI) among any reported symptoms of mental illness. By doing so among homeless populations, we find SMI not only to be a minority among the homeless population but a small fraction of those who describe symptoms of AMI, which is the sum of OMI and SMI in figure 5. Our study also confirms our proposition that the methodologies commonly used to study homelessness produce an overrepresentation of people with severe mental illness (SMI). We can justify this statement by comparing the use of simply asking bivariate, "Yes/No" questions to homeless people who may have incentive to answer "Yes" to symptoms of mental health, as seen in Lyon-Callo (2000). We also advance the literature on mental health and homelessness by delineating SMI from other types of mental illness among the homeless, which has never been done before. Those respondents who

reported symptoms categorized as OMI in this study are not considered severe enough for housing access under HUDs Shelter Plus Care housing.

On the left side of figure 5, we compare two studies on SMI and OMI among the American non-homeless population alongside our two studies of SMI and OMI in the middle among the homeless with Snow and Anderson's (1987) findings, and Shlay and Rossi's (1992) meta-analysis of 60 homeless studies, on the right side. The studies in figure 5 are the most credible studies on the prevalence of mental illness among the homeless and have received the most notoriety, thus have received the least amount of criticism. Figure 5 shows that our PIT Census findings concerning the prevalence of SMI and AMI among the homeless population are quite similar to their prevalence among the general non-homeless population.

Hedden, et al.'s (2012) meta-analysis reports on findings in seven national studies, including: The National Survey on Drug Use and Health (NSDUH) reporting 4.8% SMI, National Comorbidity Survey–Replication reporting 5.8% SMI between 2001-2003, and Uniform Reporting System reporting 5.4% SMI. Moreover, our findings on any mental illness are comparable to Shlay & Rossi's (1992) mean average of 33% reporting mental illness (Schlay & Rossi reported a standard deviation of 23% in their compilation of 60 studies on homelessness because of the inconsistencies in the methods across studies). Clarifying the seriousness of the mental illness for the homeless population is something that had not been done before.

The most striking comparison among findings seems to be that while rates of AMI were similar across all studies, reports of mental illness and the corresponding severity dramatically increased when we read off symptoms in the form of a "Yes" or "No" questionnaire to the homeless population. By having respondents confirm or deny mental health symptoms such as, "Have you ever heard things or voices that other people couldn't hear?" respondents seem to more symptoms of mental illness than if they had been asked only open-ended questions, as a therapist would in a consultation "Tell me what you experience," or "Why did you make this appointment?" or "What is bothering you?" When respondents were asked to specify symptoms of mental health in an open-

ended question in our PIT census, they reported fewer symptoms of severe mental illness than in prior research, and an overall prevalence similar to the national domiciled population. This shows that if the methods of our PIT census are used, clearer symptoms and diagnoses can be assessed on the homeless population by attempting to remove the incentive of possible housing by disallowing the respondent to merely answer, "Yes" to as many questions as possible in attempts to fit housing criteria. As can be seen from the literature review and summed up in figure 2, the results of our PIT census, which utilizes two open-ended, follow-up questions, demonstrates that by asking homeless respondents to describe what their mental health concerns are, they were less likely to report symptoms or diagnosis of SMI. Prior research from our literature review stipulates that until now research had been asking bivariate, "Yes/No" questions to homeless respondents and finding high prevalence of mental illness. Findings of a majority of mental illness among the homeless population have only been published a few times when samples are limited to institutionalized settings. We found that when the symptoms of mental illness are not spoon-fed to respondents who have incentive to answer "Yes" in exchange for housing, findings reveal that mental illness among street homeless.

The manner in which a certain set of symptoms can become diagnosable happens in a case-by-case basis, which makes diagnosing individuals open to interpretation. We confirm that the type of methods used to measure mental illness can greatly affect the results. For example, one symptom does not warrant a diagnosis of mental illness (American Psychiatric Association 2000). However, answering more than one question associated with paranoia would indicate the likelihood that a formal diagnosis may be appropriate (Sheehan et al. 2006). If our PIT census had been limited to measuring mental health concern as HUD often does, i.e. "Do you feel that you have a psychiatric or emotional problem?" or had used AMI to imply SMI as some previous research does, without allowing the respondent to describe their mental health concern or mental illness symptoms in detail (as is done in a typical face-to-face assessment with a formal diagnostician), the resulting implied prevalence of SMI would show a much higher percentage.

Further analysis shows that respondents occasionally reported that they "heard voices" or that "someone was out to get them" without reporting any other symptoms of mental illness. While one of these answers represents a single symptom of schizophrenia, actual diagnosis per the DIS, MINI, or other similar diagnostic assessments indicate that more information would need to be observed by a diagnostician before a formal diagnosis could be given, and that it is at the "clinician's judgment" to do so (Sheehan et al. 2006:20). Including such data into our study would be similar to methodologies used in previous research (by asking "Yes/No" questions), and would have simply been an addition to the wide range of prevalence of mental illness found by Shlay & Rossi's (1992) meta-analysis. Instead, the amended survey used in our PIT Census shows that homeless people report rates of mental illness similar to those reported by the non-homeless population (see Figure 5). The lack of research specific to studying types of mental illness and the prevalence of mental illness in recent years points to the necessity of our study. By not limiting our studies to people who simply appeared homeless, these studies provided data that allowed for the consideration of some of the homeless population who may not be approached by a surveyor who is purely interested in studying their version of "the homeless population."

Through their interactions with service providers, homeless respondents may have been socialized about the benefits of answering affirmatively to diagnostic questions. Therefore, it is possible that some respondents may inaccurately or falsely report mental illness in order to fit housing stipulations set by Shelter Plus Care, so underreporting is likely to be low. Some respondents even reported symptoms unrelated to mental health, causing speculation as to why they would report a mental health concern in the first place. In other words, homeless people may show signs of conforming to the incentive to respond "Yes" to questions regarding experienced mental illness, as a diagnosis of SMI is one possible means to eligibility for housing assistance. This finding challenges HUD's methods of measuring mental illness among the homeless, while removing the word-coaxing mechanism within a traditional assessment that is based purely on "Yes" or "No" responses. Measuring mental illness among the homeless without regard for the

incentive to fit the housing requirements per HUD's Shelter Plus Care significantly limits the findings in prior research. This study has the same limitation but we remove the aid of providing symptoms to coax respondents to give a medicalized response. That is to say that the incentive for housing is still present, but respondents had to provide their responses instead of checking "Yes" from a list of symptoms. The incentives homeless people have of fitting into a framework of mental illness in order to satisfy their basic needs, in this case housing, should be controlled for in future research. Until adequate assessment tools that are similar to those used to study the general non-homeless population, such as the DIS or MINI, are used to study homeless people, social scientists, and practitioners should at least acknowledge the methodological errors involved in asserting a prevalence of mental illness among the homeless population.

Those who are hiding their mental illness are a population difficult to identify, meaning those who do not report their mental health symptoms even if they have been formerly diagnosed, or are unwilling to share their symptoms of undiagnosed mental illness are uncounted. However, this possible limitation not only affects this study but any study attempting to measure mental illness. In fact, any study gathering stigmatizing information from non-homeless respondents would be equally affected by this possible limitation when measuring mental illness. Further research is be necessary to conclude if homeless people are particularly sensitive to further stigmatized of SMI diagnoses considering their housing options, should they qualify as SMI.

Another limitation of measuring mental illness in general is the difficulty of asserting the severity of mood disorders. Mood disorders can cover a range of mental illnesses in the DSM-IV from situational depression, which is experienced by anyone who has ever had a sad experience, to Major Depressive Episode. Extensive qualitative information must be gathered to give the respondent's answers context in these situations. Although the argument could be made that depression and anxiety can be debilitating it is not applicable under current HUD Shelter Plus Care polices. Those respondents who reported depression were categorized as OMI in this paper because are not considered SMI by Shelter Plus Care policies.

Finally, some respondents in our PIT census could have had a mental health concern, but because it was not severe enough to be counted as a mental illness according to the flow chart in Fig 1, the percentage who were recorded as reporting symptoms of AMI may have been underreported; in other words the OMI category could be higher than reported. However, this possible limitation actually makes the recorded SMI percentage more valid, because surveyors recorded actual SMI data rather than assuming SMI based on all, even non-severe, symptoms. The methodology of specifically looking for valid symptoms or diagnosis of SMI also establishes that the underreporting of mental illness is unlikely to account for the majority of discrepancies between the results of our homeless PIT Census.

Future research could include a full diagnostic interview using assessment tools such as the MINI and DIS. As with previous research, the surveyors who collected the data for these studies were not diagnosticians, nor were formal diagnostic tools used to conduct this study. However, we provide a contribution to homeless research by attempting to use better methods to formulate conclusions based on interviewers' ability to give a good faith diagnoses.

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Tables

Table 1 *Demographics*

	Valid Percentage (n=678)(%)
Gender	
Male	81.3
Female	18.8
Age	
25 and under	14.7
26 to 50	44.5
Over 50	40.9
Ethnicity	
American Indian	1.5
Asian	0.1
Black	9.2
White	22.6
Hispanic	66.5
Primary language	
English	45.5
Spanish	54.5
Raised	
El Paso Region	36.3
In the U.S.	29.2
Abroad	34.5
Time in El Paso	
Unknown	2.7
Less than 4 months	7.0
4 to 6 months	3.6
7 to 12 months	3.5
1 to 2 years	8.3
2 to 5 years	13.6
Over 5 years	61.3
Enrolled in school	12.4
Education level	
Up to 6^{th} grade	22.0
More than 6^{th} < High School	22.6
Completed High School/GED	34.8
Trade/ Tech School	11.8
Bachelor's Degree	7.4
Graduate/ Professional Degree	1.4

Table 2 *Reasons and Risk Factors for Homelessness*

	Valid Percentage (n=678)(%)
Primary Factor	
Loss of job	20.7
Unable to get a job	21.6
Left foster care	0.5
Loss of public assistance	1.8
Have a job but can't afford housing	9.1
Can't keep a job due to disability	2.9
Medical Problems	2.9
Mental Health Problems	1.7
Domestic Abuse	2.7
Drug/Alcohol Problems	5.2
Release from an institution	2.1
Violence in Juarez	1.4
Foreclosure	0.5
Rent Affordability	3.0
Deportation/ Immigration	2.1
Family conflict	7.9
Other	13.9
Discharged from Institution in last 6 months	
Drug/Alcohol Treatment	5.3
Psychiatric Facility	2.5
Jail/Prison/ Halfway house	9.7
Hospital	5.9
None	76.6
Have you been in foster care?	18.5
Agricultural worker?	19.5
Disabled	24.4
Type of Disability	
Mental	6.3
Physical	12.7
Developmental	0.6
Substance Abuse	2.0
Unknown	2.4
Refuse	0.5
Not Disabled	75.6
Have you or your family ever served in the U.S. military?	26.9

Have you ever registered with the VA?	7.8
Have you ever been convicted of a felony?	19.2
Do you think you have any current psychiatric or emotional problems?	19.6
Do you think you have a problem with alcohol or drugs?	23.2

Table 3 *Experience of Homelessness*

	Valid Percentage (n=678)(%)
Time Homeless	
Don't know	6.3
Less than 1 week	1.4
1 to 4 weeks	4.4
1 to 3 months	5.9
4 to 6 months	7.2
7 to 12 months	7.4
1 to 2 years	15.1
2 to 5 years	16.9
Over 5 years	35.3
Homeless four or more times in the last three years	50.8
Chronically homeless	78.1
Housing status	
Shelter	24.0
Street or Unspecified	52.5
Marginally housed	22.6

Table 4 *Services Needed but not Received in Last 12 Months*

	Valid Percentage (n=678)(%)
Finding a job	41.1
Finding a place to live	27.0
Transportation	15.0
Case management	3.1
Health care	15.2
Eye care	9.7
Dental care	9.4
Mental health care	6.3
Budgeting	7.7
Child care	4.9
Substance use counseling	5.5
Legal	7.4
Educational	6.0
Securing benefits	3.8

Table 5 *Demographic Comparison*

	Hispanic (n=445)(%)	Non-Hispanic (n=225)(%)	X^2	*df*	*p*
Gender			2.124	1	.145
Male	79.9	84.6			
Female	20.1	15.4			
Age			14.397	2	<.001
25 and under	17.5	8.6			
26 to 50	40.2	53.4			
Over 50	42.3	38.0			
Primary language			323.584	1	<.001
English	20.2	95.7			
Spanish	79.8	4.3			
Raised			238.383	2	<.001
El Paso Region	40.3	28.4			
In the U.S.	10.7	68.0			
Abroad	49.1	3.6			
Time in El Paso			54.655	6	<.001
Less than 4 months	3.4	13.8			
4 to 6 months	3.2	4.6			
7 to 12 months	3.2	4.1			
1 to 2 years	6.6	11.5			
2 to 5 years	11.9	17.5			
Over 5 years	70.0	43.3			
Enrolled in school	13.4	6.4	7.352	1	.007
Education level			31.409	5	<.001
Up to 6^{th} grade	27.6	10.2			
More than 6^{th} < High School	22.9	22.3			
Completed High School/GED	29.9	45.7			
Trade/ Tech School	11.2	13.2			
Bachelor's Degree	7.5	6.1			
Graduate/ Professional Degree	0.9[a]	2.5			

Notes: The superscript "a" denotes a percentage representing fewer than 5 respondents.

Table 6 *Reasons and Risk Factors for Homelessness*

	Hispanic (n=445)(%)	Non-Hispanic (n=225)(%)	X^2	*df*	*p*
Primary Factor			54.999	16	<.001
Loss of job	21.8	18.6			
Unable to get a job	19.8	25.6			
Left foster care	0.0[a]	1.4[a]			
Loss of public assistance	1.1[a]	3.3			
Have a job but can't afford housing	11.3	5.1			
Can't keep a job due to disability	2.1	4.7			
Medical Problems	2.8	3.3			
Mental Health Problems	0.9[a]	2.8			
Domestic Abuse	3.4	1.4[a]			
Drug/Alcohol Problems	3.2	9.3			
Release from an institution	2.1	2.3			
Violence in Juarez	2.1	0.0[a]			
Foreclosure	0.5[a]	0.5[a]			
Rent Affordability	3.9	1.4[a]			
Deportation/ Immigration	3.0	0.0[a]			
Family conflict	9.2	5.1			
Other	12.9	15.3			
Discharged from Institution in last 6 months			35.104	5	<.001
Drug/Alcohol Treatment	4.3	7.5			
Psychiatric Facility	0.9[a]	5.8			
Jail/Prison/ Halfway house	8.0	13.6			
Hospital	4.1	9.9			
Have you been in foster care?	19.6	16.4	.961	1	.327
Agricultural worker?	25.8	7.7	30.168	1	<.001
Disabled	17.7	38.9	34.887	1	<.001
Type of Disability			38.667	6	<.001
Mental	3.9	11.6			
Physical	10.5	17.6			
Developmental	0.5[a]	0.9[a]			
Substance Abuse	1.1[a]	3.7			
Have you or your family ever served in the U.S. military?	19.1	43.3	42.540	1	<.001
Have you ever registered with the VA?	5.1	12.8	11.561	1	<.001
Have you ever been convicted of a felony?	12.6	33.7	39.663	1	<.001
Do you think you have any current psychiatric or emotional problems?	16.3	27.7	11.870	1	<.001

Do you think you have a problem with alcohol or drugs?	19.1	31.6	12.590	1	<.001

Notes: The superscript "a" denotes a percentage representing fewer than 5 respondents

Table 7 *Experience of Homelessness*

	Hispanic (n=445)(%)	Non-Hispanic (n=225)(%)	X^2	*df*	*p*
Time Homeless			34.680	8	<.001
Less than 1 week	1.4	0.9[a]			
1 to 4 weeks	5.3	2.3			
1 to 3 months	6.2	5.5			
4 to 6 months	9.2	3.2			
7 to 12 months	8.5	5.5			
1 to 2 years	14.0	17.4			
2 to 5 years	17.4	16.0			
Over 5 years	34.9	36.5			
Homeless four or more times in the last three years	45.4	62.3	16.466	1	<.001
Chronically homeless	75.5	84.0	12.133	2	.002
Yes	75.5	84.0			
Housing status			22.209	3	<.001
Shelter	24.0	24.7			
Street or Unspecified	48.7	63.2			
Marginally-housed	27.2	12.1			

Notes: The superscript "a" denotes a percentage representing fewer than 5 respondents.

Table 8 *Services Needed but not Received in Last 12 Months*

	Hispanic (n=445)(%)	Non-Hispanic (n=225)(%)	X^2	*df*	*p*
Finding a job	44.3	34.4	5.624	1	.018
Finding a place to live	25.5	30.0	1.445	1	.229
Transportation	14.4	15.2	0.070	1	.791
Health care	9.7	27.1	33.335	1	.000
Eye care	8.3	12.9	3.373	1	.066
Dental care	7.4	13.9	6.946	1	.008
Mental health care	4.6	10.0	6.986	1	.008
Child care	5.1	4.3	.184	1	.668
Substance use counseling	3.4	10.0	11.536	1	.001
Legal	6.9	7.6	.117	1	.733
Educational	6.0	6.2	.015	1	.904

Figures

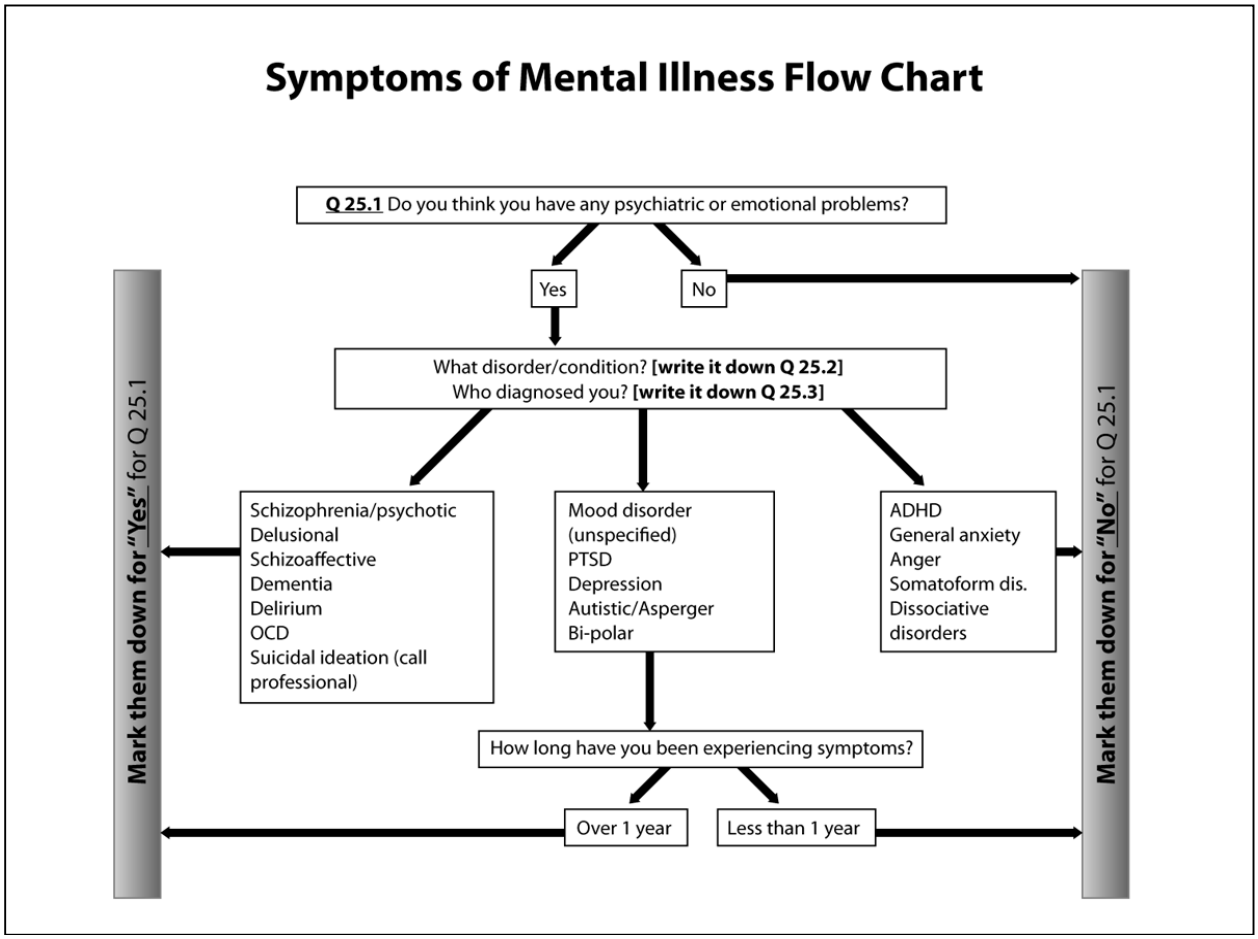

Fig. 1 Flow chart by authors with data from DSM-IV and Brennaman and Lobo (2011)

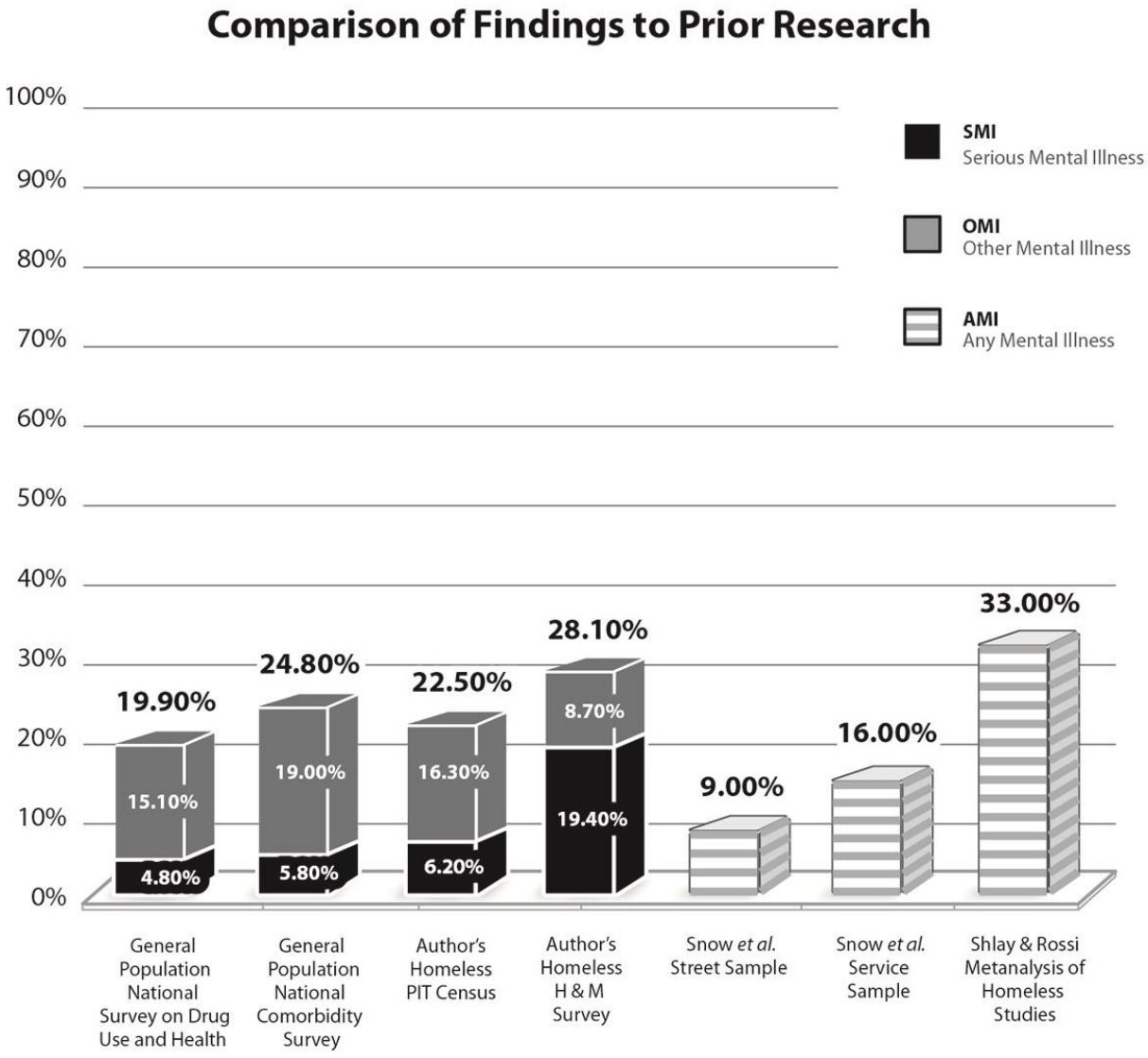

Fig 2 by author with data from Hedden *et al.* (2012), Shlay and Rossi (1992), and Snow *et al*. (1986). As Shlay & Rossi (1992) point out, many studies included in their 60-study meta-analysis counted various degrees of mental illness as SMI in their measurements and many studies measured from samples of 100% mentally ill respondents, which focus more on finding causes of mental illness among the homeless population. Therefore, their mean average of 33% has a standard deviation of 23 and the degree of mental illness is unclear, i.e. SMI vs. OMI.

Appendix

El Paso Homeless· Point in Time Survey- English Indian or Alaska Native

1. (a)Age_____ (b) City & Street you grew up _____
2. Gender
a. Male b. Female
3. Race
a. American Indian or Alaska Native
b. Asian
c. Black or African American
4. Ethnicity
a. Hispanic b. Non-Hispanic
5. What is the primary factor in your being homeless?
a. Recent loss of a job/couldn't maintain housing payment
b. Unable to get a job
c. Left State Foster Care System
d. Loss of public assistance/aid
e. Have a job and can't afford housing
f. Can't keep job because of problems such as medical, mental, etc.
g. Medical/Health Problems
h. Mental Health Problems
i. Domestic Abuse/Violence
j. Drug or Alcohol Problems
k. Release from an institution (Incarceration, Hospitalization)
l. Violence In Juarez
m. Foreclosure
n. Rent Affordability
o. Deportation/Immigration
p. Family conflict (evicted)
q. Other _____
6. Are you enrolled in school or working on a degree?
a. Yes b. No
7. Are you enrolled in a trade/technical school or apprenticeship program?
a. Yes b. No
8. Education Level
a. No School Completed
b. Pre-School to 4th Grade
c. 5th to 6th Grade
d. 7th to 8th Grade
e. 9th Grade
f.
g. 10th Grade
h. 11th Grade
i. 12th Grade
j. High School Diploma
9. Length of time in El Paso

a. Unknown/don't know

b. Less than 1 week

c. Between 1 and 4 weeks

d. Between 1 and 3 months

e.

f. Between 4 and 6 months

10. How long have you been homeless?

a. Unknown/don't know

b. Less than 1 week

c. Between 1 and 4 weeks

d.

e. Between 1 and 3 months

f. Between 4 to 6 months

11. Have you been released or discharged from any of the following in-patient services in the past six (6) months?

a. Drug/Alcohol Treatment Center

b. Psychiatric facility

c. Jail/Prison/Half-way house

d. Psychiatric Center

12. Have you ever been in Foster Care?

a. Yes b. No

13. Are you an agricultural worker?

a. Yes b. No

14. What is your primary Language?

a. English b. Spanish c. Other

15. Household Group

a. Unknown/don't know

b. Individual (not affiliated family)

c. Head or Household (Affiliated with Family)

d. Spouse (Affiliated with Family)

e. Child (Affiliated with Family)

f. Other (Affiliated with Family)

16. Are you pregnant?

a. Yes b. No c. Refuse d. Don't know

17. How many children are with you now _____

18. Are you disabled?

a. Yes b. No

19. If so, please indicate disability

a. Mental

b. Physical

c. Developmental

d. Substance/Alcohol Use

20. Have you been homeless four or more times in the last three years?

a. Yes b. No

21. Have you or family members ever served in the U.S. Military?

a. Yes b. No

22. Have you ever registered with the VA?

a. Yes b. No

23. Please identify a source(s) of income that you are currently receiving

a. No income

b. Earned income

c. Unemployment

d. Workers Compensation

e. Veterans Disability Payments

f. Private Disability Insurance

g. Social Security Disability Insurance (SSDI)

h. Supplemental Social Security (SSI)

i. Social Security Retirement Income

j. Veterans Pension

k. Pension from a former job

l. Child Support

m. Temporary Assistance to Needy Families (TANF)

n. General Public Assistance (GA)

o. Alimony or Spousal Support
p. Other source of Income_____
24. Have you ever been convicted of a felony?
a. Yes b. No
25. 25.1 Do you think that you have any current psychiatric or emotional problem(s)?
a. Yes b. No

a. GED
b. Trade/Technical School
c. Post Secondary School
d. Associate Degree
e. Bachelors Degree
f. Masters Degree
g. Doctorate Degree
h. Other Professional Degree
i. Refuse Don't Know

j. No School Completed
k. Pre-School to 4th Grade
l. 5th to 6th Grade
m. 7th to 8th Grade
n. 9th Grade
o. 10th Grade
p. 11th Grade
q. 12th Grade
r. High School Diploma

f. Between 7 and 12 months
g. Between 1 and 2 years
h. Between 2 and 5 years
i. Over 5 years

a. Unknown/don't know
b. Less than 1 week
c. Between 1 and 4 weeks
d. Between 1 and 3 months
e. Between 4 and 6 months

a. Between 7 to 12 months
b. Between 1 and 2 years
c. Between 2 and 5 years
d. Over 5 years

e. Unknown/don't know
f. Less than 1 week
g. Between 1 and 4 weeks
h. Between 1 and 3 months
i. Between 4 and 6 months

d. Psychiatric Center
e. Hospital
f. No

a. Drug/Alcohol Treatment Center
b. Psychiatric facility
c. Jail/Prison/Half-way house

a. Substance/Alcohol use
b. Unknown
c. Refuse

d. Mental
e. Physical

f. Developmental

a. Not familiar with locations
b. No privacy in shelter
c. Banned from shelter
d. Other_____

e. Don't feel safe
f. Pets not allowed
g. Too crowded
h. No trans to shelter
i. Shelter rules to restrictive

a. Help with budgeting
b. Help with child care
c. Substance use counseling
d. Legal Assistance
e. Educational assistance (GED/ESL)
f. Help with securing benefits
g. Other_____

h. Help finding a job
i. Help finding a place to live
j. Transportation assistance
k. Case management assistance
l. care services
m. Eye care
n. Dental care
o. Mental health care

25.2 What disorder/condition do you have? _____
25.3 Who diagnosed you? _____
26. Do you think that you have problems with alcohol or drug use?
a. Yes b. No
27. Are you in a shelter?
a. Yes b. No
28. If not in a shelter, why not?
a. Don't feel safe
b. Pets not allowed
c. Too crowded
d. No trans to shelter
e. Shelter rules too restrictive
f.
29. What type of services did you really needed buy you could not get in the last 12 months?
a. Help finding a job
b. Help finding a place to live
c. Transportation assistance
d. Case Management Assistance
e. Health Care Services
f. Eye Care
g. Dental Care
h. Mental Health Care

El Paso Homeless· Point in Time Survey- Español

a. Nativo de Hawaii u otra Isla del Pacifico
b. Blanco
c. Otro

1. (a)Edad_____ (b) Ciudad y called donde crecio _____
2. Sexo a. Masculino b. Femenino
3. Raza
a. Indigena Americano or Nativo de Alaska
b. Asiatico
c. Negro o Africo-Americano
d. Nativo de Hawaii otra Isla en el Pacifico
4. Etnicidad
a. Hispano b. No hispano
5. Cual es el factor primario por el que esta sin hogar?
a. Perdida reciente de trabajo/dificultad en realizar pagos del hogar
b. Imposibilidad de encontrar trabajo
c. Dejo el Sistema de Cuidado del Estado
d. Perdida de la asistencia/ayuda publica
e. Cuento con un trabajo pero no puedo pagar el hogar
f. No puedo mantener un trabajo por problemas medicos o mentales, etc.
g. Problemas medicos/salud
h. Problemas de Salud Mental
i. Abuso/Violencia domestica
j. Drogas o abuso del alcohol
k. Salida de una institucion (encarcelamiento, hospitalizacion)
l. Violencia en Juarez
m. Hipoteca
n. Problemas con la renta
o. Deportacion/Immigracion
p. Conflicto familiar (desalojo)
q. Otro _____
6. Esta registrado en alguna escuela, o estudiando en la Universidad?
a. Si b. No
7. Esta registrado en alguna carrera tecnica/programa de aprendizaje?
a. Si b. No
8. Nivel de Educacion
a. Escuela incompleta
b. Preescolar a 4to Grado
c. 5to a 6to Grado
d. 7mo a 8vo Grado
e. 9no Grado
f. 10mo Grado
g. 11vo Grado
h.
i. 12vo Grado

d. Indigena Americano o Nativo de Alaska
e. Asiatico
f. Negro o Africo-Americano

a. GED
b. Carrera Tecnica
c. Escuela Post Secundaria
d. Diploma de Asociado

e. Carrera Universitaria
f. Maestria
g. Doctorado
h. Otro Diplomado Profesional
i. No se

j. Escuela incompleta
k. Preescolar a 4to Grado
l. 5to a 6to Grado
m. 7mo a 8vo Grado
n. 9no Grado
o. 10mo Grado
p. 11vo Grado
q. 12vo Grado
r. Preparatoria

a. Entre 7 y 12 meses
b. Entre 1 y 2 años
c. Entre 2 y 5 años
d. Más de 5 años

e. Desconocido/No sabe
f. Menos de 1 semana
g. Entre 1 y 4 semanas
h. Entre 1 y 3 meses
i. Entre 4 y 6 meses

f. Entre 7 y 12 meses
g. Entre 1 y 2 años
h. Entre 2 y 5 años
i. Mas de 5 años

a. Desconocido/No sabe
b. Menos de 1 semana
c. Entre 1 y 4 semanas
d. Entre 1 y 3 meses
e. Entre 4 y 6 meses

a. Centro Psiquiatrico
b. Hospital
c. No

d. Centro de Atencion a Drogas/Alcohol
e. Hospital Psiquiatrico
f. Carcel/Prision

a. Conyugge
b. Hijo (afiliado a la familia)
c. Otro (afiliado a la familia)

d. Desconocido/No sabe
e. Individual (no afiliado a la familia)
f. Cabeza de familia (afiliado a la familia)

a. Mental
b. Fisica
c. De desarrollo

d. Relacionada con substancia/alcohol
e. No sabe
f. Sin contestar

a. No conozco donde se encuentran

b. No hay privacidad
c. Expulsado del refugio
d. Otro_____

e. No me siento seguro
f. No admiten mascotas
g. Sobrepoblados
h. No tengo transportacion al refugio
i. Las reglas son muy estrictas

9. Tiempo de estancia en El Paso
a. Desconocido/No sabe
b. Menos de 1 semana
c. Entre 1 y 4 semanas
d. Entre 1 y 3 meses
e. Entre 4 y 6 meses
f.
10. Cuanto tiempo lleva sin hogarHow long have you been homeless?
a. Desconocido/No sabe
b. Menos de 1 semana
c. Entre 1 y 4 semanas
d. Entre 1 y 3 meses
e. Entre 4 y 6 meses
f. Entre 7 y 12 meses
11. Ha sido liberado de alguno centro de atencion a pacientes en los ultimos seis (6) meses?
a. Centro de Atencion a Drogas/Alcohol
b. Facilidad Psiquiatrica
c. Carcel/Prision

i. Ayuda con presupuestos
j. Ayuda con los hijos
k. Consejeria para el abuso de substancias
l. Asistencia Legal
m. Asistencia Educativa (GED/ESL)
n. Ayuda asegurando mis beneficios
o. Otra, por favor indicar_____

a. Ayuda encontrando un trabajo
b. Ayuda encontrando un hogar
c. Transportacion
d. Asistencia en Manejo de Casos
e. Servicios de Higiene
f. Salud Visual
g. Salud Dental
h. Salud Mental

12. Alguna vez ha estado en casa de asistencia?
a. Si b. No
13. Usted trabaja en la agricultura?
a. Si b. No
14. Cual es su primer lenguaje?
a. Ingles b. Español c. Otro
15. Grupo Familiar
a. Desconocido/No sabe
b. Individual (no afiliado a la familia)
c. Cabeza de Famillia (Afiliado a a Familia)
d. Conyuge (Afiliado a la Familia)
16. Esta embarazada?
a. Si b. No c. Sin contestar d. No sabe
17. Cuantos hijos tiene con usted ahora? _____
18. Esta usted discapacitado?
a. Si b. No

19. Si respondio que si, especifique su discapacidad.
a. Mental
b. Fisica
c. De desarrollo
d. Relacionada con substancia/Alcohol
20. Ha estado sin hogar cuatro o mas veces en los ultimos tres años?
a. Si b. No
21. Usted o algunos de sus familiares ha sido miembro de las fuerzas armadas de Estados Unidos?
a. Si b. No
22. Alguna vez se ha registrado en el VA?
a. Si b. No
23. Por favor, identifique alguna forma de ingreso economico que actualmente recibe
a. No tengo ingresos
b. Ingreso de trabajo
c. Desempleado
d. Compensacion laboral
e. Pagos por ser Veterano
f. Aseguranzapor discapacidad Privada
g. Aseguranza por Discapacidad del Seguro Social (SSDI)
h. Seguro Social Secundario (SSI)
i. Ingreso de Retiro del Seguro Social
j. Pension de Veterano
k. Pension de un empleo anterior
l. Pago por Hijos
m. AsistenciaTemporal a Familias Necesitadas (TANF)
n. Asistencia General Publica (GA)
o. Ayuda de Conyuge
p. Otra forma de Ingreso_____
24. Alguna vez ha sido condenado por un delito grave?
a. Si b. No
25. 25.1Usted considera que tiene algun problema psiquiatrico o emocional actualmente?
a. Si b. No

25.2 Que problema tiene? _____
25.3 Quien lo diagnostico? _____
26. Usted considera que tiene problemas con drogas o alcohol?
a. Si b. No
27. Esta en algun refugio?
a. Si b. No
28. Si no esta en un refugio, porque no lo esta?
a. No me siento seguro
b. No admiten mascotas
c. Sobrepoblados
d. No tengo transportacion al refugio
e. Las reglas son muy estrictas
f. No conozco donde se encuentr
29. Que tipo de servicios usted necesito realmente en los ultimos 12 meses y no pudo obtener?
a. Ayuda encontrando un trabajo
b. Ayuda encontrando un hogar
c. Transportacion
d. Asistencia en Manejo de Casos
e. Servicios de Higiene
f. Salud Visual
g. Salud Dental
h. Salud Mental

Vita

Curtis Smith is a master's student of Sociology at the University of Texas at El Paso. His fieldwork with homeless individuals spans over 10 years as a homeless street outreach worker in Cincinnati, OH, USA; Covington, KY, USA and Phoenix, AZ, USA, and El Paso, TX, USA. His work has published in Social Movement Studies and the Journal of Healthcare for the Poor and Underserved. He is interested in the social context in which homeless individuals are researched.

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