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Crazy, Dirty, and Lazy?: Stigmatization of Homeless Mentally Ill People by Providers of Homeless Services

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Doctor of Medicine
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Thesis Committee Chair: Roger Rochat, M.D.

An abstract of
a thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
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2011

Abstract

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Background

Stigmatized populations, such as the homeless and mentally ill, maintain significantly poorer health outcomes, dying over 25 years younger than the general population. Workers who provide homeless services control which individuals receive temporary shelter, transitional and permanent housing, food, resources to assist in employment, and access to free medical care. Stigma towards homeless people with mental illness among workers may negatively affect health outcomes in this vulnerable population.

Objective

In this study, I examine stigma towards people experiencing homelessness and mental illness by volunteers and workers who provide homeless services, both from the perspective of the service providers and the homeless clients.

Methods

I utilized data collected during a Community Needs Assessment of Homeless Health Initiative to quantify positive and negative observations of service providers and experiences of homeless individuals. Surveys of service providers and homeless clients provide quantitative data on provider behavior towards their homeless clients. Individual interviews with homeless individuals with mental and addictive disorders provide qualitative data to better understand the experience of stigma among this population.

Results

According to service providers and homeless clients, stigma towards homeless people with mental and addictive disorders is prevalent among workers providing homeless services. Half of service providers reported stigma among service providers and ranked the level of stigma as moderate to severe. Though homeless clients were reticent to criticize workers who provide for their physical needs, half of homeless participants reported rudeness and 40% felt disrespected in interactions with service providers.

Discussion

This study demonstrates stigma and maltreatment of homeless individual with mental illness by workers paid to provide services for this population. Organizations providing homeless services should implement stigma reduction campaigns and education on mental and addictive disorders among workers to reduce stigma and improve health outcomes. Further research is necessary to examine specific health consequences resulting from shame and emotional damage as well as poor access to services.

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Introduction

Violent, crazy, dirty, lazy, dangerous: these words characterize common public perceptions of “the homeless,” labeling them as sub-human and unworthy of respect. The public similarly stigmatizes people with mentally illness. Stigma, defined by Goffman, is an “undesired differentness” that provokes others to view stigmatized groups as“not quite human,” generating discrimination against them (1963, p. 5). As Corrigan describes, individuals with severe mental illness and addictive disorders are perceived as being at fault for their illness, unable to recover, and possibly unable to be self-sufficient (2000). Stigmatized groups, such as the homeless and mentally ill, maintain significantly poorer health outcomes, dying over 25 years younger than the general population. The health consequences of this stigma and discrimination demonstrate a need to better understand the nature of stigma towards homeless people with mental illness.

Service workers can strongly influence homeless individuals’ ability to exit homelessness. Gatekeepers to food, clothing, and education, such workers provide access to transitional and permanent housing; they enable homeless individuals to secure incomes by helping them obtain employment or navigate the Social Security Administration. Stigmatization of subsets of the homeless population, such as people with mental and addictive disorders, has the acute potential to further negatively influence the health of this vulnerable population.

Using quantitative and qualitative methods, I examine the presence of stigma among service workers toward homeless individuals with mental and addictive disorders.Within the context of a Community Needs Assessment for Homeless Health Initiative, Isurveyed homeless individuals with mental and addictive disorders and service providers to determine the prevalence of positive and negative service provider actions. Homeless Health Initiative(HHI) is a non-profit student-run mental health clinic located in an Atlanta homeless shelter.This study will provide information missing in current mental and public health literature necessary for improving health and social determinants of health for mentally ill homeless persons.

In this study, I use the term “stigma” synonymously with the words “discrimination” and “prejudice.” Stigma, in this context, signifies the negative attitudes held towards people who do not occupy socially accepted rolesor whose behavior is perceived not to fit in with social norms. In this study, I use the Homeless Health Initiative definition of homelessness, which states that a homeless person is someone who does not have a stable, fixed address and sleeps in places unfit for permanent human living (cars, outdoors, tents, abandoned buildings), shelters, or transitional living facilities, or who lives doubled up with family or friends due to inability to afford rent, or who lives in hotels or motels and is within 30 days of being unable to afford a room. A service provider in this studyis a person who provides services to the homeless either as a volunteer or as a paid employee. I also use the words “service worker,” “worker,” and “provider” with the same meaning in this study. Services may include, but are not limited to, shelter, food, clothing, medical care by organizations targeting the homeless, and assistance with disability benefits. Services provided byhospitals andgovernment organizations, such as the Social Security Administration, are not included as services for the homeless in this study. I define homeless organizations as nonprofit organizations and churches that provide services for the homeless. Adults are individuals older than age 18.

I use the words “client,” “patient,” and “consumer” interchangeably to reference a homeless person receiving services from homeless organizations.

Literature Review

Epidemiology of Mental Illness Among the Homeless

The prevalence of mental illness among the homeless population varies significantly by study, owing to differences in study designs and sample populations. According to the National Survey of Homeless Assistance Providers and Clients (NSHAPC) (Burt et al, 1999), performed by the United States Census Bureau, 86% of homeless individuals were identified as having an alcohol, drug, or mental health problem in their lifetime. Specifically, 39% reported a mental health problem in the past year and 57% reported a lifetime prevalence of a mental health problem. NSHAPC findings are listed in Table 1 (Burt et al, 1999).

Table 1: 1999 NSHAPC Prevalence of Mental and Addictive Disorders Among Homeless Adults

Disorder	Past Month Prevalence	Past Year Prevalence	Lifetime Prevalence
All	66%	74%	86%
Mental Health	39%	45%	57%
Alcohol	38%	46%	62%
Drug	26%	38%	58%

According to Fischer and Breakey (1991), studies reporting prevalence of alcohol, drug, and mental disorders among homeless individuals vary based on city, ratio of males to females, and instrument or clinical exam used to diagnose the disorders. Among the most rigorous studies, Fischer and Breakey found point prevalences of alcohol use disorders ranging from 12.2% to 68%. All studies with over 100 participants, however, demonstrated a prevalence of at least 28.3% with a range from 1% to 37.1%. Fischer and

Breakey compare these findings to the prevalence of mental illness among housed individuals in a five-city National Institute of Mental Health (NIMH) household survey. Among housed individuals, the prevalence of alcohol and drug disorders is 13.3% and 5.9%, respectively. Three studies of mental disordersreviewed by Fischer and Breakey, each sampling over 200 homeless individuals, demonstrated “remarkable consistency in their estimates of prevalence: 10% to 13% were schizophrenic, 21% to 29% had affective disorders, 2% to 3% were demented, and 14 to 20% had antisocial personality disorder” (1991, p. 1122). Comparatively, the NIMH survey demonstrated a 1.3% prevalence of schizophrenia, 8.3% prevalence of affective disorders, 1.3% prevalence of dementia, and 2.5% prevalence of antisocial personality disorder among housed individuals (Fischer &Breakey, 1991, p.1122).

Stigma and Mental Illness

A large body of literature on stigma and mental illness exists. Many studies indicate that the general population holds negative views even towards people who have recovered from mental illness. Figure 1 demonstrates opinions from a random sample of 7,246 German citizens in six cities (Gaebel et al, 2002). This study reveals that most people think less of persons with mental illness, would not treat them equally to people without mental illness, and attach ideas of shame and failure to mental hospitalization. Corrigan et al (2000) report prejudicial views toward people with mental illness in their study of 152 Chicago community college students. Respondents compared mental retardation, psychosis, depression, and cocaine addiction with two physical illnesses, AIDS and cancer, on likelihood of recovery and degree of responsibility of the individual for their diagnosis.

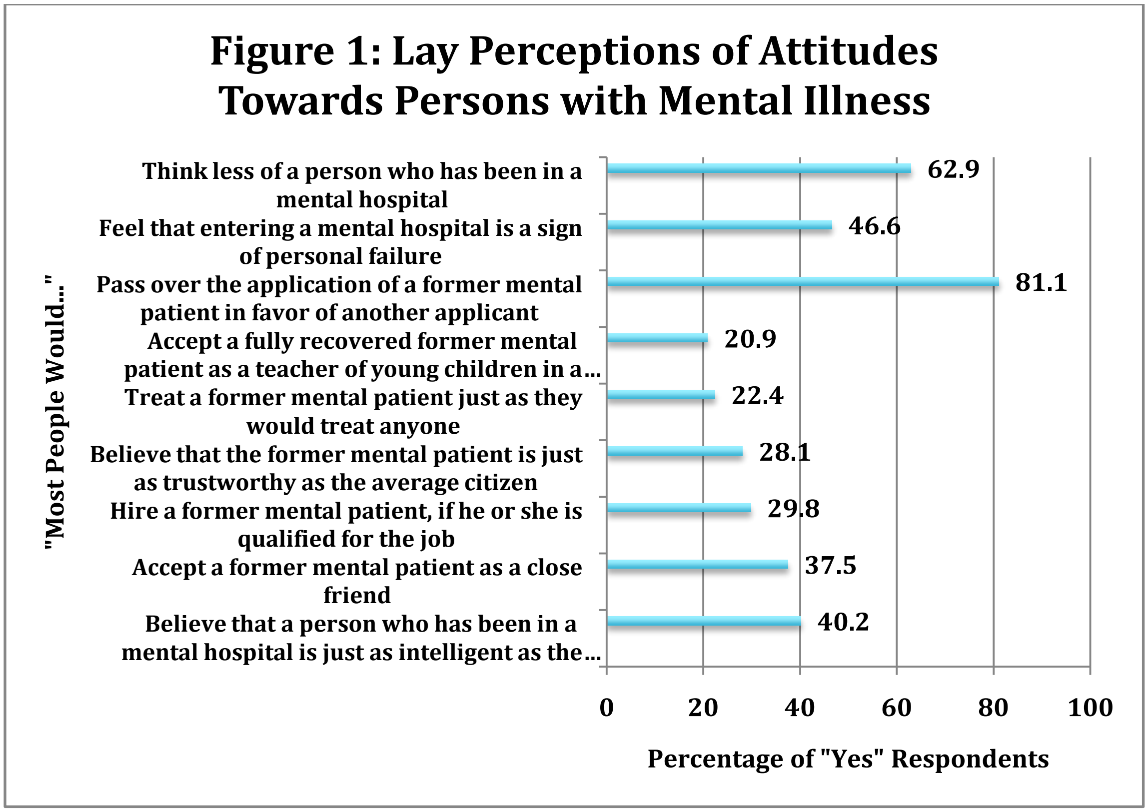

Figure 1: Lay Perceptions of Attitudes Towards Persons with Mental Illness

*Gaebel, Baumann, Witte, and Zaeske, 2002

Respondents held people with cocaine addictions most accountable for their illness, followed by people with psychosis and AIDS. Respondents blamed people with cancer least for their illness, followed by mental retardation. People with depression were moderately blamed, but ranked most likely to recover. The students ranked cocaine-addicted and mentally-retarded individuals as least likely to recover, followed by people with AIDS. Psychosis was considered moderately treatable, followed by cancer, which respondents deemed most likely to respond to treatment. A study of 36,000 French participants demonstrates that “over 75% of respondents associated the words ‘insane’ and ‘mentally ill’ with violent and dangerous behaviors” (Reolandt et al, 2010). Respondents described “insane” and “mentally ill” individuals as “abnormal, irresponsible, unconscious, socially excluded,” and “far from curable.”

Perhaps the most obvious form of public stigmatization of mental illness is its portrayal in the media. Angermeyer and Schulze (2001) qualitatively analyzed articles from a prominent German newspaper in 1997. Of the 186 articles mentioning mental illness, 51.1% reported criminal activity of mentally ill individuals; almost 79% of these crimes were violent in nature.

Stigma Towards Homeless People with Mental Illness

Overall, a paucity of research exists on the stigmatization of homeless people with mental illness. Apart from the Phelan et al study described below, most research examines perceived stigma from the perspective of homeless people with mental and addictive disorders.

Phelan, Link, Moore, and Stueve (1997) interviewed 544 randomly selected Americans, using a vignette research design to differentiate the degree of stigma towards two categories of poverty-stricken individuals, housed poor versus homeless people, suffering with two categories of illness, back pain verses mental illness. Respondents scored housed poor and homeless people with mental illness as almost twice as likely (OR = 1.9) to be dangerous in comparison for housed poor and homeless people hospitalized for back pain. Respondents also scored all people hospitalized for mental illness as 2.2 times more likely to deserve economic aid. Regarding prejudice towards homeless individuals in general, Phelan et al found that respondents were two times more likely to desire social distance from homeless people than housed poor people. Independent of illness status, participants felt homeless and housed poor individuals both had a relatively low likelihood of dangerousness. Participants did not believe homeless individuals deserve economic aid more than the house poor. Phelan et al observe that homelessness and mental hospitalization are independently associated with higher levels of stigma, suggesting that homeless people with mental illness suffer more stigmatization than people who are either homeless without mental illness or mentally ill but not homeless. These findings suggest respondents view homeless people with mental illness as less socially desirable, more dangerous, and possibly more deserving of economic aid, the latter perhaps reflecting the Corrigan's description of mentally ill individuals as unable to be self-sufficient.

O'Reilly and colleagues (2009) explore negative perceptions of the phrase "mental health" among homeless individuals with mental health diagnoses ages 15 – 24. The participants viewed the words "schiz," "psycho," "fruit loop," and "nuts" as synonyms for "mental health." O'Reilly et al conclude that these stigmatizing labels "nurture a culture of fear and judgment," making it difficult for young homeless people to engage in services with providers titled "mental health coordinators." In a larger quantitative study of 154 recently homeless mentally ill adults, perceived stigma was the most important underlying factor in why individuals did not seek mental health care (Kim et al, 2007). Respondents indicated concerns that their "partner, parents, or others might find out about" and were worried about what other might think if they sought help. In multivariate modeling, the likelihood of reporting this stigma-related barrier to care was 3.36 ($p < 0.05$) times more common among men and 2.82 ($p < 0.05$) times more common among Caucasians. People with less severe mental health symptoms were less likely to report stigma as a barrier to seeking mental health care (OR 0.26, $p < 0.05$).

Butters and Erickson's (2003) qualitative study of crack-addicted women in Toronto identified discriminatory attitudes of healthcare workers as a barrier to receiving care. One respondent stated, “Yeah, I went there to a hospital, it wasn’t important to them because I was a drug addict” (Butters and Erickson, 2003, p. 11). In contrast, the women described good healthcare providers as being non-judgmental, responsive, accepting, and helpful.

Health Consequences of Stigma

Populations that experience discrimination have poorer mental and physical health compared to populations that do not suffer discrimination, even when controlling for socioeconomic status, education, genetic, and behavioral characteristics. Racism is the most frequently studied form of stigma in health literature. In 1997, David and Collins published evidence that American-born black women are 3.1 (95% CI 2.9, 3.2) times more likely to have low birth weight babies than American-born non-Latina white women. The authors dispel the idea that genetic differences cause this disparity, as African-born black women in the study are only 1.6 (95% CI 1.4, 1.9) times more likely to have a low birth weight infant compared to white American women. Following up on the hypothesis that racism is associated with disparities in infant birth weight, Collins and David (2004) found that among American-born black women, those who experienced racism in one or more categories were 1.9 (95% CI 1.2, 3.1) times more likely to have a very low birth weight (VLBW) infant. Women experiencing racism in three or more categories were 3.2 (95% CI 1.5, 6.6) times more likely to have a VLBW infant.

Paradies’ (2006) systematic literature review demonstrates an association between racism and high blood pressure, poor mental health, and cigarette, alcohol, and illicit drug use. In ten studies included in Paradies’ review, most authors found that self-reported racism explained 18% of variance in ill health. Of the 206 potential negative mental health outcomes, 72% were positively associated with racism. The most common outcomes associated with racism were “psychological/psychiatric/emotional distress” and “depression/depressive symptoms”; these outcomes were also the most commonly studied negative mental health outcomes (Paradies, 2006). Depression and emotional distress associated with stigma and discrimination also induce poorer health outcomes of stigmatized health conditions, such as HIV/AIDS and tuberculosis(Rao et al, 2011; Deribew et al, 2009). Depression and emotional distress associated with stigma also negatively impact medication adherence among persons with HIV and AIDS, worsening morbidity and mortality (Carrico et al, 2011; Shuper et al, 2010).

Mortality Among Homeless and Mentally Ill Populations

Though there is no research on stigma-related mortality among homeless people with mental illness, evidence exists suggesting that mental illness and homelessness independently increase risk of mortality. Many researchers have studied causes of death among homeless individuals, finding that homeless people are more likely to die from mental illness, illicit substance misuse, alcohol misuse, and suicide. Fewer researchers have studied mortality specifically within the homeless mentally ill population. The majority of these studies compare mortality among homeless mentally ill people to the general non-homeless population, rather the non-homeless mentally ill population. Differences between studies in sample populations, definitions of homelessness and mental illness, and source of diagnoses of mental illness (by self-report, clinical interview, or diagnostic scale), make comparisons challenging. Despite these differences, however, homeless individuals with mental illness appear to have higher all-cause mortality rates compared to housed mentally ill and general samples of homeless populations.

Individuals with mental illness who are treated in the public mental health system die on average 13.5 to 32.2 years younger than non-mentally ill individuals, according to an eight-state U.S. study by Colton and Manderscheid (2006). A Swedish study (Hannerz, Borga, &Borritz, 2001) calculated life expectancy for populations with nine different psychiatric diagnoses. In this study, “at age 40 years, conditional life expectancy was seven years less for patients withschizophrenia or affective psychosis, 13 years less for substance abuse disorders, and 12 years less for personality disorders” (Lawrence, Kisely, &Pais, 2010, p. 753), compared to the general Swedish population.Table 2 shows a comparison of Standardized Mortality Ratios (SMR) for various mentally ill populations in the United States, Sweden, and among a sample of 25 high-, middle-, and low-income countries. SMR is calculated by dividing the number of observed deaths by the number of expected deaths. Saha, Chant, and McGrath found a statistically significant (p-value = 0.03) increase in SMR for people with schizophrenia over time; the median SMRs for the 1970s, 1980s, and 1990s were 1.84, 2.98, and 3.20, respectively” (2001, p.1126). They comment, “the worsening SMRs associated with schizophrenia noted in recent decades suggest that this already disadvantaged group is not benefiting from the improved health of the community in an equitable fashion” (2001, p.1129).

Table 2: Standardized Mortality Ratio Among Mentally Ill Populations

Study	Year	Study type	Disorders	Location	N	SMR (95% CI)
Colton &Manderscheid	2006	Case-control	SMI[*], MDD[§], Delusional and psychotic disorders, ADHD[†]	United States (8 states)	NR[#]	1.2 – 4.9 (NR)
Chang et al	2010	Case-control	SMI	England	422	2.15 (1.95, 2.36)
Chang et al	2010	Case-control	Substance use disorders	England	348	4.17 (3.75, 4.64)
Chang et al	2010	Case-control	Depressive episode, recurrent depression	England	620	1.29 (1.19, 1.40)
Saha, Chant, & McGrath	2001	Meta-analysis	Schizophrenia	25 countries	22296	2.98 (1.75[∫])

[*] SMI – Serious Mental Illness (Schizophrenia, Schizoaffective and Bipolar disorders)
[§] MDD - Major Depressive Disorder
[†] ADHD – Attention Deficit Hyperactivity Disorder
[#] NR - Not recorded
[∫] standard deviation

Chronic diseases including cancer, cardiovascular and cerebrovascular disease, chronic respiratory disease, and diabetes accounted for the majority of deaths in the Colton and Manderscheid study (2006). Suicide rarely accounted for more than 10% of premature deaths per state per year. In a systematic review, Lawrence, Kisely, and Pais note, “while suicide rates are much higher in people with mental illness than the general community, the absolute number of deaths are small compared with excess deaths owing to natural causes,” (2010, p. 754). Chang et al (2010) suggest that the health disparities seen among mentally ill populations result not only from “social dysfunction, stigma, and direct consequences of psychopathology, but also potential deleterious physical consequences of long-term antipsychotic use and adverse lifestyle choices (e.g. smoking, diet, illicit drug use, and physical inactivity).”

Of note, when SMR was analyzed by ethnic group in the Chang et al study, actual deaths among “African and other black background” with serious mental illness were 3.51 (CI 2.61-4.62, n=51) times more frequent than expected. Within the same population, SMR for substance use disorders was 2.23 (CI 1.02-4.23, n=9) and 1.07 (CI 0.46-2.11, n=8) for depressive disorders. These findings are of particular interest in that the population at the Homeless Health Initiative mental health clinic is predominantly black. This data must be interpreted with caution, however, as the black population sampled in the Chang et al study may lack generalizability to the black HHI mental health clinic population.

Similar to mental illness, homelessness confers risk of mortality through multiple mechanisms. High prevalence of alcohol and drug use, physical and mental diseases, lack of access to medical care, and exposure to violence place homeless individuals at increased risk of death. In a Scottish cohort study that compared mortality among homeless and non-homeless populations of varying socioeconomic status, homelessness was found to be an independent risk factor for death, with an adjusted hazard ratio of 1.6 (95% CI 1.3, 1.9) (Morrison, 2009, p. 879). In addition, Morrison found that homeless individuals were 1.4 (95% CI 1.1, 1.7) times more likely to die than housed individuals of the lowest socioeconomic status (2009). Figure 2 shows SMR among the homeless population in shelters, rooming houses, and hotels in Canada. In this graph, mortality from any cause was 2.01 times more common among the homeless compared to the general Canadian population during the eleven-year follow-up period. All Relative Risks presented in Figure 2 are significant at the 0.05 level.

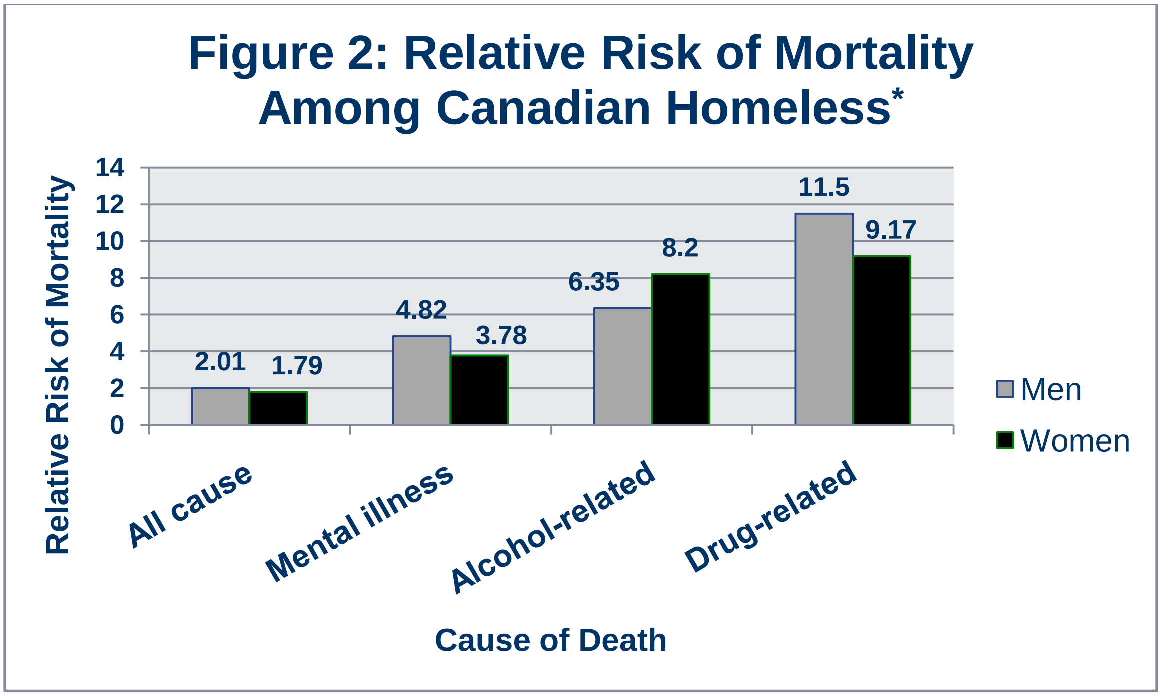

Figure 2: Relative Risk of Mortality Among Canadian Homeless*

*Hwang et al. (2009)

Psychiatric illness and substance use disorders appear to confer a greater risk of death among homeless populations compared to age-matched housed counterparts. Morrison determined that among people who died from drug use, individuals were 7.2 (95% CI 3.4, 15.2) times more likely to be homeless. Similarly, among people who died of circulatory and respiratory diseases, individuals were 1.8 (95% CI 1.1, 2.9) and 2.9 (95% CI 1.4, 5.9) times more likely to be homeless, respectively. Death from alcohol use, intentional self-harm, and assault was equally as common among the housed and homeless cohorts (Morrison, 2009). Beijer et al found that death from self-harm (suicide) was 6.6 (95% CI 1.4, 19.5) times more common among homeless women compared to age-matched housed women, but there was no increased risk among men. Table 3 below demonstrates SMR measured in homeless populations diagnosed with mental and addictive disorders.

Table 3: Standardized Mortality Ratio Among Homeless Mentally Ill Populations

Study	Design	Location	Population	Cause of Death	N	SMR (95% CI)
Babidge et al	Case-control	Sydney	Homeless men with mental illness*	All causes	637	3.14 (2.46, 3.95)
Babidge et al	Case-control	Sydney	Homeless women with mental illness*	All causes	71	3.76 (1.80, 6.91)
Beijer et al	Case-control	Stockholm	Homeless men with mental and/or addictive disorders	All causes	82	4.7 (2.7, 7.7)
Beijer et al	Case-control	Stockholm	Homeless men with primary psychiatric disorder	All causes	19	none†
Beijer et al	Case-control	Stockholm	Homeless men with primary alcohol use disorder	All causes	40	3.2 (NR)
Beijer et al	Case-control	Stockholm	Homeless men with primary illicit drug use disorder	All causes	13	52.6 (NR)

*71% of the population was diagnosed with schizophrenia
†No individuals in this sub-population died during the 5-year follow-up period

Stigma towards homeless and mentally ill populations put individuals at significantly increased risk of morbidity and mortality. Stigma may affect their health directly through violence and emotional trauma and indirectly through public policy and poor access to healthcare and housing. Because of the pervasive stigmatization of homeless people and people with mental illness, service providers - the individuals who work at shelters, soup kitchens, clothing closets, and health clinics for the homeless – may also endorse prejudice towards the very people they serve. Stigmatization by service providers may affect the ability of this vulnerable population to receive needed services such as food, shelter, mental and physical healthcare, and assistance transitioning out of homelessness.

Methods

In January 2011, volunteers initiated a Community Needs Assessment for the Homeless Health Initiative (HHI) mental health clinic, held weekly clinic at a homeless shelter in Atlanta, Georgia. Because many clinic clients had complained of being poorly treated by local service providers (HSP), I collected information on stigma and client treatment during the needs assessment. I used three data collection instruments: a survey of service providers, a survey of homeless clients who attend the HHI mental health clinic, and individual interviews with clients who attend the HHI mental health clinic. The data collection instruments are attached as Appendices A, B, and C.I developed each instrument in conjunction with HHI volunteers. The instruments reflect concerns expressed by homeless clients at their mental health appointments and actions of service providers I observed in the community. The Emory University Internal Review Board (IRB) determined this study did not require IRB approval.

For theservice provider survey,workers selectedpositive and negative actions they had observed among other providers. They also selected positive and negative comments they had heard about other providers from their homeless clients with mental illness. Respondents were also asked if stigma among providers towards homeless people with mental illness is a problem and to rank the extent of the problem. Providers rankedstigma on a scale from one to five, one was defined as “a little problematic,” and five as “extremely problematic.” Idistributed the survey to a group of 77 providers who attend the Outreach Collaborative Meetings, held by United Way and the Regional Commission on Homelessness. I targeted this group of service providers for the survey, as they supply most of the clinic client referrals. Via email, I requested that providers complete the survey on Survey Monkey. These online surveys were collected between December 17, 2010 and January 7, 2011. I collected 26 surveys through Survey Monkey and another 21 surveys at the following Outreach Collaborative Meeting on January 7, 2011. The response rate was 61%.

The homeless client survey asked clients to select positive and negative attributes of service providers they had encountered in Atlanta. Choices for positive and negative attributes were designed to obtain a client perspective on the similar issues captured in the HSP survey. Respondents also ranked how service providers treat them on a scale of “Very Good,” “Good,” “Ok,” “Bad,” and “Very Bad.”HHI volunteers distributed surveys to homeless clients with mental illness in the waiting room of the HHI clinic on five clinic nights in February and March 2011. Because the surveys were anonymous, volunteers separatelyrecorded the names of clients who responded to the survey to assure each client responded only once.Response rate for the survey was 84%. HHI volunteers asked a total of 25clientsto fill out the survey, threeindividuals refused, and one respondent did not return the survey.

HHI volunteers performed semi-structured individual interviews with ten HHI clinic clients. Recruitment for interviews took place at the weekly mental health clinic from January 18, 2011 through February 22, 2011 and relied on convenience sampling. The interviewers paid clients ten U.S. dollars for their time. Of the fifteen individuals recruited, fourteen agreed to an interview, four of whom were unable to be contacted to set up an interview time. Volunteers initially excluded one client for interview due to cocaine intoxication, but interviewed the client on a subsequent day. Four trained interviewers performed nine interviews; one interviewer conducted sixinterviews during clinic hours in a private clinic room and the other volunteers conducted one interview each. I organized the interview schedule, contacted participating clients, and conducted one interview with a client seen by another psychiatrist at the clinic. These interviews took place at the clinic during non-clinic hours, and one took place at a coffee shop convenient for the homeless client. The volunteer interviewers had each worked at the clinic zero to three nights during the previous year; none of the interviewers had any involvement in clinical care of the clients interviewed. All clients provided oral consent for the interview and to digital recording of the interview. An individual experienced in qualitative interviewing among homeless people transcribed each interview prior to analysis; this person had no affiliation with the HHI clinic.

Quantitative Analysis

I performed quantitative data analysis for both the service provider and homeless client surveys usingSASVersion 9.2(SAS Inc., Cary, NC, USA).I cleaned the data and checked for errors using frequency analysis of categorical variables and univariate analysis of continuous variables. I obtained frequencies for demographic characteristics of survey respondents on the HSP and client surveys.

Service provider survey analysis.

I analyzed all demographic data using frequency analysis, as all demographic variables were categorical. In the survey, I divided age into an ordinal categorical variable to protect anonymity among the small sample of service providers. I performed frequency analysis to determine the number of positive and negative actions providers observed and the percent of providers observing each type of action.I used Chi-square analysis to determine if age, sex, and job type differed between respondents who think stigma towards homeless people with mental illness is a problem among service providers and respondents who think stigma is not a problem. In addition, to determine if mean stigma severity rating differed by demographic characteristics, I used analysis of variance (ANOVA).

To ensurethe ratings of stigma severity were meaningful, I performed ANOVA to determine differences in the mean stigma severity rating among groups of respondents who ranked stigma as “problematic,” “not problematic,” and “unsure.”Because the question asking service providers to rank stigma severity did not offer the option, “none,”(see Appendix A) this analysis examines the validity of the responses to this poorly worded question. The data met all three assumptions of ANOVA: subjects were independent, the dependent variable was normally distributed and the variances were equal (Brown and Forsythe’s Test p-value 0.2971) for each group. UsingTukey’s approach, the means for each group were statistically compared to determine which means were statistically different among the three groups (Kleingbaum et al, 2008).

Homeless client survey analysis.

I cleaned the data by looking for errors in frequencies of responses and improbable responses. I then examined all demographic variables using frequency analysis. Because I collected age data as a continuous variable, I used univariate analysis. I also divided age into the same categories from the HSP survey and compared age distributions between surveys. I similarly analyzed the same demographic information for all clients attending the Homeless Health Initiative clinic to provide a comparison between the sample population and the general clinic population. Homeless Health Initiative collects demographic characteristics of its clients in a database each time a new client registers with the clinic. A HHI volunteer removed all client names from the database prior to analysis.

Similar to the service provider survey, I utilized frequency analysis to demonstrate the number of positive and negative actions experienced by clients. Frequency analysis also provided information on the percentage of clients experiencing each individual service provider action. I used Analysis of Variance (ANOVA) to determine if overall treatment by service providers varied by demographic characteristics. The data met all prerequisites for using ANOVA. I then dichotomized age into clients younger and older than the mean age, 46. I also dichotomized sleeping location, separating clients on the basis of sleeping in a bed provided by a homeless service organization. I analyzed the dichotomous client demographics using t-tests to determine if they differed in how service providers treat them.

To determine how clients' experiences with service providers affected their rating of overall treatment by service providers, I divided clients into two groups.The Homeless Client Survey asked clients, "Have you had any of the following experiences" with a service provider; clients responded, "Yes," "No," or "Don't Know." In order to dichotomize client groups, I examined the average client rating of treatment providers for each service provider action by the client's response.Table 4 below demonstrates the analysis for negative service provider actions.I divided clients into groups based on how they responded to each question about service provider actions.For example, the "Yes," "No," and "Don't know" groups represent survey participants who responded that they had been blamed by a service provider for homelessness, they had not been blamed, and they did not know if they had been blamed, respectively. Because the clients answering

"Yes" and "Don't Know" had either identical or statistically similar means, they were grouped together. I then utilized t-test analysis to determine if client mean ranking of provider treatment differed between the group that experienced negative HSP actions and the group that did not.

Table 4: Client Rating of Provider Treatment by Negative Provider Actions

	Mean Treatment Rating			Number of respondents		
Negative Service Provider (SP) Actions	**No**	**Yes**	**Don't know**	**"No"**	**Yes**	**Don't know**
SP blamed client for homelessness	1.86	3.00	3.00	14	2	2
SP blamed client for mental disorder	1.93	3.00	3.00	15	1	1
SP blamed client for addictive disorder	1.93	3.00	2.67	14	1	3
SP made a racist comment about the client	1.92	N/A	2.6	13	0	5
SP made a sexist comment about the client	1.92	2.5	2.67	13	2	3
SP made a negative comment about client's sexual orientation	1.93	3.00	2.67	14	1	3
SP wrongfully accused client of lying	1.77	3.00	3.00	13	4	1
SP yelled at the client	2.06	3.00	N/A	17	1	0
SP was rude to the client	1.88	2.13	3.00	8	8	1
SP appeared unhappy when working with client	1.82	2.5	3.00	11	6	1

Table 5 below demonstrates the same data for positive HSP actions. There was little consistency in mean rating of service provider treatment based on positive experiences; therefore, I did not combine response groups. I analyzed mean treatment rating using ANOVA to determine if rating differed by "Yes," "No," and "Don't Know" responses. I also compared mean treatment rating of only "Yes" and "No" responses, but the results did not differ from the analysis of variance.

Table 5: Client Rating of Provider Treatment by Positive Provider Actions

	Mean Treatment Rating			Number of respondents		
Positive Service Providers (SP) Actions	"No"	"Yes"	"Don't know"	"No"	"Yes"	"Don't know"
SP was nice	N/A	2.07	N/A	0	17	0
SP apologized when wrong	2.20	1.67	2.20	10	3	5
SP provided food	2.00	2.13	N/A	3	15	0
SP provided clothing or blankets	2.00	2.13	N/A	3	15	0
SP asked about client's goals	2.33	2.00	2.00	6	11	1
SP helped client achieve goals	2.00	2.11	2.5	7	9	2
SP appeared happy when working with the client	1.75	2.0	2.6	4	9	5
SP believed in the client	2.00	2.09	2.5	5	11	2
SP stood up for the client	2.00	2.00	2.66	6	9	3
SP respected the client	1.5	2.00	2.75	2	12	4

Qualitative Analysis

Homeless client individual interview analysis.

I analyzed the interviews thematically with MAXQDA software using a deductive approach, looking for themes of respect, humanity, dignity, and various types of stigma (stigma towards homeless people, people with addictive disorders, and people with mental disorders). Participants made many broad statements about being treated well or poorly, but did not fully describe what being treated well or poorly meant to them. Therefore, I divided generalized comments about treatment into two categories, good and bad. On examination, components of inductively derived themes of favorable versus unfavorable treatmentemerged.The favorable category includes descriptions of service providers who were "nice" and "helpful." Participants most commonly associated negative treatment with organizations that provided few services or that offered dirty or uncomfortable living conditions. These themes are described in the results section of the interviews.

Results

Service Provider Survey

Demographic characteristics of the service provider survey respondents were listed in Table 6below. Over 71% of respondents marked their age between 35 and 54 years old. An equal number of male and female respondents participated in the survey. Nearly half of the respondents were case managers (43%) and another 26% were program managers. A majority of respondents (60%) had previously referred homeless clients to the Homeless Health Initiative mental health clinic.Though I did not collect data on race to protect the anonymity of this small group of service providers, subjectively a majority of providers in the survey sample were black.

Table 6:Referring Service provider Characteristics (N=46)

Characteristic	**Percent(N)**
Age	
Less than 25	2.17(1)
25 to 34	8.70(4)
35 to 44	32.61(15)
45 to 54	39.13 (18)
55 to 64	15.22 (7)
65 or older	2.17 (1)
Sex*	
Female	51.11 (23)
Male	48.89 (22)
Job Title	
Case manager	43.48 (20)
Program coordinator	26.09 (12)
Volunteer	13.04 (6)
Healthcare provider	10.87 (5)
Housing specialist	2.17 (1)
Benefits (SSI/SSDI) specialist	2.17 (1)
Peer specialist	2.17 (1)
Referrals to Clinic	
Have referred clients	60.87% (28)
Have not referred clients	39.13% (1)

* N=45

Table 7 demonstrates provider observations of positive actions of other workers. Table 8 below demonstrates positive comments providers heard about other providers from their homeless clients. Providers most frequently observed positive attitude about working with homeless people (67%) and beliefs that individuals with psychosis can have a meaningful sense of life (63%). Fewer than half of respondentsreported they saw workers providing for physical needs of clients by giving clothes or blankets to (49%) or providing food to clients (44%). Equally for providers who are supposed to provide these services,less than half observed other workers advocatingfor the rights of homeless mentally ill clients (44%), asking clients about their goals (47%), and encouraging clients to obtain their goals (44%). Only 30% of respondents observed other service providers promoting autonomy among homeless clients and only 26% observed workers apologizing to homeless clients when wrong. Equally, only 20% of respondents received reports from clients that other workers promoted autonomy or apologized when wrong.

Table 7:What positive actions of service providers have you observed or heard about?(N=46*)

Observation	N	Percent
Positive attitude about working with homeless people	29	67
Believing individuals with psychosis can have a meaningful sense of life	27	63
Providing clothing or blankets for a client	21	49
Asking clients what their goals are	20	47
Encouragement of clients in obtaining their goals	19	44
Advocating for rights of homeless mentally ill clients	19	44
Providing food for a client	19	44
Seeking to understand why a client is upset	14	33
Promotion of client autonomy	13	30
Apologizing to a client when wrong	11	26

*Number missing = 3

Table 8: What positive comments have you heard homeless clients say about other service providers? (N=46*)

Comment	N	Percent
He/she is really nice	30	73
He/she gave me food	21	51
He/she helped me get clothing or blankets	18	44
He/she discussed my goals with me.	17	42
He/she encouraged me to obtain my goals	17	42
He/she tried to understand why I was upset	16	39
He/she believes in me	15	37
He/she stood up for me.	8	20
He/she lets me decide what is best for me	8	20
He/she apologized to me	8	20

*Number missing = 5

Service provider responses regarding negative service provider actions are listed in Tables 9 and 10. Over half (57%) of respondents had observed a provider being rude to a client and a similar percent of respondents (55%) had heard this complaint from their clients. Approximately one third of providers had observed providers making prejudiced statements about homeless people, but only 20% of providers had heard clients complain that providers do not like homeless people. Though fewer providers had heard or observed other providers blaming clients for their mental or addictive disorders, twice the number of providers had seen clients blamed for their addictive disorders compared to mental health disorders. More providers had heard clients complain about being yelled at, hearing racist statements, and feeling providers had disinterest in their goals or solutions to problems than the providers had observed

Table 9: What negative actions of service providers have you observed or heard about? (N=46*)

Observation	N	Percent
Being rude to a client	24	57
Making prejudiced statements about homeless people	14	33
Appearing frequently unhappy when working with clients	14	33
Accusing clients of lying	12	29
Disinterest in client’s solutions to problems	11	26
Blaming the client for his or her addiction problem	10	24
Disinterest in client goals	8	19
Yelling at a client	6	14
Blaming the client for his or her mental health diagnosis	5	12
Making racist statements	5	12

*Number missing = 4

Table 10: What negative comments have you heard clients say about other service providers? (N=46*)

Comment	N	Percent
He/she was rude to me	22	55
He/she does not care about my solutions to problems	13	33
He/she does not care about what I want	12	30
He/she said I was lying	11	28
He/she is racist	10	25
He/she yelled at me	9	23
He/she does not like homeless people	8	20
He/she never seems happy when working with me	7	18
He/she said my addiction problem is my fault.	7	18
He/she told me I don’t have mental health diagnosis, that it’s “all in my head.”	4	10

*Number missing = 6

Among the 46 service providers surveyed, 25 (59%) responded that stigma among homeless providers towards homeless people with mental illness is a problem. Nine (21.43%) of the respondents did not think stigma is a problem and eight (19%) stated they do not know if it is a problem.The three groups of respondents did not differ in distributions by age, sex, or job title (data not shown). On a scale from one to five, with five representing stigma as a severe problem, respondents rated how severe stigma towards homeless mentally ill people is among service providers. The average ratings of stigma severity differed among providers who think stigma is a problem and providers who do not think stigma is a problem (Table 11). On average, people who thought stigma was a problem rated stigma severity 2.3 points higher than those who did not think stigma was a problem. Stigma severity rating did not differ between the “stigma is a problem” and the “unsure” groups.

Table 11: Is stigma towards people with mental illness a problem among service providers? (N=46*)

Service providerResponse	N	Mean Stigma Rating	SD	F-statistic p-value	Tukey Groupings
“Stigma is a problem”	23	3.7826	0.9023	0.0002	A
“Stigma is not a problem”	4	1.500	1.0000		B
“Unsure”	3	3.000	0.0000		A

*Number missing = 16

Service providers who think stigma is a problem differ from providers who think stigma is not a problem in the average number of negative observed actions (Table 12). Providers who think stigma is problematic within the service provider community reported observing, on average, three more negative homeless provider actions than providers who do not think providers stigmatize their clients. The groups did not differ on mean number of positive actions observed or in mean number of positive or negative actions reported to providers by homeless clients.

Table 12: Mean Number of Positive and Negative Actions Reported by Service Provider Subgroups

	Providers who think stigma is a problem			Providers who do not think stigma is a problem			
Variable	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**p-value**
Number of positive actions observed by providers	25	4.7600	2.8178	8	4.7500	2.4928	0.9929
Number of negative actions observed by providers	24	3.7917	2.9189	9	0.7778	0.6667	<0.0001*
Number of positive actions reported to providers by clients	25	4.6400	2.8705	8	3.1250	1.9594	0.1758
Number of negative actions reported to providers by clients	24	3.2500	2.8628	9	1.4444	1.7401	0.0877

*Satterthwaite p-value used because of unequal variance between the two groups

Homeless Client Survey

Table 13 compares homeless client survey respondents’ demographic characteristics with characteristics of the HHI clinic client population. Mean age for total client population is 44.5. Ages range from 18 to 79. Mean age for the homeless client survey sample is 46 and age ranges from 28 to 79. T-test analysis demonstrates that these populations are statistically similar in age (p-value 0.51).No difference in genderexists between the clinic and survey populations. The survey sample population contains a significantly higher percentage of individuals living in houses or apartments provided by homeless organizations and a lower percentage of individuals living in shelters.

Table 13: Homeless Client Characteristics

	Client Survey Sample (N=21)		Total Clinic Population (N=161)	
Characteristic	**N**	**Percent***	**N**	**Percent***
Age*				
Less than 25	0	0	11	7
25 to 34	4	19	18	12
35 to 44	3	14	35	23
45 to 54	10	48	61	40
55 to 64	2	10	26	17
65 or older	1	5	2	1
Gender				
Female	14	67	108	67
Male	7	33	53	33
Where client sleeps most often$				
House/apartment provided by a homeless organization	12	57	56	39
Homeless shelter	3	14	57	40
House/apartment that I rent	2	10	NR^	NR^
At friend/family's house/apartment	2	10	2	1
Outside	1	5	5	6
Other	1	5	22	15

*Number missing for survey sample =1; Number missing for clinic population = 8

$Number missing for clinic population = 19

^Not recorded

Figure 3 demonstrates the percentage of clients who observed each positive service provider action. Ninety-five percent of clients reported a service providerwas nice to them, 85% of clients received food from a service worker, and 84% received either clothing or blankets. Sixty percent of clients felt respected by at least one provider and just over half of clients felt a HSP believed in them. Fewer than half (45%) of clients responded that a service provider had stood up for them and only 20% of clients reported that a HSP apologized when wrong.

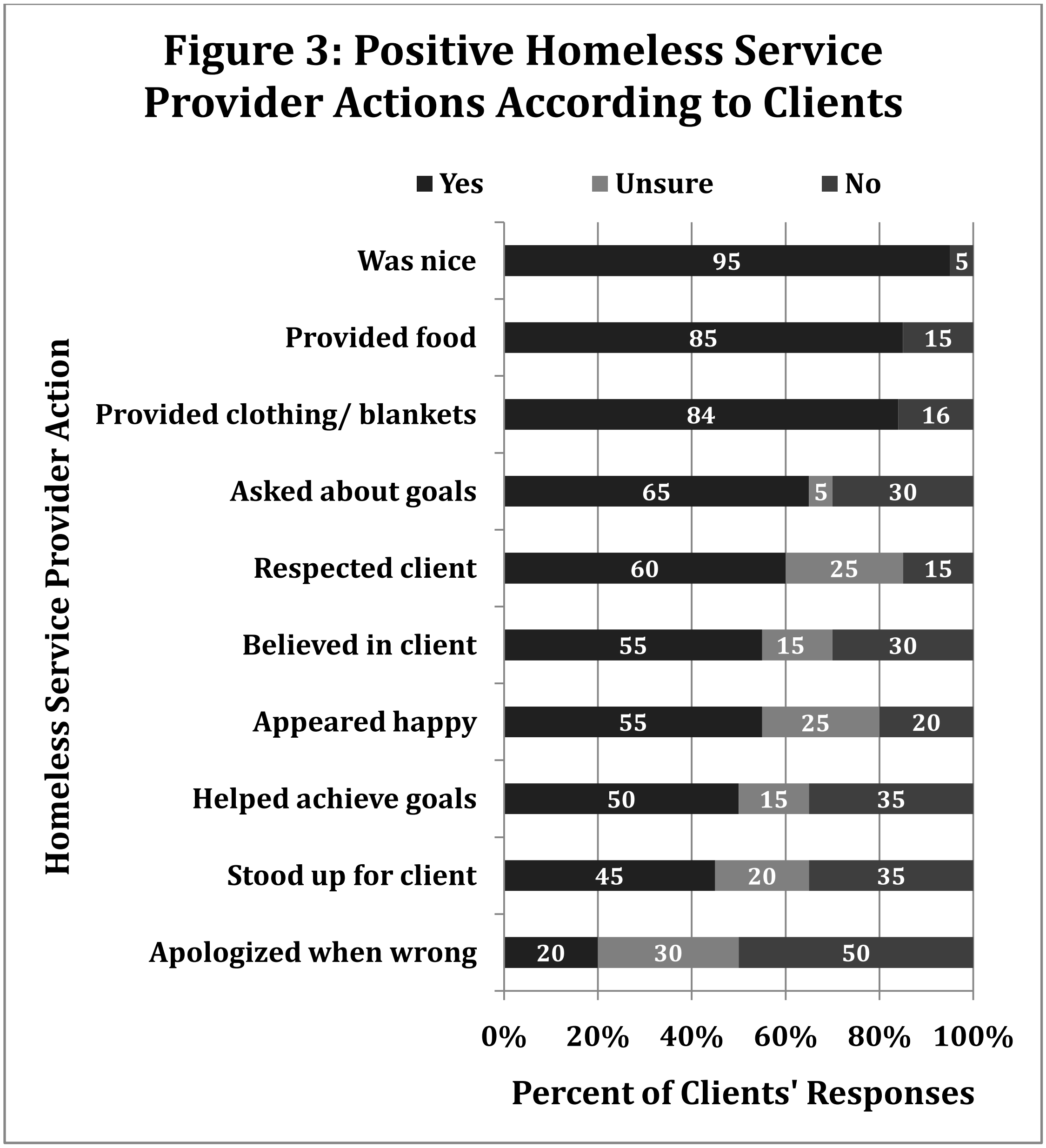

Figure 4 demonstrates negative experiences with service providers reported by homeless people in the Client Survey.Almost half, 47%, reported that a service provider had been rude to them, 35% reported that a provider had appeared unhappy while working with them, and 20% felt they had been wrongfully accused of lying.Ten percent of clients reported that a worker had yelled at them. Few people reported the experience of being blamed for homelessness, mental health diagnosis, and substance addictions, but more frequently clients were unsure if they had been blamed. “Yes” and “Don’t know” responses were slightly more common regarding negative comments about race, gender, and sexual orientation.

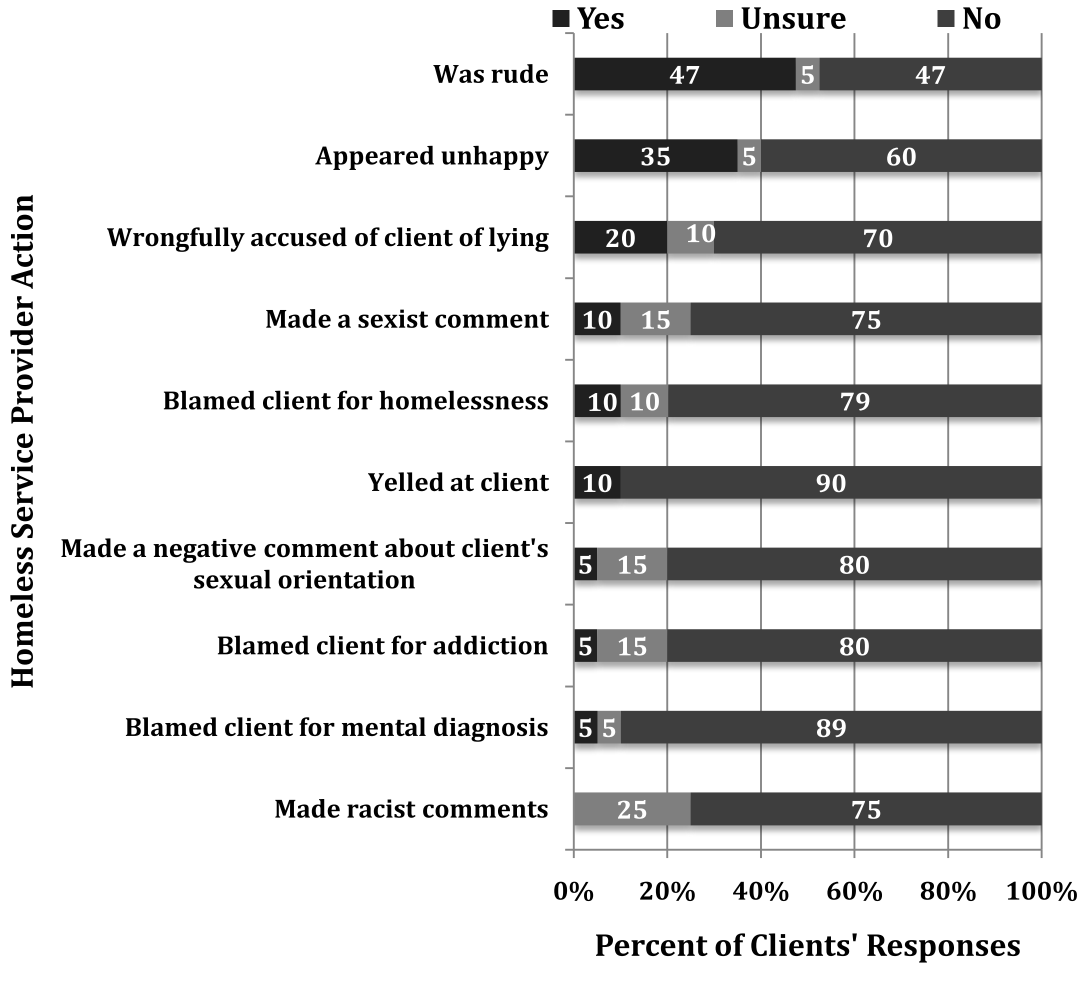

Figure 4: Negative Homeless Service Provider Actions According to Clients

On average, out of ten positive and ten negative HSP actions, clients experienced 6.1 (SD 1.94) positive actions and 1.45 (SD 1.50) negative actions (Table 14).No correlation exists between the number positive and negative actions clients experienced(Pearson Correlation Coefficient = 0.07, p-value 0.8).

Table 14: Frequency of Homeless Provider Actions Observed by Clients

Number of positive actions observed	Percent (N)	Number of negative actions	Percent (N)
0	0	Less than 3	30 (6)
1 to 2	0	1 to 2	55 (11)
3 to 4	30 (6)	3 to 4	5 (1)
5 to 6	25 (5)	5 to 6	10 (2)
7 to 9	45 (9)	7 to 9	0

Overall, client rating of treatment by service providers ranged from “Ok” to “Very Good.” No positive experience affected how clients rated treatment by service providers (data not shown). Negative treatment experiences, however, were associated with differences in average treatment rating (Table 15). Clients who experienced blame by a service provider for being homeless, for their mental diagnosis, or for their addictive disorder all rated treatment significantly poorer than clients who did not have those experiences. In addition, clients who were wrongfully accused of lying by a provider, heard a provider make a negative comment about the client’s sexual orientation, and had a provider appear unhappy to work with them also rated treatment by workers significantly lower than clients who did not have these experiences.

Table 15: Comparison of Client Ratings of Overall Treatment by Service providers According to Negative Experiences (N=20)

Service provider (HSP) actions according to surveyed clients	"Yes" or "Don't Know" Response			"No" Response			p-value
	N	Mean Treatment Rating*	SD	N	Mean Treatment Rating*	SD	
HSP blamed client for homelessness	4	3	0.00	14	1.86	0.53	<0.0001^
HSP blamed client for mental disorder	2	3.00	0.00	15	1.93	0.59	<0.0001^
HSP blamed client for addictive disorder	4	2.75	0.50	14	1.93	0.61	0.03
HSP made a racist comment about the client	5	2.60	0.55	13	1.92	0.64	0.05†
HSP made a sexist comment about the client	5	2.60	0.54	13	1.92	0.64	0.05†
HSP made a negative comment about client's sexual orientation	4	2.75	0.50	14	1.93	0.62	0.03
HSP wrongfully accused client of lying	5	3	0.00	13	1.77	0.44	<0.0001^
HSP yelled at the client	1	3	0.00	17	2.06	0.66	0.18†
HSP was rude to the client	9	2.22	0.44	8	1.88	0.83	0.29†
HSP appeared unhappy when working with client	7	2.57	0.53	11	1.82	0.60	0.02

*Significance of mean values: 1=very good; 2=good; 3=OK; 4=bad; 5=very bad

^Satterthwaite p-value used because of unequal variance

†Not significant at alpha level of 0.05

Homeless Client Interviews

Table 16 lists the demographic characteristics of the interview participants. The age of participants ranges from 31 to 54 years old. Half of participants were female. Interviewers asked clients to state their race or ethnicity; 70% of participants identified their race or ethnicity as “Black,” “African,” or “African American.” Three of the ten participants live in a shelter, all of whom were women. People who live in transitional housing are over-represented in this sample compared to the general client population at the Homeless Health Initiative clinic. This group of participants represents a wide-range of homeless experience. One person has been homeless six months, while a 51 year-old participant has been homeless most of her life. Seven out of ten participants have been homeless two years or longer.

Table 16: Demographic Characteristics of Homeless Client Interview Participants

Participant	Age	Gender	Race (in the client’s words)	Where participant sleeps most often	Length of current homeless episode
1	49	Male	Black	Transitional housing	2 years
2	39	Male	White	Transitional housing	4 years
3	36	Female	White	Transitional housing	10 months
4	48	Male	White	Transitional housing	10 years
5	54	Female	African descent	Shelter	“most of my life”
6	51	Female	Black	Transitional housing	5 years
7	40	Female	Brown or African American	Shelter	10 years
8	31	Female	Black or African American	Shelter	6 months
9	52	Male	Black	Transitional housing	2 years
10		Male	Black	Transitional housing	NR[*]

Participants reviewed 20 organizations that provide homeless services in Atlanta. Participants listed more than 20 places where they had received services, but evaluated only 20. Nine out of ten participants identified both negative and positive services at the places where they received homeless services. One person gave positive reviews of all places he received services. Table 17 lists the total number of participants that evaluated each organization and the number of participants that gave positive and negative reviews for each organization.

Table 17: Frequency of Positive and Negative Homeless Client Reviews of Homeless Organizations

Organization	**Total number of clients who reviewed the organization**	**Number of clients who commented positively**	**Number of clients who commented negatively**
1	8	6	8
2	6	6	2
3	3	2	3
4	3	3	2
5	2	2	2
6	2	2	1
7	2	2	0
8	2	0	2
9	2	2	0
10	1	1	0
11	1	1	1
12	1	1	1
13	1	1	0
14	1	1	0
15	1	1	0
16	1	1	1
17	1	0	1
18	1	1	1
19	1	1	1
20	1	1	0

Overall, participants reviewed nine organizations as more positive than negative; these organizations are highlighted in white. Six organizations, listed in gray, obtained an equal number of positive and negative reviews and four organizations, listed in black, received more negative than positive reviews. Seven places received only positive reviews and two places received only negative reviews; however, most of these reviews only reflect the opinion of one person.

Treatment of homeless individuals by service providers.

The interviewers attempted to gain an understanding of how workers at organizations providing services for the homeless treat homeless people with mental and addictive disorders. All participants identified workers who had treated them well, describing these providers as “nice,” “great,” and “helpful.” Eight out of ten participants mentioned that good service providers treat them with respect, equality, dignity, and “like a human being.” Participants described “good” providers as, “decent,” “kind,” and “respectful.” Several participants pointed out that the experience of homelessness and living in shelters degrades their self worth, but that service providers can help repair their self-esteem. Participant E stated, “It’s, you know, places like [Homeless organization], they make a man feel human again. A man don’t even feel human in a shelter.” Participant F mentioned that workers at one organization “spend a lot of time trying to teach us that we are worth something.” Participants emphasized that workers can help restore dignity by treating homeless clients as equals and “the same as anybody else with a three-story home.”

Only one individual defined the word “nice,” when describing her experience of positive service provider treatment. Participant A explained, “Yeah, just polite and not completely, you know, ignore that I’m even there. But not, you know…um, cater to me completely.” This participant noted that she dislikes workers who treat her “like a best friend” when they first meet; she prefers providers who are “polite,” “straightforward,” and “business-like,” but not cold.

Most participants described “nice” workers as helpful, observing that these providers help clients obtain medical and social services. Participants noted that, without the aid of workers that serve the homeless, many of these resources would be difficult to access. Workers who provided better housing accommodations were mentioned most often in the context of being helpful, particularly when workers assisted clients in moving out of shelters into transitional housing, moving from under a bridge to inside, and moving from sleeping on the floor in a building to having a bed.Participant G stated,

> “That’s my case manager. He, um, found me under a bridge…and you know, he got up on my medical conditions and stuff and he said, ‘We need to get you outta here.’ So he and another person. They, uh, they’re good people. They helped me out a lot.”

Other clients mentioned assistance getting state identification, birth certificates, resume assistance, and eyeglasses.

Many participants noted that they could sense a positive attitude from certain workers. Participants commented that workers with positive attitudes smile more often and “go out of their way” to assist their clients. One participant described a nurse who provided a lot reading material about different physical illnesses. Another participant observed that, when he asked for information on different places that serve meals, “good” workers provided a list of many resources, while “unhelpful” workers provided only one or two names of locations.Also, three participants mentioned that when workers had a positive attitude or provided extra aid, the participants were willing to overlook other faults, such as making the participant wait a long time.

Two participants felt that some providers were nice to them only when it benefited the provider. One participant mentioned that a shelter manager wanted information about a worker who was having sex with homeless clients living at the shelter. In exchange for this information, the manager assured the participant she would never be kicked out of the shelter. Another participant noted that she had seen workers treat other homeless individuals poorly, but because she gave the workers food, they extended her stay at the shelter.

Though most participants identified service providers who were not helpful, they were incredibly hesitant to say anything negative about workers who adequately provided for their physical needs. In this vein, participants mostly criticized workers who provided abysmal living conditions. Participant C said with disgust, “It’s nasty. I mean they got us sleeping on chairs that have urination on it, and BM [bowel movement]. And then we have to lay on that. Yeah, we need new chairs. But they don’t care.” Participant B described treatment at one shelter as degrading; “They treat us like cattle. The just give us a mat and a blanket on the floor.”Participant H refused to return to one shelter, remarking that workers never washed blankets or cleaned mattresses that were used by different men each night. This participant pointed to worker laziness, rather than lack of money or resources, as the cause of this poor treatment. Similarly, participants discussed a common theme of workers performing the minimum required of their jobsand working with homeless people for the wrong reasons, such as a paycheck. When asked to describe a providers who are not helpful, Participant F stated, “Uh, they’re there for a paycheck, not a job," and "Some of them are slack." Participant C agrees, "They're just there cause they wanna get paid or whatever." Participant A described this "laziness" among providers asa lack of desire to obtain knowledge about homeless services. She observed, "well no, most of them, I know more than they do. I give them tips. I tell them stuff. They just don't seem to be involved with really helping people."

In addition, someparticipants viewed providers as unhelpful or as treating homeless people poorly because the providers used their power improperly. Participant G revealed that, at multiple organizations that take donations for homeless people, workers took home donated food and clothing for themselves. Participant G felt indignant that these workers, who had homes and paying jobs, withheld donations from homeless individuals. Participant A related a story about an owner of a transitional housing program:

> "That was one of the worst, *the* worst experience I ever had in my *life* in any place that called themselves helping people or a shelter. One woman was like pure evil. I never saw anybody treat people the way she treated 'em. She would put people out in the middle of the night, with children. And everything, just because on a whim. She was very arbitrary."

Participant A also explained that when workers abuse their power, the homeless individuals suffer consequences, such as sleeping outside with exposure to harsh weather and unsafe surroundings. She remarked "You know, you already homeless, ok. You're staying here based on your income. It's not like you can just go anywhere you know. I have a felony background. It's not like I can just go get any place."

Participants also spoke of Atlanta service providers as unhelpful because they felt services for large portions of the homeless population were absent. Participant B expressed frustration that many services available to homeless men are not available to homeless women. Participant E felt incensed that, despite being homeless before and after release from state prison, several organizations would not help him because “I didn’t meet the criteria for a chronic homeless person.” Participant E stated, “since my previous address was the state prison, they told me I had to live on the street for a year before they could help me. So I never went back there.” Participant G remarked on the lack of services for people with addictions in Atlanta, sarcastically pointing out that providers “help” people overcome addiction by kicking them out of programs when they relapse. She notes, “and that’s not helping ‘em a bit.”

Service provider stigma towards homeless individuals.

Many participants described service providers treating others with less respect and dignity because of being homeless. When interviewers mentioned they had heard some homeless people say that service providers do not like homeless people, eight out of ten participants agreed. Participants described workers as “snooty,” “mean,” and “disrespectful.” One individual stated, “Man, she was just straight talking to me like I was a dog!” Participant B described workers at food and clothing organizations looking “like we’re gonna ruin their morning.” She depicted workers’ attitude as, “a certain look they get in their eyes or a certain way they sit in their seat or adjust their seat when you walk up to their desk like ‘Oh God, here comes another one.’” Participant C described rude behavior among workers towards homeless clients, asserting, “They don’t like homeless people. Oh yeah, I’ve seen that. You know, they’re hard on us. Especially at [Homeless organization], uh, they were mean. And they act like they didn’t like you. They look down on you.” Participant H felt degraded as workers took school children on a tour of the shelter where he lived:

> "They brought these school kids in, like, to show 'em around the place. Show 'em what it looks like to be homeless. And we was just in there, you know, experiencing the worst part of our lives and they put us on display. It was like we was a circus for them." (Participant K)

Stigma towards homeless individuals with mental and addictive disorders.

Participants agreed that, while many of them had not experienced discrimination because of their mental or addictive disorder, they observed others being treated poorly. Participants identified that workers are both scared of people with mental and addictive disorders and they are not well trained to work with this population. Two participants described workers who quickly became frustrated working with mentally ill individuals. Participant F observed workers treat her roommate poorly because they failed to recognize that the client's "stupid" behavior was due to mental illness and not under the client's control. Participant D described one of the most striking examples of stigma among workers towards a man symptoms of schizophrenia.

> "Well I mean you go out to [Homeless organization], you see it all. I mean down there, they'll take them, and I've seen them talk just real nasty to this one fella. But he always kinda like, you know, sick. You don't still treat them like that, you don't treat him like dirt. I mean and you know, I've seen a couple of staff members just really talk crazy to him. And talk about whooping him and stuff like that." (Participant D)

Several participants observed that providers appeared as if they would prefer to lock individuals with mental and addictive disorders out of shelters. Participant B stated that in addition to refusing services, workers "look at them like, 'I wish you were anywhere else but here in my face.'"

Some individuals did experience poor treatment because of their mental health and addictive diagnoses. One person, Participant F, explained that a case manager yelled at her for being absent from an addictions class for two days while she attempted to obtain her psychotropic medications. Another participant felt he was prevented from receiving services available to other homeless people because he had shared his mental health diagnosis. He said, “They’d put it in their computer that you was mental. They tried to block me like that. Wouldn’t help me.” Two participants felt they were discriminated against because of their addictive disorders, which are characterized by relapsing and remitting symptoms similar to other medical diagnoses. ParticipantH expressed fears of being forced to live outside, stating, “Just in case I relapse I’m gonna have to worry about still having a roof over my head.”

Consequences of service provider stigma towards homeless clients.

Several participants remarked on the consequences of poor treatment and stigmatization by service providers. Participant D noted that when workers judge homeless clients negatively because of their diagnosis, “it’s not healthy, for the individual [with mental illness]. Or respectful.” Three participants mention organizations where they refuse to return due to poor treatment; in fact their experiences with some workers made them reluctant to trust other workers. Participant F described the emotional shame associated with being treated poorly for being homeless and having mental and addictive diagnoses.

> “If I meet you, and you look at me and treat me as if I’m less, or if I feel like you treat me like I’m less than you…of course, you know, then that little piece of you that already feels bad because you’re homeless and because you have nothing, and because you know you already feel like you’re less than everybody else. So of course that’s going to affect you, you know.”

To avoid this shame, Participant A preferred not to share her diagnoses with many workers, even though these workers could help her access additional services and support.

Discussion

Homelessand mentally illpeople experience significant stigma and suffer health poor health outcomes, dying over 25 years younger than the general population. Using data from a Community Needs Assessment of the Homeless Health Initiative clinic, I explore stigma and treatment of homeless people with mental and addictive disorders by the service providers who work with themin this mixed-methods study. Though provider surveys,homeless client surveys, and homeless client interviews demonstrate positive and negative reviews of service providers, maltreatment of homeless mentally ill individuals is prevalent. Half of workers reported stigma among service providers and ranked the level of stigma as moderate to severe. Despite hesitance to criticize workers, half of homeless participants reported rudeness and 40% felt disrespected in interactions with service providers. Individual interviews with homeless clients provide examples of workers who look down on clients, prevent clients from receiving services, and in one case, taunted and threatened to beat a mentally ill homeless man. This study offers evidence of the pressing need to implement stigma-reduction and educational campaigns among service providers for homeless people with mental illness. In addition, the findings warrant further exploration of mental, emotional, and physical health consequences of stigma among service providers.

While 95% of homeless client respondents reported that a service provider had been nice to them in the past, only 55% of respondents reported that a provider appeared happy to work with them. In addition, all homeless participants in the individual interviews reported an experience in which a provider was nice, but “happy” was infrequently mentioned. This idea of providers being happy or unhappy when working with homeless clients may play more subtly into how they feel treated by providers. Some interview participants indicated that, while providers were “nice” and “helpful,” they sometimes had discriminatory attitudes. Appearances of happiness or unhappiness while working with homeless clients may be more closely aligned with perceptions of respect. Though I did not ask clients if providers smiled at them, many people view failure to smile as a sign of unhappiness. Clients likely perceived workers to be indifferent, cold, or disrespectful when workers looked unhappy or did not smile. Though perhaps coincidental, clients’ rating of happiness among providers (55%) and being treated with respect (60%) are more similar than ratings of niceness (95%). In fact, ratings of clothing and food provision, which interview participants provided as examples of helpfulness and niceness, are more similar to the ratings of niceness. In the analysis to determine similarity between these variables, however, none were significantly related to each other. The small sample size may partially influence the lack of significance.

Approximately half of both service providers and homeless clients observed or experienced service workers being rude to homeless individuals. More subtle examples of rudeness include failure to apologize when wrong, failure to clients achieve their goals, and lack of respect for the autonomy of another person. Despite the prevalence of rudeness and disrespect reported by homeless clients, no clients rated treatment by service providers as poor or very poor. As noted in the homeless client interviews, homeless individuals are extremely reticent to criticize service workers as long as the worker meets the client’s physical needs. Possibly, homeless individuals with mental and addictive disorders think poorly of themselves and have low expectations for how they should be treated. Equally, physical needs may be so important to homeless people that they overlook discrimination when workers assist them with food, clothing, and shelter.

Though nearly all of the homeless client interview participants reported examples of service providers treating clients poorly or disliking clients because of their homelessness and mental or addictive disorders, few clients actually endorsed that experience themselves. Possibly, the shame associated with maltreatment prevented clients from disclosing their own experiences to interviewers. The client survey only asked clients to report their own experiences, which may explain why fewer clients endorsed maltreatment on the survey compared to responses in interviews. Qualitative data may also be more sensitive in discerning nuances in perceptions of prejudice than quantitative surveys.

Interestingly, participants rarely mentioned racism as a problem both in surveys and interviews. No client interviews participants discussed racism and having a service provider make a negative comment about a client's race was not associated with a statistically lower treatment rating score. Differences in interviewer and participant race may have reduced participants' comfort level in discussing race issues. All interviewers for the qualitative interviews were white, whereas most of the interview participants self-identified as black. Participants, already reticent to criticize workers providing homeless services, likely felt uncomfortable discussing painful and shaming experiences of racism with white interviewers. Maintaining dignity is crucial for populations that suffer prejudice, and black homeless people with mental and addictive disorders endure a heavy burden of discrimination. Though surveys were anonymous, most of the volunteers collecting surveys were also white; the race discrepancy between homeless clients and volunteer interviewers and survey collectors likely also affected reporting on the survey. Future researchers should pair interviewers and participants by race to reduce this bias.

Service provider observation of negative actions by other providers appears to be the only significant factor in whether they believe that stigma is a problem among service providers. Similarly, many client experiences of negative treatment were associated with overall poorer ratings of treatment by service providers, whereas positive experiences were not associated with better ratings. In client interviews, a negative experience with one service provider appears to color the clients' opinion of the entire organization where that provider works. These findingssuggest that workers who behave negatively towards homeless individuals significantly diminish trust and affect the ability of homeless mentally ill individuals to transition out of homelessness.

Examples of negative client treatment associated with homelessness, mental diagnoses, and addictive disorders poignantly demonstrate issues of stigma and discrimination among service providers. Particularly, the example of the service providers taunting and threatening to "whoop" a homeless man with obvious symptoms of mental illness validates the potential negative physical health consequences of stigma. In addition, the emotional trauma associated with maltreatment and discrimination along with resultant mental health consequences can be disabling.Other health consequences include a reticence to discuss mental health and addictive disorders with providers that may result in lack of referrals to needed mental health services. Untreated mental and addictive illnesses are likely to prolong an individual's exposure to homelessness, which is, from the literature review, obviously associated with morbidity and mortality. Homeless mentally ill individuals who encounter stigma and discrimination may be less likely to trust service providers in general and may be less likely to seek services, such as housing or shelter, food, clothing, and medical care. Lack of trust in service providers, though not examined in this study, may be associated with increased likelihood of living outdoors, in unsafe abandoned buildings, or in cars. Equally, clients who fear discrimination from workers at soup kitchens may eat unsafe food from trashcans or dumpsters, resulting in food-borne illnesses. Clients who choose panhandling or theft over eating at soup kitchens are more likely to be arrested, which makes obtaining Social Security benefits and other needed services more difficult.

Further research should explore these potential negative physical, mental, and emotional consequences of stigma among homeless people with mental illness. In addition, future researchers should more closely examine issues of mistrust and associated consequences that stem from disrespect by service workers. Larger and more representative samples in future studies will likely produce more statistically significant results that can be applied to the broader population of people experiencing homelessness and mental illness. Equally, use of control groups in studies would help elucidate differences between people with mental and addictive disorders compared to people without these disorders. Researchers may also consider using housed poor control groups with and without mental disorders to distinguish between issues related to homelessness, issues related to mental illness, and issues related to both. A large study comparing morbidity and mortality among homeless people with mental disorders, homeless people with addictive disorders, homeless people with dual diagnoses (mental and addictive diagnoses), and their housed counterparts would also provide potentially valuable information on the health consequences of stigma.

Despite the need for further research, the findings of this study necessitate immediate interventions within the service worker population. First, as suggested by one participant in the individual interviews, organizations serving the homeless should screen workers for their ability to work with individuals with mental and addictive disorders. Organizations should also provide training for service providers to recognize and better understand mental and addictive disorders. Though monetary resources are scarce within homeless organizations, academic psychiatrists are often willing to provide free training. In addition, numerous free online resources exist for education on mental and addictive disorders. NAMI, the National Alliance on Mental Illness, has branches in all 50 states and many local offices. Their website contains specific information on fighting stigma towards people with mental and addictive disorders (NAMI, 2011). The National Alliance to End Homelessness website contains specific information for service providers on mental illness among homeless individuals. A free online 2009 National Alliance to End Homelessness report, “Strategies of State Mental Health Agencies to Prevent and End Homelessness,” addresses specific issues and key interventions for the homeless population experiencing mental and addictive disorders.

In addition to online resources and education, service organizations for the homeless will benefit from including homeless individuals with mental illness on their board of advisors. These board members can help identify stigmatizing policies within the organization as well as point to solutions to reduce alienation of homeless mentally ill clients. Homeless organizations should also consider holding focus groups to identify concerns and knowledge gaps among their workers. Eliciting feedback from homeless clients utilizing the organizations’ services and having an anonymous “complaints box” may also allow organizations to respond to specific concerns that homeless clients have. Because clients are so hesitant to criticize service workers, however, sensitivity and ongoing evaluations will be necessary to break down barriers to trust that prevent clients from providing feedback on these extremely sensitive topics.

Several major limitations exist in this study. First, the small sample size of participants in both survey and in qualitative interviews limits the ability to determine significant relationships between provider treatment of homeless individuals, positive and negative actions, and stigma. In addition, the samples are not representative of the total populations of service providers and homeless individuals living in Atlanta. The study design as a Community Needs Assessment for the Homeless Health Initiative mental health clinic limits its external validity, reducing its applicability to the general population of homeless people in Atlanta and elsewhere.

Despite these limitations, however, the study has several strengths. The small sample size of the client survey did not reduce the ability to determine that clients' perception of provider treatment is significantly influenced by provider discrimination regarding homelessness, mental health, and addictions.In addition, the common findings among the three different sources of data also give the results strength.

As homelessness continues to grow and resources become scarce, particularly in difficult economic times, stigma towards the most vulnerable subsets of the homeless population remains problematic. Stigma towards homeless people with mental and addictive disorders, especially by the providers paid to help this population exit homelessness, will likely worsen morbidity and mortality. Findings from this study indicate the need for future research on stigma among service providers and suggest that education and projects focused on stigma reduction may be helpful in Atlanta. Service providers and organizations that strive to reduce stigma towards homeless people with mental illness will likely achieve great success in helping this vulnerable population transition out of homelessness.

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Appendix A: Service Provider Survey

Dear Service provider:

Please take 5-10 minutes to fill out this survey. The purpose of the survey is to determine how well the Tuesday night mental health clinic at City of Refuge is serving your client's needs and your satisfaction with the clinic's services. In addition, there are several questions aimed to provide better understanding of stigma about homeless people with mental illness. This survey is anonymous and confidential. You will not be identified by your answers to these questions, nor will your answers be shared with others. Please only fill out the survey once, either by hand or online. Trends in survey responses will be used in my thesis at the Emory School of Public Health.

Thank you so much for your help!
Liz Frye, M.D.

Age:

a. Less than 25
b. 25 to 34
c. 35 to 44
d. 45 to 54
e. 55 to 64
f. 65 or older

Sex:

a. Female
b. Male
c. Other (please specify)

What is your position at the agency where you work?

a. Volunteer
b. Case manager
c. Peer specialist
d. Program coordinator
e. Healthcare provider
f. Housing coordinator
g. Benefits (SSI/SSDI) specialist
h. Administrative assistant

What is the primary objective of the department/agency where you work?

a. Housing
b. Health care
c. Social Security benefits or Job placement
d. Job training
e. Ministry
f. Case management
g. Street outreach

h. Food service
i. Other (please specify)

Section 2: Questions about City of Refuge Mental Health Clinic:

Do you work at an agency or organization that provides services for homeless individuals?

a. Yes
b. No

Have you ever referred a homeless client to the Tuesday night mental health clinic at City of Refuge?

a. Yes
b. No **(skip to Section 2b)**

SECTION 2A (Only answer these questions if you have referred clients to the clinic):

Why do you refer clients to the Tuesday night mental health clinic at City of Refuge? Circle all that apply

a. Availability of appointments
b. Ability to have HUD-McKinney forms (Verification of Disability) signed
c. Ability to have Social Security forms signed
d. Friendliness of volunteer staff and doctors
e. Quality of care provided
f. My clients refuse to go to Grady
g. My clients have mental health needs that cannot wait until an appointment at Grady.
h. My clients cannot find a provider who accepts Medicare or Medicaid.
i. Other (please specify): ______________________________

Please rate your satisfaction with clinic overall.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied

Please rate your satisfaction with the availability of appointments.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied

Please rate your satisfaction with the ease of making appointments.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied

Would you prefer to make appointments using email?

a. Yes
b. No

Please rate your satisfaction with the quality of care provided.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – I do not know

Please rate your satisfaction with the student volunteers at the clinic.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – I do not know

Please rate your satisfaction with the doctors who volunteer at the clinic.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – I do not know

Please rate your satisfaction with the availability of volunteers by phone during non-clinic hours.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with the length of time it takes for phone calls to be returned.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with obtaining medical records.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with the number of appointments required to have a HUD-McKinney (Verification of Disability for housing) form signed.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with the number of appointments required to have Social Security forms signed.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with referrals made for your clients to Grady Hospital for a continuation of mental health treatment.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Please rate your satisfaction with the cost of prescriptions your clients receive.

1 – Very satisfied
2 – Satisfied
3 – Neutral
4 – Unsatisfied
5 – Very unsatisfied
6 – Not applicable

Is your agency or a partner agency able to assist clients in paying for $4 prescriptions?

a. Yes
b. No
c. I do not know

If you refer some of your clients with mental illness and not others, why? **Circle all that apply.**

a. Client preference
b. Some of my clients need a psychiatrist who will visit them because of the severity of their illness.
c. Some of my clients already have psychiatrists.
d. Some of my clients refuse to have a mental health evaluation.
e. Some of clients are children.
f. Concern with quality of care.
g. Sometimes I can get an appointment for a client faster elsewhere.
h. The clinic is only open once weekly.
i. Other (please specify): ____

What have you heard clients complain about in regards to the clinic? **Circle all that apply.**

a. I have not heard any complaints.
b. Long wait time at the clinic
c. Appointments finish too late at night
d. Location of clinic
e. Inability to obtain transportation to the clinic
f. Inability to pay for prescriptions
g. Referrals to Grady Hospital
h. Having a different care provider at follow-up visits
i. Gender of the volunteers or doctors
j. Race of the volunteers or doctors
k. Volunteers are racist.
l. Volunteers and/or doctors do not listen to clients.
m. Clients do not want to see a psychiatrist.
n. Other (please specify):____

What have you heard that clients like about the clinic? **Circle all that apply.**

a. I have not heard anything.
b. Friendliness of volunteers and/or doctors
c. Ability to obtain prescriptions
d. Ability to have HUD-McKinney forms signed
e. Cleanliness of facilities
f. Location of clinic
g. Overall treatment
h. Gender of the volunteers or doctors
i. Race of the volunteers or doctors
j. Evening appointments
k. Free mental health care
l. Other (please specify):____

If Tuesday is not a good night to have the clinic, what evening do you prefer?

a. Monday
b. Wednesday
c. Thursday
d. Friday
e. Saturday
f. Sunday

SECTION 2B (Only answer these questions if you have NOT referred clients to the clinic):

Please select all of the reasons you do not refer to the Tuesday night mental health clinic at City of Refuge.

a. I have never heard of it before.
b. I do not have clients with mental illness.
c. The location is too far for my clients.
d. Client preference
e. My clients need a psychiatrist who will visit them because of the severity of their illness.
f. My clients already have psychiatrists.
g. My clients refuse to have a mental health evaluation.
h. Concern with quality of care.
i. I can get an appointment for a client faster elsewhere.
j. The clinic is only open once weekly.
k. My clients cannot pay for medication.
l. Other (please specify):
____

If Tuesday is not a good night to have the clinic, what evening do you prefer?

a. Monday
b. Wednesday
c. Thursday
d. Friday
e. Saturday
f. Sunday

SECTION 3 (Please answer questions regardless of whether you have referred clients to the clinic):

What positive actions of service providers have you observed or heard about? **Circle all that apply.**

a. Positive attitude about working with homeless people
b. Promotion of client autonomy
c. Asking clients what their goals are.
d. Encouragement of clients in obtaining their goals.
e. Seeking to understand why a client is upset
f. Providing food for a client
g. Providing clothing or blankets for a client
h. Advocating for consumer rights.
i. Believing individuals with psychosis can have a meaningful sense of life
j. Apologizing to a client when wrong
k. Other: ____

What negative actions of service providers have you observed or heard about? **Circle all that apply.**

a. Being rude to a client
b. Yelling at a client
c. Making prejudiced statements about homeless people
d. Making racist statements
e. Disinterest in client goals
f. Disinterest in client’s solutions to problems
g. Appearing frequently unhappy when working with clients
h. Accusing clients of lying
i. Blaming the client for his or her addiction problem
j. Blaming the client for his or her mental health diagnosis.
k. Other:____

What positive comments have you heard homeless clients say about other service providers? **Circle all that apply.**

a. He/she is really nice
b. He/she lets me decide what is best for me
c. He/she discussed my goals with me.
d. He/she encouraged me to obtain my goals
e. He/she tried to understand why I was upset
f. He/she gave me food
g. He/she helped me get clothing or blankets
h. He/she stood up for me.
i. He/she believes in me
j. He/she apologized to me
k. Other: ____

What negative comments have you heard clients say about other service providers? **Circle all that apply.**

a. He/she was rude to me
b. He/she yelled at me
c. He/she does not like homeless people
d. He/she is racist
e. He/she does not care about what I want
f. He/she doesn't care about my solutions to problems
g. He/she never seems happy when working with me
h. He/she said I was lying
i. He/she said my addiction problem is my fault.
j. He/she told me I don't have mental health diagnosis, that it's "all in my head."
k. Other:____

Do you think that stigma about mental illness is a problem among service providers?

a. Yes
b. No
c. I don't know

On a scale from 1-5, please rate how much stigma is a problem among service providers.

1- a little problematic
2-
3-
4-
5- extremely problematic

Section 4:
Please provide additional comments regarding questions asked in this survey.

____

____

____

____

____

____

____

____

Thank you for filling out this survey! Your answers are very helpful and will aid the mental health clinic at City of Refuge in improving its services.

Appendix B: Homeless Client Survey

Dear Participant,

The purpose of this survey is to find out if you are happy with services at the Tuesday night mental health clinic at City of Refuge. Also, this survey asks questions about how you are treated by people who work at homeless shelters, soup kitchens, and other homeless agencies. Your answers will be kept confidential. None of the information you provide today will be put in your chart. Answers to these questions will be used for a Community Needs Assessment that Dr. Frye is doing at the Emory School of Public Health. Your answers will also be used to improve our services at this clinic. Thank you for filling out this survey.

Sincerely,
Dr. Liz Frye and the Homeless Health Initiative

Are you willing to fill out this survey? Yes / No

****Please fill out this first page, even if you do not want to fill out the survey.****

Number: ________

Age: ________

Gender: Male Female Transgender

Race: Black White Bi/Multiracial Asian Other
Latino/a Native American Southeast Asian Pacific Islander

Where do you sleep most often?

1. At a house/apartment that I own
2. At a house/apartment that I rent
3. At a friend or family member’s house/apartment
4. At a house/apartment provided by an organization that works with homeless people
5. At a homeless shelter
6. Outside
7. In my car
8. Other: ____

1. How satisfied are you with your overall treatment at the mental health clinic at City of Refuge?

Very satisfied Satisfied Neutral Unsatisfied Very unsatisfied

2. What do you think about the mental health clinic at City of Refuge? Please check good, neutral, or bad for each section.

	GOOD	NEUTRAL	BAD
The location of this clinic			
Friendliness of front desk staff			
Helpfulness of front desk staff			
Friendliness of doctors			
Helpfulness of doctors			
Prescriptions you can get at this clinic			
Cost of prescriptions ($4)			
Evening appointments			
Amount of time waiting at the clinic			
Gender of the doctors			
Race of the doctors			
Ability to get papers signed by doctors			
Free mental health care			
Different doctor every time you come to this clinic			
Referrals to Grady Hospital mental health			

3. Please check YES, NO, or DON'T KNOW for each question.

	YES	NO	DON'T KNOW
Do you feel safe at this clinic?			
Do the doctors/staff listen to you?			
Do the doctors/staff care about what you think?			
Do the doctors/staff respect you?			
Are the doctors/staff nice to you?			

4. If you did not get mental health treatment here, where would you go? (Circle all that apply)
    1. Grady mental health clinic (also called Auburn Avenue Recovery Center or Florida Hall)
    2. Grady 13th floor
    3. A hospital other than Grady
    4. A Fulton or DeKalb mental health center
    5. A different free clinic
    6. An emergency room
    7. I would not get mental health treatment.
    8. Other: ____________________________________

5. If the clinic offered other services, what would you use? (Circle all that apply.)
   1. Substance abuse groups
   3. Individual substance abuse counseling
   4. Group therapy for mental health issues
   5. Individual therapy for mental health issues
   6. Treatment for physical illness
   7. Lab tests –tests for pregnancy, medical conditions, sexually transmitted infections
   8. Foot care
   9. Transportation to/from this clinic
   10. Other: ________________________________

6. Think of the people who work for organizations that provide services, housing, or food for homeless people. Have you had any of the following experiences? Check yes, no or don't know.

	YES	NO	DON'T KNOW
A worker nice to me.			
A worker was rude to me.			
A worker yelled at me.			
A worker said they were sorry when they were wrong.			
A worker gave me food.			
A worker helped me get clothing or blankets.			
A worker asked me what my goals are.			
A worker helped me work on my goals.			
A worker said I was lying when I was not.			
A worker seemed unhappy when working with me.			
A worker seemed happy when working with me.			
A worker told me it is my fault I am homeless.			
A worker was not nice to me because I use drugs or alcohol.			
A worker was not nice to me because I have a mental health diagnosis.			
A worker said he/she believes in me.			
A worker stood up for me.			
A worker said something bad about my race.			
A worker said something bad about my gender.			
A worker said something bad about my sexual orientation.			
A worker respected my ideas.			

7. How do people who provide services for homeless people treat you? Circle one.
Very good Good Ok Bad Very bad

Did anyone help you fill out this survey? Yes / No
Name of person: ___________________________

Appendix C: Homeless Client Interview Guide

Introduction:

Hi, my name is __________________. As Dr. Frye may have told you, the purpose of this interview is to understand your level of satisfaction with the Tuesday night mental health clinic at City of Refuge. I also want to gain a better understanding of how you are treated by people who provide services for the homeless. The information you provide will help Dr. Frye make the mental health clinic at City of Refuge better and will help Dr. Frye with a paper she is writing for school at Emory. As Dr. Frye told you, you will be given $10 as a thank you for your time once we finish the interview.

The information you share with me today is confidential. Any information that identifies you will be removed before it is shared with anyone who works at the clinic or in the paper Dr. Frye is writing. Any questions that you do not feel comfortable answering, please tell me. I would like to have your permission to tape record the interview to make sure I remember the information you share with me correctly. Do you mind if I record this interview? (Start recording device).

Introductory Questions

1. So, I'd like to get started by getting to know you. Tell me a little about yourself. (silent probe)
    - How long have you lived in Atlanta?
        - Where were you born? Grow up?
    - How old are you?
    - What race or ethnicity do you identify with?
    - How far did you go in school?
    - Tell me about the place where you live or sleep.
        - What is the place like?
        - Do you have your own room or do you share? Do you have a bed?
        - Is it clean or dirty?
        - How long have you lived there? How long do you get to stay there?
        - Who else stays there?

2. How long have you been homeless?
    - Have you ever been homeless more than once?
        i. How long (months or years) total?

Main Questions

1. Could you tell me about some of the places where you've received homeless services? (probe for experiences at Gateway, City of Refuge, St. Joseph's Mercy Care, soup kitchens,churches like First Presbyterian, Central Presbyterian, or others)
    - What did you like? (if nothing, probe: was there anything that you liked even a little?)

- What did you dislike? (if nothing, probe: was there anything you didn't absolutely love about it?)
- How did their staff treat you?
    - How did they treat you as far as respect or dignity goes?
    - How do they treat you in terms your worth as a human being?
    - Do they treat you as an equal – equal to them?
    - How much time did they spend with you (enough, not enough); did they answer all of your questions?
- Can you think of a time when someone was nice to you? (probe for details)
    - If the answer is no, ask about seeing other people being treated well?

- What about a time when someone treated you poorly (probe for details)
    - If the answer is no, ask about seeing other people treated poorly?

Repeat for each agency participant is familiar with – then ask what they know about organizations where they have not received services.

3. Some homeless people have told me that workers at homeless programs don't like homeless people. What do you think of that?

- Probe: Can you tell me why you think that?
- Probe: What is an experience you have had?
- Probe: Are you or other homeless people treated with respect?
- Probe: Are homeless people treated as equal to them?
- Probe: What about in terms of worth as a human being?

4. Some homeless people have also told me that workers at homeless programs don't like people with mental health diagnosis or addictions. What do you think of that?

- Why do you think that?
    - Probe: Are you or other people with diagnoses treated with respect?
    - Probe: Are people with mental health or addiction diagnosis treated as equal to the workers at homeless programs?
    - Probe: What about in terms of worth as a human being, how are homeless people with mental diagnoses or addictions?
- Are people with mental illness treated differently from people with substance addictions?
    - How so? Is one group treated better or worse?

4. How did you hear about the Tuesday night mental health clinic at City of Refuge? When did you first go to the clinic?

- What was your first visit like?
- What did you like about it?
        - Please give me an example of something you liked?
- What did you dislike about it? (probe for example)

    - Please give me an example of something you did not like?

Have you returned since then?How many times?

- What made you want to return?
- What do you think of the people who work there?
    - What did you like about the way they treated you?
    - What did you dislike about the way they treated you?

5. If you could change one thing about homeless services in Atlanta, what would it be?

Closing Questions:

1. Is there anything we haven't talked about today that you would like to tell me?

2. Are there other people who have gone to the City of Refuge mental health clinic that you think I should talk with?