

A Descriptive Study of Single Adults in Homeless Shelters: Increasing Counselors' Knowledge and Social Action

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This article is intended to help counselors increase their knowledge and social action for single adults who are homeless. Findings from a period-prevalence study of 71 single adults in a homeless shelter over 2 years reveal demographics, mental health needs, and sociopolitical issues of this population. Implications including social justice action strategies for counselors are discussed.

Este artículo se piensa ayudar consejeros aumentan su conocimiento y la acción social para adultos soltero que son sin hogar. Las conclusiones de un estudio del período-predominio de 71 adultos soltero en un refugio sin hogar sobre 2 años revelan las necesidades demográficas, la necesidades mentales de la salud, y las aplicaciones sociopolíticas de esta población. Implicaciones incluyendo las estrategias sociales de la acción de justicia para consejeros se discuten.

Counselors have received recent challenges to expand their multicultural competence through social justice leadership (Arredondo & Perez, 2003; Bemak & Chi-Ying Chung, 2005). Counselors have a social and ethical responsibility to develop multicultural counseling competencies and to engage in social action for people of differing cultures and socioeconomic classes (Sue & Sue, 2003). One diverse population that has continued to increase over the past quarter of a century is composed of people who are homeless.

The U.S. homeless population of the 1950s and 1960s was typically composed of older men living in cheap hotels and was declining significantly in the 1970s (Rossi, 1990). However, in the 1980s this "old" homeless population was replaced by a "new" homeless population that was younger, was more ethnically diverse, and included more women and children (Rossi, 1990). This "new" homeless population increased substantially in the 1980s when President Reagan's economic policies resulted in a reduction of employment opportunities for a large segment of the workforce, a decline in affordable housing units available for low income people, and a decrease in value and availability of public assistance (National Coalition for the Homeless [NCH], 2005b). In addition, Reagan's administration closed many state psychiatric facilities and cut public funding, resulting in people with mental illness living on the streets (NCH, 2005b).

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The NCH (2005a) reported that homelessness rates tripled from 1987 to 1997. Single adults in New York homeless shelters increased by 35% from 1994 to 2003 (Coalition for the Homeless, 2003). Currently, 3.5 million people are likely to experience homelessness in a given year (Urban Institute, 2000). This represents 10% of people living in poverty and 1% of the general U.S. population (NCH, 2005a).

Despite the size of this population, people who are homeless are underserved and underresearched (Dixon, Amuso, & Stozier, 1999). There is limited research and literature on counseling single adults in homeless shelters. The purpose of this article is to increase counselors' knowledge regarding people who are homeless and to increase social action for this population. This is accomplished through the following three methods. First, a literature review of adults who are homeless is reported within the framework of Arredondo and Glauner's (1992) Dimensions of Personal Identity Model (DPIM). Second, findings from a period-prevalence study of single adults in a southeastern homeless shelter are presented and compared with current literature. Third, social action strategies and counseling guidelines based on the literature review and period-prevalence study findings are presented.

the DPIM

A social justice framework views single adults who are homeless within a sociocultural context of poverty, limited access to housing, and racial disenfranchisement (Freire, 2002). A sociocultural context includes "the sociopolitical (e.g., the unequal distribution of power), sociohistorical (e.g., biased and inaccurate histories of peoples), and sociostructural (e.g., legal, education, and economic systems)" (Liu & Ali, 2005, p. 192). Counselors need to be aware of this sociocultural context and of the unique characteristics of each single adult who is homeless before they can implement social justice action strategies (Arredondo & Perez, 2003). To do so, counselors can use the DPIM (Arredondo & Glauner, 1992), which "describes multiple fixed and flexible dimensions that may contribute to an individual's sense of identity and worldview within a sociopolitical and historical context" (Arredondo, 1999, p. 105).

This model illustrates how "A" dimensions of immutable identities, such as race and culture, and "C" dimensions of sociopolitical, economic, and historical eras have a direct influence on an individual's "B" dimensions of education, work experience, and health care practices/beliefs (Arredondo, 1999). This model may help counselors dispel prevalent myths about people who are homeless, such as that they are "uneducated, freeloading bums who choose to live on the streets" (King, 1989, p. 8) or that "they are mentally ill or alcoholic, elderly, and poorly educated" (Maynard, Gross, & Kent, 1989, p. 215). Recent research literature, which is presented below within the framework of Arredondo and Glauner's (1992) DPIM, challenges these long-held

myths and reveals more accurate characteristics of people who are homeless. This literature review applies specifically to those who are 18 years old and older.

"A" DIMENSIONS: DEMOGRAPHICS

In the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC; Aron & Sharkey, 2002), the most comprehensive published study of people at homeless shelters to date, 81% of single adults in homeless shelters were between 25 and 54 years old. In the same study, 77% of the single adult homeless population was male, and 23% was female. Race and ethnicity of the single adult homeless population was 41% European American, 40% African American, 10% Hispanic/Latino American, and 8% Native American.

"B" DIMENSIONS: EDUCATION, EMPLOYMENT, AND MENTAL HEALTH

Education and employment. People who are homeless were found to have lower levels of education than people who were not homeless (Phelan & Link, 1999). However, interviews conducted by Khanna, Singh, Nemil, and Best (1992) of more than 100 women who were homeless revealed that many were high school graduates and had job skills in the health care, educational, and clerical fields. In the single adult homeless population of the 1996 NSHAPC, 37% had less than a high school education, 36% had a high school degree or a general equivalency diploma (GED), and 28% had some education beyond a high school degree (Aron & Sharkey, 2002).

King (1989) reported that 22% of people who were homeless were employed in some capacity, and the majority had a high school education. Approximately 10 years later, the U.S. Conference of Mayors (2001) also reported that approximately 20% of people who were homeless were employed. Hence, consistently, about one fifth of people who are homeless are employed but do not make enough money to maintain housing and other needs.

Mental health and substance abuse. In the 1996 NSHAPC, 57% of persons who were homeless experienced some form of mental health problem in their lifetime, and 39% did so within the last month (Aron & Sharkey, 2002). However, according to the 2001 U.S. Conference of Mayors' survey, only 5% to 7% of persons who were homeless and had mental illness required inpatient treatment. Substance abuse occurs in approximately 34% of single adults who are homeless, according to NCH (2005a), although previous reports have provided higher percentages. For example, in the 1996 NSHAPC, 62% reported alcohol problems, and 58% reported drug problems (Aron & Sharkey, 2002). A diagnosis of substance abuse was found to be significantly higher in people who are homeless compared with people who are poor but housed (Toro, Bellavia, Daeschler, & Owens, 1995).

“C” DIMENSIONS: SOCIOPOLITICAL ISSUES AND REASONS FOR HOMELESSNESS

The most prominent sociopolitical issues of the homeless population appear to be poverty and lack of affordable housing, which are “largely responsible for the rise in homelessness over the past 20–25 years” (NCH, 2005b, p. 1). Explanations for homelessness are usually categorized as either (a) structural problems of society, such as limited affordable housing, low paying jobs, and rising poverty, or (b) individual characteristics, such as mental illness and substance abuse. Most evidence points to structural determinants (Wright & Rubin, 1998). NCH (2005b) contended, “Homelessness results from a complex set of circumstances which require people to choose between food, shelter, and other basic needs” (p. 6). In addition to domestic violence, mental illness, and substance abuse, leading causes of homelessness include poverty, eroding work opportunities, decline in public assistance, a lack of affordable housing, and a lack of affordable health care (NCH, 2005b). The 1996 NSHAPC (Aron & Sharkey, 2002) identified the following reasons people gave for homelessness: insufficient income (30%), lack of employment (24%), lack of suitable housing (11%), and addiction to alcohol or drugs (9%). These responses appear to confirm that homelessness is mainly attributed to “C” dimensions of sociopolitical issues that affect “B” dimensions of education, work experience, and mental health.

summary of literature review

In conclusion, the literature review challenges long-held myths that people who are homeless are elderly (Maynard et al., 1989) and “uneducated, freeloading bums who choose to live on the streets” (King, 1989, p. 8). On the contrary, Wright and Rubin’s (1998) review of 15 years of research on homelessness reveals that the single adult homeless population is a heterogeneous, diverse group that tends to be under the age of 54, male, people of color, high school educated, and extremely poor. Although this literature review provides a more accurate, up-to-date understanding of single adults who are homeless, counselors should use caution in reviewing their findings because some studies use point prevalence (i.e., measuring the conditions of a population at a certain point in time) as opposed to period prevalence (i.e., measuring the conditions of a population over a period of time; Friis & Sellers, 1999). Point-prevalence studies often lead to inaccurate descriptions of people who are homeless (Phelan & Link, 1999).

the need for a period-prevalence study

Point-prevalence studies portray people who are homeless as more deviant than is actually the case in the broader population of people who were formerly homeless. For example, one point-prevalence study reported that “close to half of the

currently homeless, but only about a fourth of the previously homeless, had been in jail or prison” (Phelan & Link, 1999, p. 1336). The danger of this negative portrayal is the misconception that homelessness is an individual problem rather than an institutional or societal problem (Phelan & Link, 1999). Consequently, some counselors may mistakenly hold a moral deficit view of people who are homeless (Sue & Sue, 2003), believing homelessness was caused by people’s lack of moral discipline (e.g., abusing substances, not holding a job, not complying with psychiatric interventions, and engaging in criminal behavior).

To ensure counselors have an accurate understanding of people who are homeless, a less biased methodology is needed. Period-prevalence studies have the advantage of acknowledging and overcoming the limitations of point-prevalence studies. Therefore, a period-prevalence study of the characteristics of single adults who resided in a southeastern homeless shelter during a 2-year period was conducted. The intention of our descriptive study was to address the following five questions: (a) What are the demographics of single adults at the homeless shelter (SAHS)? (b) What is the educational and employment status of SAHS? (c) What are mental health and substance abuse treatment needs of SAHS? (d) What were the reasons SAHS gave for coming to the shelter? and (e) Are characteristics of these SAHS different from previously reported characteristics of SAHS?

method

PARTICIPANTS

From 2000 through 2002, 247 single men and women were enrolled in recovery services (i.e., housing, food, clothing, counseling, and a 180-day recovery program) at a homeless shelter in a large southeastern metropolitan area. Families and children resided in a separate facility within the same homeless shelter but were not included in this study. All single adult client files were reviewed, and 71 files contained data required for this study, indicating that only 28.7% of the single adult population stayed at the homeless shelter long enough for a counselor to complete his or her assessment. (The abbreviation SAHS herein-after is used to refer to participants.)

DATA SOURCES

The standard agency intake form, the attendance record, and the counseling services assessment form, each completed as part of the intake procedures at the homeless shelter, were used in this study. The intake form contained items regarding clients’ demographic information such as gender, age, educational level, and marital status. The attendance record reported the number of sessions attended, canceled, and missed. The shelter’s counseling services assessment form contained 67 questions, organized into 10 categories of clients’ mental health status and psychosocial history. These categories were the following:

presenting cause(s) for homeless status; initial impressions; goal setting, motivation, and self-confidence; family history; family health and mental health; client self-assessment of strengths and weaknesses; legal history; employment; housing history; and housing readiness. Intake counselors completed the items by writing down a client's answers to the open-ended questions, circling a "yes" or "no" choice, and using a 5-point Likert-type scale in which 1 meant *very low* and 4 meant *very high*. These forms were developed by the homeless shelter, and reliability and validity evidence was not established.

PROCEDURE

Graduate students, blind to the objectives of this study, reviewed all SAHS files, selected the 71 complete files, assigned a code for each file so that names could not be identified, and recorded the data into a computer database. The data were categorized into the following sections: (a) demographics, (b) education and employment, (c) mental health and substance abuse, and (d) reasons for coming to the homeless shelter. Then, the data were analyzed by calculating percentages for each variable. Our university division of research compliance and the director of the homeless shelter approved the procedures for the study.

results

DEMOGRAPHICS

The average age of this single adult homeless population was 39.2 years ($SD = 11.1$; range = 18–61), with 11.2% under the age of 25, 74.6% between 25 and 54, 8.4% at 55 or older, and 5.6% not specified. (Percentages do not equal 100% because of rounding.) Fifty-eight (81.7%) were male, and 13 (18.3%) were female. Thirty-two (45.1%) were European Americans, 34 (47.9%) were African Americans, 3 (4.2%) were Hispanic/Latino Americans, and 2 (2.8%) did not specify their race or ethnicity.

EDUCATION AND EMPLOYMENT

Thirty-eight (53.5%) SAHS graduated from high school or attended college, 13 (18.3%) obtained a GED, and 19 (26.8%) did not complete high school. Four (1.4%) records had missing data on this item. At the time of the study, 58 (81.7%) SAHS did not have a job, 7 (9.9%) participated in unskilled labor, 2 (2.8%) participated in skilled labor, and 3 (4.2%) held professional jobs. (Percentages do not equal 100% because of rounding.) Their employment histories revealed that 28 (39.4%) SAHS worked in unskilled labor, 10 (14.1%) worked in skilled labor, 6 (8.5%) worked in professional jobs, 8 (11.3%) had multiple jobs, and 2 (2.8%) had a history of unemployment. Seventeen records had missing data for this category.

MENTAL HEALTH AND SUBSTANCE ABUSE

Mental health issues were based on the subjective report of SAHS rather than a formal assessment. Twenty-one (29.6%) SAHS reported experiencing depression, 7 (9.9%) reported multiple diagnoses, 4 (5.6%) reported bipolar disorder, and 1 (1.4%) reported attention deficit disorder. All (100%) of the SAHS demonstrated good orientation to time and place and fair to very good appearance and hygiene at intake. Normal affectivity was reported for 57 (80.3%) SAHS, and withdrawn or flat affect was reported for 4 (6.6%) individuals. Seven (9.9%) SAHS reported being anxious and 1 (1.4%) being hyperactive at intake. Thirty-six (50.7%) SAHS reported feelings of hopelessness, 37 (52.1%) SAHS reported considering suicide in the past, and 21 (29.6%) indicated they had attempted suicide before. Also, 14 (19.7%) SAHS reported cutting or hurting themselves in the past.

Forty-six (64.8%) SAHS reported previous drug or alcohol treatment, with a range of treatment from 5 to 420 days. Cocaine/crack was the drug of choice for 26 (36.6%) SAHS, followed by alcohol for 22 (31.0%) SAHS; 9 (12.7%) SAHS reported abusing multiple drugs. Twenty-four (33.8%) SAHS reported no previous treatment, and 1 (1.4%) had missing data. Sixty-one (85.9%) SAHS participated in the shelter's Substance Abuse/Addiction Recovery program.

REASONS FOR COMING TO THE HOMELESS SHELTER

Findings revealed that 35 (49.3%) SAHS entered the shelter because of problems with substance abuse, 5 (7.0%) indicated that they no longer could stay with friends or relatives, 4 (5.6%) reported being new to the area, 3 (4.2%) indicated loss of employment, 7 (9.9%) reported a combination of two or more of the aforementioned reasons, and 3 (4.2%) provided other reasons for coming to the shelter. Fourteen records did not indicate reasons for requesting services.

Four (5.5%) SAHS reported having no place to live prior to becoming homeless, 8 (11.3%) stayed with friends, 9 (12.7%) lived in apartments, 5 (7.0%) owned a house, 25 (35.2%) reported multiple housing. (Twenty records contained no data on housing history.)

discussion

Characteristics of SAHS in this period-prevalence study had similarities and differences from previous studies' findings on several counts.

DEMOGRAPHICS

The average age and gender of the single adult homeless population in this study were consistent with previous studies (NCH, 2005a; Urban Institute, 2000). However, findings related to race/ethnicity indicated a higher percentage of African Americans (47.9%) and a lower percentage of Hispanics/Latinos

(4.2%), when compared with the 1996 NSHAPC (40% and 10%, respectively; Aron & Sharkey, 2002) of the single adult homeless population. African Americans represent 25% of the city's population in which the shelter operates, and Hispanics/Latinos represent 19%, indicating an overrepresentation of African Americans in the homeless shelter compared with the city population (47.9% vs. 25%) and an underrepresentation of Hispanics (4.2% vs. 19%).

One explanation for these findings may be that African Americans experience more poverty, unemployment, oppression, and health problems than European Americans and, therefore, are more vulnerable to homelessness (Sue & Sue, 2003). For example, the 2003 poverty rate for non-Hispanic Whites was only 8.2% (15,902,000) yet was 3 times higher at 24.4% (8,781,000) for African Americans (U.S. Census Bureau, 2004b). The 2004 unemployment rate for Whites was 6.1% but was more than 2 times higher at 13.3% for African Americans (U.S. Census Bureau, 2004a). Language barriers and immigration issues may contribute to underrepresentation of Hispanics/Latinos at homeless shelters (Kovaleski & Chan, 2001). In addition, Hispanics/Latinos may use a strong family network rather than seek residence in a homeless shelter because "outside help is generally not sought until resources from the extended family and close friends are exhausted" (Sue & Sue, 2003, p. 346).

EDUCATION AND EMPLOYMENT

Another difference in these findings was a higher educational attainment of the single adult homeless population with 71.8% completing high school, a GED, or some college, compared with 64% found in previous studies (Urban Institute, 2000). This finding may be due to a variety of reasons, such as a unique variation in this cohort or an increasing need for job training and job placement despite educational attainment (Acosta & Toro, 2000). The NCH (2005b) indicated that more people are becoming homeless, despite educational attainment, due to a recession in the national economy, an increase in the competitive marketplace, and a decrease in a living wage and affordable housing.

The employment findings of this study were consistent with previous studies, with approximately 80% being unemployed. The fact that 4.2% were currently employed in professional jobs but were still homeless and that 22.6% were previously employed in skilled labor or professional jobs and became homeless is a reminder that professionals are vulnerable to homelessness as well.

MENTAL HEALTH AND SUBSTANCE ABUSE

Although these findings indicated that 80% of the sample presented with a normal affect, appearance, and orientation (to time, place, and person), 29.6% of SAHS experienced depression, compared with an estimated 10% in the general population (Substance Abuse and Mental Health Services Administration [SAMHSA], 1998); 46.5% had some form of mental health problem, compared

with an estimated 30% in the general population (SAMHSA, 1998); and 52.1% previously contemplated suicide, compared with an estimated 29% of the general population (Institute of Medicine, 1997). Our findings were considerably higher than NCH's (2005a) finding that 22% experienced severe and persistent mental illness and were slightly higher than the 1996 NSHAPC's finding that 39% experienced mental health problems within the last month (Aron & Sharkey, 2002). The substance abuse rate of 64.8% for SAHS in this study is consistent with previously estimated rates but almost double the current estimated rate of 34% by NCH (2005a).

The high rate of mental health problems and substance abuse emphasizes the need for counselors to assist people who are homeless. Depression is clearly a treatable condition with an estimated 70% to 80% success rate (Beck & Weishaar, 2000; Mental Health Liaison Group, 2003), and substance abuse treatment can also be successful. Because depression and substance abuse may impair people's capacity to overcome their homelessness, early identification of these problems and treatment is needed.

REASONS FOR COMING TO A HOMELESS SHELTER

The finding that 49.3% of SAHS reported substance abuse treatment as their salient reason for coming to the homeless shelter appears to be significantly higher than the 1996 NSHAPC finding of 9% (Aron & Sharkey, 2002) reporting addiction as their reason. One possible explanation for this higher percentage is a lack of affordable and available residential substance abuse treatment within this community. The homeless shelter in this study offers support groups and individual counseling by addictions specialists as well as a structured residential setting with regular meals, life skills classes, assigned chores, and staff monitoring at no charge to residents. Hence, single adults may be using the homeless shelter as a type of residential substance abuse treatment center due to their inability to pay for typical residential treatment.

This inference is supported by the 1996 NSHAPC finding that 55% of people who are homeless do not have medical insurance as compared with 16% of all American adults who do not (Aron & Sharkey, 2002) and by Mark and Coffey's (2003) report that private insurance spending for substance abuse treatment dropped from 7.2% in 1992 to 5.1% in 1999. Thus, it appears that current business and political leaders have merely shifted the financial burden of substance abuse treatment from insurance companies and federal and state government to homeless shelters that rely on waning donations from community members.

The finding that a decrease in affordable, available housing and jobs that provide a living wage contributed to SAHS' homelessness was another sociopolitical factor. This finding supports NCH's (2005b) stance that "two trends are largely responsible for the rise in homelessness over the past 20-25 years: a growing shortage of affordable rental housing and a simultaneous increase in poverty" (p. 1).

When counselors view single adults who are homeless within the context of this era of recession and decrease in public assistance (addressing the “C” dimension of the DPIM; Arredondo & Glauner, 1992), they may have greater empathy for their clients and motivation to advocate for social change.

implications for counselors

On the basis of the literature reviewed and our period-prevalence study findings, we recommend that counselors fulfill their ethical and social responsibility of helping single adults overcome homelessness through the following social action strategies and counseling guidelines. The first strategy is for counselors to raise their awareness about people who are homeless. By considering accurate information and understanding each individual through Arredondo and Glauner’s (1992) DPIM, counselors may become more knowledgeable about those who are homeless and may experience more empathy and motivation to help single adults in homeless shelters.

The second strategy is for counselors to address potential prejudices by dispelling myths and increasing understanding through data from studies such as this one. Many people, including counselors and counselors-in-training, know little about people who are homeless and may believe that they are older and morally weak (Rossi, 1990). This article documents that people who are homeless are younger and that homelessness is not a product of a moral deficit of an individual but rather a result of complex, sociopolitical issues for which the community at large is responsible. In addition, single adults who are homeless may possess a number of strengths, including being well-groomed, having at least a GED, and having a history of employment.

The third strategy is for counselors to help people who are homeless identify what is in their control and develop realistic, future-oriented goals. Pilarc (1998) found in her qualitative study that these two strategies distinguished people who were formerly homeless from those who are currently homeless. Freire (2002) also noted that people who are oppressed often lack an organized way of transforming their knowledge into action. Counselors can help people who are homeless through problem posing so they can organize their knowledge and develop plans of action to meet their needs (Freire, 2002). Counselors should provide referrals to physicians and other resources and follow up to ensure that clients received these services and resources. Counselors should address barriers to clients’ success, such as lack of transportation. Counselors should be flexible in their frequency of sessions because many SAHS clients may need counseling sessions more than once a week to address numerous difficulties and receive guidance in meeting current goals and future plans.

The fourth strategy is for counselors to advocate for people who are homeless by working to promote social changes in community resources, such as increases in affordable and available housing, jobs that pay a living wage, ad-

equate medical care, and funding for residential substance abuse treatment. Counselors have a role as social change agents and thus have a crucial role in influencing local, state, and national social policies and political leaders as well as leading community efforts that benefit people who are homeless (Lee & Walz, 1998). For example, counselors can activate church members to build a Habitat for Humanity home for a family that is homeless, lead a fund-raiser to pay for new clothing, volunteer counseling services at their local homeless shelter, campaign for political leaders who are willing to make policy changes to decrease homelessness, or inform politicians that it is cost-effective to provide substance abuse treatment for people who are homeless (French, McCollister, Sacks, McKendrick, & DeLeon, 2002).

The fifth strategy is to increase outreach to Hispanic/Latino people who are homeless. Counselors should help facilitate Spanish advertisement for homeless services via billboards, bus benches, and flyers at churches and immigration offices. Spanish-speaking counselors at homeless shelters are particularly needed in geographic areas with a significant Hispanic/Latino American population.

LIMITATIONS

This period-prevalence study has several limitations. It focused only on single adults who are homeless. Families who are homeless may differ enough to warrant a separate study. Because this study focused only on single adults who sought shelter services, findings may not apply to single adults who are homeless but did not seek shelter. In addition, the findings of the study are not representative of the single adult homeless population at large and may not generalize to homeless populations in other communities. These findings were based on data gathered by shelter staff rather than direct interview with SAHS clients. Therefore, some bias may have occurred on the part of the staff or by clients perceiving they needed to give certain types of answers to receive services. Reliability and validity for the shelter's assessment forms were not established. The study's comparisons with other studies may be questionable because there was no control for confounding variables. Finally, these findings were based on only 71 complete records and thus represented only 28.7% of the population of single adults who were enrolled in recovery services at a particular homeless shelter (from 2000 to 2002). This limited sample is characteristic of period-prevalence studies because few adults stay at a homeless shelter over a long period of time, compared with point-prevalence studies that have large samples of adults who stay a few days.

conclusion

Single adults in homeless shelters need counselors equipped with accurate knowledge and social action strategies. The findings and recommendations from this period-prevalence study will help counselors use the DPIM (Arredondo, 1999;

Arredondo & Glauner, 1992) to increase their multicultural competence with this expanding and underserved population. In addition, using social justice interventions will help counselors increase their clients' sense of personal power, introduce novel ways of helping them, and foster sociopolitical changes that reflect greater responsiveness to the clients' personal needs (Lewis, Lewis, Daniels, & D'Andrea, 1998). Counselors are encouraged to fulfill their ethical and social responsibility to improve the lives of people who are homeless.

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