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Homelessness and Health in Central Minnesota

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Homelessness and Health in Central Minnesota

Introduction

In 2018, the U.S. Department of Housing and Urban Development wrote in their Annual Homeless Assessment Report (AHAR) to Congress, which states that an estimated 552,800 people experienced homelessness that year. Also, an estimated 111,500 of those experiencing homelessness were under the age of 18, 48,000 were between the ages of 18 and 24, and 392,000 were over the age of 24 (Henry, Mahathey, Morrill, Robinson, Shivji, and Watt, 2018). In the state of Minnesota, there was an estimated 700 homeless unaccompanied youth and 300 homeless veterans in 2018 (Henry, Mahathey, Morrill, Robinson, Shivji, and Watt, 2018). Minnesota's total estimated number of those experiencing homelessness in 2018 was around 7,200; 3,993 individuals, 3,250 people in families with children, 709 unaccompanied homeless youth, 301 veterans, and 970 chronically homeless individuals (Henry, Mahathey, Morrill, Robinson, Shivji, and Watt, 2018). Even though our homeless population is down 5.5% from 2017 and 8% from 2010, 13 in every 10,000 people are still experiencing homelessness this past year (Henry, Mahathey, Morrill, Robinson, Shivji, and Watt, 2018). To put that number into perspective, the Minnesota town of Big Lake has 10,060 residents. In the town of Big Lake, if we followed the average number of those experiencing homelessness, 13-15 people in the small cabin town do not have a shower, food, and/or home. Unfortunately, just because our states average percentage is down, that doesn't mean homelessness is any less of a problem today.

Literature Review

In the realm of health and well-being, those who are considered homeless are often overlooked. Homelessness is an issue in almost every city across the world, affecting more than 1.6 billion people (Habitat, 2015). These issues can include a variety of different components, but arguably the most important is the individual's health. With so many people facing homelessness and the problems that accompany it, how do we even begin to tackle it? This paper will explore what the health needs of the homeless in central Minnesota are and the necessary actions needed to improve the health fo the homeless by interviewing a professional who works with the homeless in central Minnesota. This paper will also address the importance of the homeless population and their health in central Minnesota and identifying areas where recommendations and solutions can be made for these problems.

Homeless people experience poor access to healthcare, leading to delayed clinical presentation, increased reliance on emergency departments, and higher rates of hospitalization, often for preventable conditions. It was found that emergency shelter users had fewer ambulatory care visits, more months without billable care, and were more likely to visit an emergency room/department (Clark, Weinreb, Flahive, & Seifert, 2019). Mind-reading can help explain this recurring incompetence for access to healthcare as many homeless feel that stigma directly affects the care that receive. Mind-reading can be explained as a patient or doctor interpreting something incorrectly (Mattingly, 2010). This is a common misconception that happens with the homeless as many doctors believe the stigmas attached to homelessness rather than the medical problems presented by the patient. Perceived and anticipated stigma can also deter people from seeking healthcare and adhering to medical treatment (Weisz & Quinn, 2017). Mind-reading

helps explain how homeless individuals may choose not to receive medical care based solely on the fact that they already know the perceived judgements that come with healthcare.

Health care for the homeless is often a broken system that does not cater to the specific needs of the population. In a study in which the homeless individuals were interviewed about their perspective regarding the delivery of their healthcare, five barriers to healthcare were identified: 1) social triaging; 2) being stigmatized for being homeless; 3) lack of care through the health system; 4) disrespectful treatment; 5) feeling ignored by healthcare providers (Martins, 2008). As a result, those interviewed admitted that they often live without essential resources even though this may compromise their health. They do not use the healthcare system unless it is an emergency and they develop underground resources (Martins, 2008).

The concept of biomedical model plays a role in the access of healthcare for homeless or lack thereof because it is a model that is scientifically based. Biomedical approach focuses primarily on biological factors and that health is the absence of pain, disease or defect. The emphasis is placed on curing the diseased bodily part (Dutta, 2008). In doing so, this model lacks the wherewithal to accept that other factors such as socioeconomic status, the environment or one's cultural belief also contribute to one's health. The problem with this model is that it does not cater to the specific needs of an individual, particularly a disadvantaged person. This model adopts a one size fits all approach in that it seeks to identify the issues at hand and administer treatment to 'cure' the problem while disregarding other social factors that can contribute to the restoration of health. On this basis, the biomedical belief system does not create a space of equitable access to healthcare and fails to take into account the difficulties and experiences that the homeless face, making it one of the largest problems the homeless continue to face.

As a team, we identified homelessness and health as an understudied social condition and the lack of the public understanding to the vastness of those experiencing homelessness is shocking. To fully understand how deep of an issue homelessness truly is, one must educate themselves and talk about the topic. For our capstone project, our team set out to learn from five local professionals who work each day to serve the homeless population in Central Minnesota. It was within these interviews and our research that we developed our purpose statement: educate others and to not stay silent on the enormity of this issue. An anonymous quote we once read said: “who are we as human beings if we ignore the suffering of others?” We are choosing not to ignore the suffering of those affected by homelessness in Central Minnesota. Educating others and discussing the contents of this project will assist in bringing the general public up to speed so they also choose not to ignore the topic as well. More specifically, we hoped to answer the following research questions:

1. What are the health needs of the homeless in central Minnesota?
2. What is needed to improve the health for the health of the homeless in Central Minnesota?

Methodology

Participants & Procedure

Homelessness and Health research began in April 2019. Those who worked directly with the homeless population in Central Minnesota were recruited to participate in an interview about the health needs of such population. There were five participants including Scott Grother who works as a Veterans Caseworker dealing directly with the affairs of veterans as it pertains to

healthcare, a place to stay, and meals, Pam Illg who is a community outreach worker assisting the homeless by informing them of current services that Stearns County has available and Karen Kessler who is a nurse at Centra Care Coordinated Clinic working directly with the homeless population to service their health needs. Also, there is Suzie Rice and Jennifer Walker who both work for Catholic Charities at the Youth House and coordinates the living arrangements for the homeless youth as well as getting health insurance and servicing their day-to-day needs.

Prior to participation in the research, participants completed consent forms approved by the CSB/SJU Institutional Review Board. A Semi-structured interview format was used and follow up questions were asked as necessary. The interviews lasted for an average of an hour and a half and were taped. All tape recordings were destroyed following data analysis.

Data Analysis

Initial data gathering and data analysis was conducted by five undergraduate students. Transcripts were created and finalized with the approval of the interviewees, who had the opportunity to omit or change any identifying material. Each student individually coded the transcripts and analyzed it for dominant themes. Themes were then compared, revised and combined by all undergraduate student researchers.

Results

During our study, there were a total of five themes that emerged in our interviews. The themes were as follow:

- Mental Health

- Trauma
- Stigma
- Stereotypes
- Health Literacy as a Barrier to Healthcare

The analysis of the data allowed us to categorize our interviewees' examples into the different themes that we found. Throughout our analysis and with these examples provided by our interviewees, we were able to understand that there are many vulnerable people exposed to homelessness.

Mental Health

This central theme emerged in our interviews when asked what some of the main issues the homelessness community dealt with, we defined mental health as, "A person's condition and well-being in regards to their psychological health and the effects of homelessness on one's cognition". Mental health came to be an issue that was seen abundantly throughout our interviewees experiences with homeless. Interviewees described mental health as being one of the main issues in the homeless community where interactions amongst them could lead to serious circumstances. For example:

Scott: I work with veterans and most of my veterans have mental health issues not really connected to the military, but we get a lot of schizophrenia or illnesses along that spectrum, some bipolar a lot of depression there's a lot of attachment issues and trust issues that go on

Scott: We've had people go psychotic here (Salvation Army Shelter), at one point we had

two guys in my transitional housing program and at the same time were both psychotic and not only were they both convinced that they were trying to kill each other, but one of them thought I was with Al-Qaeda and one of them thought I was with the mob and that I was trying to kill both of them or frame them for different things

With these examples, we are able to see to what extent mental health issues can get to. In addition, these examples provide insight of what it can be like living in an environment surrounded by people who have mental health issues. Whether it'd be bipolar disorder, schizophrenia, depression or being psychotic, mental health can lead to unfortunate circumstances amongst the homeless who all live together under one shelter.

Trauma

During our discussion and analysis of our transcripts, we discovered that Trauma is one of the major themes that goes hand in hand with mental health, which heavily affects the health of the homeless community. Our interviewees also provided multiple examples and stories that demonstrate how traumatic experiences could lead to serious consequences within the homeless community, which ultimately affects their mental health. We define trauma as “A terrifying, scarring, disturbing or distressing experience for a person.”

Karen: “...they have been through traumas that we can't even wrap our brain around... They do whatever they can and whatever they know to get rid of the anxiety and not think about what happened to them. A lot of the times it's drugs and alcohol and you can't just not think about it. These people have never lived a normal life in their entire lives and so what you do is you take away their support system which is their drugs and all their friends and you say to them you're in treatment, you've graduated go live a

normal life now.”

Jennifer: “I was at the shelter, and there was somebody who came in who identifies as transgender, and the shelter had a very difficult time in finding where they should place him. If whether they should place him in the women section, the men section, when biologically a woman but identifies as men and it was very uncomfortable to watch because the shelter staff didn’t know where to put him. It was uncomfortable for the people watching, and they were concern about the safety of placing him here vs. the comfort of the individuals that was coming into the shelter. So, he had stated he had a lot of violence after being a man in his life and has stated that the last shelter he was in, they has assaulted him for being a transgender.”

With Jennifer’s story specifically, she talked about how the homeless youths in the LGBTQ+ community face different stigmas not only from the society, but also from the healthcare system. These stigmas have shown that they would lead to significant mental health problems and create traumatic experiences within homeless youth. The LGBTQ+ group is one of the largest populations within homeless youth (Keuroghlian, Shtasel & Bassuk, 2014, p.#). This cultural group just received more attention in the recent years nationally, yet they have already been seen as one of the most vulnerable group, and the highest population of having various health problems. According to Keuroghlian et al., the transgender population faced multiple challenges and obstacles when transforming from female-to-male and male-to-female. There were not only limited studies and researches on homeless transgender youth, they were also frequently ignored or unaddressed. These youth faced a higher victimization rate in school when compared to the non-transgender gay and lesbian youth, which often led to serious mental and physical health problems. These vulnerable individuals often obtained unmonitored hormones

and silicone injections from street suppliers as well, which further worsen their health (Keuroghlian et al., 2014, p.#).

Stigma

This theme of stigma was highly prevalent when our interviewees were asked to state the attitudes that the homeless had when encountering the stigmas that surrounded them. They stated many different areas in which stigma affects them, however, stigmas surround the person as a whole was the highest issue presented. Many of these stigmas presented were issues like personal hygiene, work ethic, living situations and alcohol/substance abuse. The official definition of stigma as defined by the Merriam- Webster Dictionary is “a mark of shame or discredit”. However, we took this definition even further in an attempt to better incorporate the homeless. Our final result was this: “the misconceptions of a certain group of people based on attributed qualities, behaviors, physical appearance or social status.” Below are the examples from two of our interviewees on the stigmas that are primarily associated with the homeless.

Pam: “They’re lazy and they don’t want to work. People make assumptions and don’t know about trauma or the backstory of mental health and people saying that they don’t work hard and that they just want a handout”

Karen: “Why don’t they just stop doing drugs, why don’t they get help, why don’t they just go out and get a job, what people don’t realize is that these people don’t want to be this way umm they have been through traumas that we can’t even wrap our brain around”

These are just two examples of the common stigmas that the homeless face in their day to day lives. As a population, we are quick to make assumptions about people who live different lives than we do. However, do we really know how these assumptions are affecting the homeless? One study of homeless youth found that perceived homeless stigma predicted negative outcomes including loneliness, suicidal ideation, and low self-esteem (Kidd, 2007). Perceived stigma can impair health and well-being through a number of processes including stress, social isolation, and unhealthy coping behaviors such as smoking, drinking, and substance abuse. (Weisz & Quinn, 2017).

Stereotypes

This overarching theme emerged through each of our interviews when the professionals were asked to describe attitudes or ideas that people in the public may have about the homeless community. Merriam-Webster Dictionary defines stereotype/stereotyping well by saying, “a standardized mental picture that is held in common by members of a group and that represents an oversimplified opinion, prejudiced attitude, or uncritical judgment”.

Karen: “Why don’t they just stop doing drugs? Why don’t they get help? Why don’t they just go out and get a job? What people don’t realize is that these people do not want to be this way...”

Suzie: “You think of the stereotypical, you know sleeping in a cardboard box and things like that. That’s not how it goes. They’re staying with a friend for a week... then on to the next friend for a week. Ope I don’t have buddies to stay with... so oh I found this bathroom. I can lock the door. I’m safe in there for the night”.

To connect our findings, especially the examples provided in the stigma and stereotype section in our findings, we discovered a study conducted by Sean A. Kidd which is titled *Social Stigma and Homeless Youth*. Kidd and his fellow researchers conducted a study with homeless youth 24 years old and younger, who had no fixed address or was currently living in a shelter at the time of interview (Kidd, 2009). The study contained 208 homeless youth based in New York City and Toronto, Canada, and the study contained a 12-item survey which measured the sense of social stigma around homelessness (Kidd, 2009). The survey was formatted as a 4-point Likert-scale, ranging from strongly disagree to strongly agree the participating homeless youth were asked to complete the survey which included prompts like: “I have been hurt by how people have reacted to me being homeless”, “Knowing that you are homeless, people look for things wrong about you”, and “Most people think that homeless people are lazy and disgusting.”(Kidd, 2009). After rating statements like those stated, Kidd and fellow researchers studied the effects of these stigmatized statements on homeless youth. It was found through this study that homeless youth who experienced high levels of perceived stigma reported higher levels of low self-esteem, loneliness, feelings of being trapped, and suicidal thoughts and attempts (Kidd, 2009). Also, it was within these findings that suggests that society has a well-documented tendency of blaming homeless persons for their current situation and could further compromise the mental health of youth already grappling with the risks and challenges of being on their own in harsh environments (Kidd, 2009). This study shows how stigma and stereotypes are very much a common occurrence for those experiencing homelessness, especially youth.

Health Literacy as a Barrier to Healthcare

Another dominant theme that emerged from our interviews with those who work directly with the homeless was that of Health Literacy and how it poses as a barrier to accessing adequate health care for the homeless. Health Literacy can be defined as one's ability to understand and use health information (Zachardoolas, Pleasant, Greer, 2006, p. 46). Many of the interviewees noted that health literacy was a major barrier for the homeless when attempting to access the health care system. The homeless had difficulties understanding their health conditions, comprehending appropriate treatments, and accessing the care needed such as being able to distinguish between when to use the emergency room and when to seek a primary care provider. This lack of knowledge often resulted in overuse of certain sectors of the healthcare system primarily designed for crisis as demonstrated in the following examples:

Suzie: "A lot of them don't know their health history or their family health history, and to fill out those forms are difficult. They might not have the skills to understand what is being asked or they don't want to lead on that they don't understand."

Scott: "Not understanding medical terminology like if you go to a doctor and they give you this diagnosis or piece of paper that says something, you may not know what that is or understand it so you might just ignore it like I don't know what this is I'm going to ignore it or they'll give you something and just choose not to do the treatment or can't do the treatment."

Karen: "I see someone in the shelter and they won't be feeling great and they want to go the ER and we really try and not use the ER because it's not built that way and so many clients use it as their primary care. I'm hoping with the coordinated care clinic that it will take away some of that pressure for them to use that clinic because they don't always

receive the best care in the ER. So having a place where they can go and get the help they need with the care that is designed for them is huge.”

These phrases emphasize the lack of health literacy by the homeless and how their lack of knowledge makes it difficult for them to access the health care system and obtain the proper care they deserve. For the average person accessing the health care system is very complicated and for someone who is homeless this is more challenging because they have experienced so much trauma as well as discrimination due to their state being. These people have greater priorities and so being aware of their family’s health or even their own is not their main concern. They are troubled and tasked with finding a safe place to sleep for the night, getting a good meal, and staying out of harm's way. In addition, like most people understanding medical terminology is a huge health literacy barrier. If they are unable to fully understand what the provider is saying to them, they are more than likely not going to follow through with the prescribed treatment and so ultimately their health is neglected.

Discussion

Through analyzing and examining our five themes: Mental Health, Trauma, Stigma, Stereotypes, Health Literacy as a Barrier to Healthcare, and having different experiences provided by our interviewees, we were able to gain insight of what the issues and the needs in the homeless community were.

Throughout our capstone course, we closely studied health disparities and the impacted level of health literacy. Health disparity is defined as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” (Spector, 2017). In

our case, the homeless population is affected not only by the items listed above, but also the stigma and stereotypes attached to their current situation. In an article written in the Journal of American Board of Family Medicine titled, *A Primary Care–Public Health Partnership Addressing Homelessness, Serious Mental Illness, and Health Disparities*, it was found that people with histories of homelessness or currently are homeless experience a high level of health disparities (Weinstein, et al., 2013). The researchers found that 59% of those who were homeless and participated in the study had more than two diseases, either untreated and/or treated incorrectly (Weinstein, et al., 2013). The article also brings into account that programs that try to assist with the health issues within the homeless community suffer due to sustainability. The services offered to the homeless population are very rarely reimbursed under insurance programs and are often done pro-bono (Weinstein, et al., 2013). With the health disparities being far too great, health literacy also takes a hit. Health literacy is defined by “referring to people’s abilities to understand and use health information” (Zachardoolas, Pleasant, Greer, 2006, p. 46). We highlighted examples of health literacy above, however it closely relates to health disparities due to the nature of not understanding the health system and nervousness the homeless population may feel when it comes to fully accessing their healthcare rights. The example above from Suzie where she discusses, “...A lot of them don't know their health history or their family health history, and to fill out those forms are difficult. They might not have the skills to understand what is being asked or they don't want to lead on that they don't understand”, it shows that even the questions we see as the easiest may stop a person from going into an appointment all together.

After assessing the barriers to healthcare within the homeless population are, we identified that the two other health belief systems, “Magico-religious-spiritual Model” and “Holistic Model” were also other factors that affects how the homeless view the healthcare system (Biomedical Model). While these beliefs affect their motive in seeking help from the hospital, their socio-economics status prohibit their access to healthcare. According to Galanti, the belief in “Magico-religious-spiritual Model” is to have strong spiritual relationships with supernatural forces. People believe their health and illnesses are “results of an active intervention, supernatural forces, a non-human being (ghost, spirit, god), or a human in a form of witch or sorcerer” (as cited by Kramer, 2019).

Our interviewees also provided multiple examples and stories

Overall, health issues and communication about these issues have a very linear model of health decision making that is based on universal health assumptions. In other words, health is determined by those in power. Consequently, these assumptions can deprive patients of receiving effective health care. Instead, health care should be dealt with a cultural centered approach where solutions to health problems

Conclusion & Future Directions

The information gathered from our five interviewees has provided us with a basis of recommendations and suggestions for the general public, but more specifically for college students. After completing our analysis, it was determined that the general population in central Minnesota does not know enough about the homeless and the various traumas and backstories these individuals face. This was evident when Pam, a social worker from Stearns County who works with the homeless outreach said, “There’s so much trauma that affects people more than

we can really understand.” It is extremely important to learn how the homeless are affected by the assumption we put on them, as it becomes the foundation that the homeless are forced to build upon. With outside variables like mental health, substance abuse and barriers to accessing healthcare, the homeless deserve more than the stigmas and stereotypes that surround them.

The Ecological Model for health promotion and intervention is a critical component for the upward mobility of providing better health care for those vulnerable and disadvantaged, more specifically for the homeless. It is vital that we understand that there are multiple levels that affect health behaviors and these factors tend to translate into health disparities as well as accessibility to care, affordability of care, and whether one receives adequate care. These levels include intrapersonal, interpersonal, organizational, community, and policy. Intrapersonal relates to personal behavior and intrinsic qualities specific to a person including innate traits such as race, age, sex, and biological factors for example if they are a smoker or a drug addict. Interpersonal refers to relationships. It is the social aspect of this model that includes family connections and community networks. Organizational is a huge compartment to this model as it pertains to living and working conditions. These living and working conditions can then be influenced by many other factors such as employment status, socioeconomic status, psychosocial factors, public health services and health care services. This is important when considering access because many of these factors contribute to disparities that lead to differences in the services many receive regarding their health. In addition community and policy play a significant role in cultural, economic, and environmental conditions at the local, national, and global levels.

Environmental contexts are significant determinants of behaviors. For the homeless, the environment impacts how they live, their safety and ultimately their health. Moving forward to

bridge the gap between health and homelessness we must recognize that these influences on behaviors interact on all levels for example certain policies can affect one's living and working conditions. In understanding this concept, intervention and the promotion of health for the homeless will be most effective when there is a multilevel approach for the solution. There must be some understanding of the needs of the homeless on the individual level reinforced by peers and partners to promote better health. This must then be coupled with engagement through local organizations and implementing community initiatives to reduce stigmas and alert people of this understudied issue. The ecological model for health promotion intervention allows us to take a step closer towards providing those who are bereft of the basic necessities to live a healthy meaningful life.

The information collected and analyzed from our interviewees is merely a starting point for further research in the health disparities that the homeless face in central Minnesota. By taking the time to become educated of the current misconceptions and respecting that the homeless do not want to be the way that they are, we will be better equipped as a population to discuss and continue to suggest ways that we can dramatically decrease the problems that the homeless populations in our community face. We cannot stay silent. Our hope is that our research will be the spark that ignites conversations about the health of the homeless and how it demands and deserves more than the current system allows. We look forward to suggesting improvements, continuing open discussions, as well as fostering and creating an environment where all homeless populations finally feel like their voices will be heard.

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