Assessing Trauma, Substance Abuse, and Mental Health in a Sample of Homeless Men

Mimi M. Kim, Julian D. Ford, Daniel L. Howard, and Daniel W. Bradford

This study examined the impact of physical and sexual trauma on a sample of 239 homeless men. Study participants completed a self-administered survey that collected data on demographics, exposure to psychological trauma, physical health and mental health problems, and substance use or misuse. Binomial logistic regression analyses were used to examine the relative significance of demographic factors and the four types of trauma exposure associated with three outcomes: mental health, substance abuse, and physical health problems. The authors found that trauma history was significantly associated with more mental health problems but was not associated with substance abuse problems for homeless men. This study reinforces service providers' perceptions that because many homeless men experience the long-term, deleterious effects of not only current stressors, but also abuse and victimization that often begin in childhood, homeless men are a subpopulation in need of proactive prevention services that emphasize long-term continuity of care rather than sporadic crisis-based services. Study findings suggest that mentally ill, homeless men need proactive services that address the sequelae of abuse with care that is specialized and distinctly different from care for homeless adults with substance abuse or physical health care issues.

KEY WORDS: homeless; substance abuse; trauma

Although much of the literature on posttraumatic stress and homelessness focuses on women or families (Banyard, Williams, & Siegel, 2001; Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk, Dawson, Perloff, & Weinrub, 2001; Bean & Moller, 2002; Gully, Koller, & Ainsworth, 2001; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Tyler & Cauce, 2002), the majority of homeless people are men (U.S. Conference of Mayors, 2002). Men tend to remain homeless longer and report more episodes of homelessness than women (Grimm & Maldonado, 1995; Sumerlin, 1999). Although women are more likely than men to report symptoms consistent with posttraumatic stress disorder (PTSD), men are at higher risk than women for exposure to psychological trauma (Kessler, Sonnega, Brommet, & Nelson, 1995).

Psychological trauma and PTSD may have a substantial negative effect on the lives of already vulnerable homeless men, particularly those who are experiencing serious mental illness or addictive disorders, but a review of the research literature has determined that these questions have not been systematically studied with men (Kim & Ford, 2006). There are many potential reasons why research on mental health and addictions and psychological trauma among homeless people has focused primarily on women and largely excluded men: Compared with homeless women, homeless men tend to more often live in isolation (homeless women often are caring for children or involved in family relationships), to be severely psychiatrically impaired, and to be military veterans with severe PTSD. All of these conditions may make homeless men less readily accessible to or less willing to engage with researchers than homeless women. These factors are directly related to psychological trauma and PTSD in many, if not most, cases, thus making it particularly important to investigate the role of exposure to traumatic stressors and experiencing problems with posttraumatic stress in the lives of homeless men.

Psychological trauma takes many forms and has many sequelae. Although physical injury or harm may occur when psychological trauma is inflicted (for example, physical or sexual assault, domestic violence, vehicular accidents, disasters involving death or life threats), survivors of psychological trauma often are unhurt physically (for example, witnesses rather than direct victims, sexual abuse survivors who were coerced or manipulated but not physically injured). Psychological trauma often involves
intentional violence (for example, rape, combat, community or domestic violence) but may alternatively involve accidental harm (for example, fatal accidents, human-made disasters), natural hazards (for example, weather-related disasters), and death or severe physical harm due to illness. The most widely used definition of psychological trauma was developed by the American Psychiatric Association (2000) for the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision) (DSM-IV-TR) and requires the direct experiencing or witnessing of life-threatening events or violation of bodily integrity and a subjective reaction of extreme fear, helplessness, or horror. Psychological trauma, as used in this article, follows this definition, including a range of events and experiences that vary widely in their specifics but have the common feature of exposure to the reality or threat of death or bodily violation in a manner that evokes a reaction of emotional terror or horror.

**HOMELESSNESS**

**Etiology**

Etiological research concerning homelessness focuses on risk factors, including poverty, low education, lack of work skills, physical or mental disability, substance abuse problems, minority status, and family dysfunction (that is, divorce, family psychopathology, or conflict) (Fischer & Breakey, 1991; Morrell-Bellai, Goering, & Boydell, 2000; Snow & Anderson, 1993). Tessler, Rosenheck, and Gamache (2001) postulated three interrelated pathways to homelessness: social selection, socioeconomic adversity, and traumatic experiences. The first pathway—social selection—involves a breakdown in the capacity for living independently due to mental illness (Eynan et al., 2002; Herman, Susser, Jandorf, Lavelle, & Bromet, 1998; Van de Putte & Johnson, 2002) or substance abuse (Sacks, Drake, & Williams, 2003). A second pathway—socioeconomic adversity—involves socioeconomic deficits (for example, low education, job loss, declining income). The third pathway—traumatic experiences—involves a failure to develop or sustain socially normative roles and support systems (for example, domestic violence, spousal abandonment).

**Pathway 1: Social Selection.** The first pathway is consistent with causal models that begin with mental illness or substance abuse (for example, “social selection” or “drift down,” in which people with chronic mental illness or additions are at risk of social isolation and educational and economic deficits). Psychological trauma and PTSD are associated with both the risk of developing mental illness and substance abuse and with an exacerbation of prior mental illness and substance abuse (Chilcoat & Menard, 2003; Leverich et al., 2002; Lysaker, Meyer, Evans, & Marks, 2001; Lysaker, Nees, Lancaster, & Davis, 2004). Homeless women who have experienced psychological trauma are at risk of depression (Bassuk et al., 1998). However, the role of psychological trauma in the mental illness and substance abuse experienced by homeless men has not been investigated.

**Pathway 2: Socioeconomic Adversity.** The second pathway is consistent with causal models in which socioeconomic adversity may lead to homelessness as well as placing the person at risk of mental illness and addiction (North, Smith, & Spitznagel, 1994) as a result of hopelessness, diminished self-efficacy, and social alienation (Bentley, 1997; Hopper & Baumohl, 1994; Morrell-Bellai et al., 2000). Exposure to psychological trauma and PTSD place people at risk for socioeconomic deficits (Kessler et al., 1995) and, thus, may play a role in this second pathway to homelessness among men.

**Pathway 3: Traumatic Experiences.** The third pathway often involves specific traumatic experiences (for example, domestic violence) and may represent a direct pathway from psychological trauma (and PTSD sequelae such as social isolation or problems with anger and mental concentration) to homelessness for some people. Although studies with homeless women have suggested that psychological traumas such as domestic violence affect the risk and severity of homelessness (Bassuk et al., 1998), the contribution of exposure to traumatic stressors or PTSD to this potential pathway to homelessness also has not been investigated.

**Prevalence of Trauma and Related Risk Factors**

Exposure to traumatic stressors is prevalent among homeless people, but the role of traumatic stress as a risk factor for homelessness is not clear. This is of particular relevance because trauma is prevalent among homeless adults, and most risk factors for homelessness also are risk factors for PTSD (Kessler et al., 1995). For example, Buhrich, Hodder, and Teesson (2000) found that more than 90 percent of 157 homeless people (119 men and 38 women) in Sydney, Australia, reported at least one traumatic
life event, comparable to the prevalence reported among adults with chronic mental illness in the United States (Mueser et al., 1998) and more than 50 percent higher than the prevalence reported among housed adults (Kessler et al., 1995). Furthermore, research suggests that exposure to traumatic events, particularly if PTSD develops, is associated with an increased risk (but not the certainty) of developing addictive problems (Kauer-Sant’Anna et al., 2007; Min, Farkas, Minnes, & Singer, 2007; Ouimette & Brown, 2003; Reed, Anthony, & Breslau, 2007).

Considering violent trauma specifically, more than half of a sample of homeless teenagers reported past childhood physical abuse (MacLean, Embry, & Cauce, 1999). Clarke, Williams, Percy, and Kim (1995) reported that in a sample of 157 homeless men and women, 74 percent disclosed abuse histories occurring after becoming homeless. Exposure to violence is prevalent among the homeless population and is associated with immediate and long-term psychological and physical health problems (Fitzpatrick, LaGory, & Ritchey, 1993; LaGory, Fitzpatrick, & Ritchey, 2001; Padgett & Streuning, 1992). Violence may increase the likelihood of prolonged or chronic homelessness (Fitzpatrick, LaGory, & Ritchey, 1999). Women living in poverty, whether homeless or not, have elevated rates of lifetime PTSD or other mental illness and of growing up in family environments characterized by violence, threat, and anger (Bassuk et al., 2001; Davies-Netzley, Hurlburt, & Hough, 1996). Specifically, women and girls are slightly less likely than men or boys to experience psychological trauma but are more likely to experience sexual trauma and domestic violence and twice as likely to develop PTSD (Salgado, Quinlan, & Zlotnick, 2007; Tolin & Foa, 2006). Homelessness per se may confer additional risk: Homeless mothers have higher lifetime rates of violent abuse and assault than do equally poor housed mothers (Bassuk et al., 1998).

Although men and women share many risk factors for homelessness (for example, poverty, family system breakdown, unemployment), homeless men are more likely than homeless women to have serious substance abuse problems, to have been hospitalized for substance abuse, and to have histories of criminal activity and isolation from family social support networks (Morrell-Bellai et al., 2000; Roll, Toro, & Orrola, 1999). Men generally are more likely than women to experience violent assault (being shot or stabbed, mugged or threatened with a weapon, or beaten badly), other injury, and shocking events (Breslau, Chilcoat, Kellser, Peterson, & Lucia, 1999; Jainchill, Hawke, & Yagelka, 2000; Kessler et al., 1995; Lisak & Luster, 1994). Men are also less likely than women to develop PTSD (Kessler et al., 1995) or depression (Breslau, Davis, Andreski, Peterson, & Schultz, 1997) following traumatic events and more likely to develop substance use disorders (Andreski, Chilcoat, & Breslau, 1998). Wenzel, Koegel, and Gelberg (2000) found that substance dependence was predictive of victimization among homeless women and possibly among homeless men. Lam and Rosenheck (1998) found that recent victimization was prevalent among homeless men and women (44 percent experiencing victimization in the past two months) and that victimization was associated with severity of psychotic symptoms, alcohol abuse, criminal history, chronicity of homelessness, and poorer quality of life.

Together with the well-documented relationship between traumatic stress disorders, substance abuse (Jacobsen, Kosten, & Southwick, 2001), and mental illness (Mueser et al., 1998), these findings suggest a need for studies examining the relationship of exposure to trauma, posttraumatic stress, substance abuse, and mental illness in the origin and course of homelessness among men. Homeless men appear to be at higher risk for further traumatic stressors, especially victimization, than their housed counterparts, but what role this and the associated PTSD play in persistent or recurrent homelessness and substance abuse among men is unknown. Social support may be confounded by involvement with peers or other people who are suffering from the effects of mental illness, substance use disorders, and psychological trauma and PTSD. The role of the family and of social support from friends and significant others in mediating or moderating the impact of trauma on homelessness and associated social adjustment problems among men is not known. Recent retrospective research indicates that family functioning mediates, and possibly moderates, the relationship between childhood maltreatment and adult adjustment in a housed community sample (Higgins, McCabe, & Ricciardelli, 2003).

**OBJECTIVES**

This study therefore was designed to begin to explicate the complex associations among traumatic stress, PTSD, substance abuse, mental health, and homelessness among men by addressing three questions:
Is exposure to traumatic abuse in childhood or adulthood associated with mental health problems (compared with not having experienced traumatic abuse)? (2) Are the significant covariates associated with mental health problems also significantly associated with substance abuse and physical health problems? (3) Do traumatic experiences differ across specific outcomes (that is, mental health, substance abuse, and physical health problems)?

**METHOD**

**Participants**
A sample of 239 homeless men was recruited from four shelters in urban, rural, and suburban areas of North Carolina. A power analysis indicated that 130 participants would be needed to have 70 percent power. Thus, with the recruited 239 participants, the study had more than adequate power.

The shelters provide temporary housing, basic needs, peer support, substance abuse, and mental health services to homeless adults. Project staff first posted flyers at the various sites that asked men who might be interested in participating in a study regarding trauma, homelessness, and substance use to speak with their case manager to find out more about the study. Once the potential participants spoke with agency staff, the agency staff compiled a list of the participants they believed would be able to handle the level of sensitivity of the questions. Some of the criteria used by staff to determine study participation included mental health and substance abuse recovery status and the potential participant’s ability to discuss traumatic events. On the day of data collection, the agency staff was present to assist the project staff in finding the participants on the list as well as any additional participants who agency staff believed would be appropriate candidates for the study. Participants were provided with a $25 gift card to a local store within walking distance of the agency that does not sell alcoholic beverages as compensation for completing the survey.

Prior to recruitment, project staff obtained human participants certification and institutional review board approval. Data collection was completed by Mimi M. Kim and a trained research assistant, who administered a survey, consisting of seven questionnaires, to each participant in a semiprivate space in the shelter. Most (n = 180) participants completed all measures, and t tests conducted on demographic variables showed no differences between the scores of participants with missing data and the scores of participants with complete data.

**Measures**

**Demographics/Background.** Age (above the median age of 42 years old), marital status (married or not), and race (white versus nonwhite) were collected using a background questionnaire created for the study.

**Exposure to Psychological Trauma.** Trauma history was assessed with two items from the Stressful Life Experiences Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998):

1. I was hit, spanked, choked, or pushed hard enough to cause injury.
2. I was forced to have unwanted sexual contact.

Participants were asked to describe their experience on a scale (ranging from 1 to 10), with 1 = did not experience this, 5 = somewhat like my experiences, and 10 = exactly like my experiences. Separate ratings were obtained for each trauma item during the respondent’s childhood, adolescence, and adulthood. Dichotomous scores for adult and childhood physical abuse and sexual abuse were created according to the response scale in which any response above 1 indicated the presence of the traumatic experience.

**Physical Health and Mental Health Problems.**
The SF–12v1 (Ware, Kosinski, Turner-Bowker, & Gandek, 2002) was used to assess health-related impairment with two relatively orthogonal standardized scores (that is, physical component and mental component), each scored from 0 to 100, with higher scores indicating more impairment. Each score was split above and below the median to represent physical health problems and mental health problems.

**Substance Use/Misuse.** Seven items from the Stages of Change Readiness and Treatment Eager- ness Scale (Miller & Tonigan, 1996) Personal Drug Use Questionnaire were summed as a measure of substance use problems:

1. Sometimes I wonder if my drug use is hurting other people.
2. I have a drug problem.
3. I have serious problems with drugs.
4. My drug is causing a lot of harm.
5. I know that I have a drug problem.
6. There are times when I wonder if I use drugs too much.
7. I am a drug addict.

The total score across the items was dichotomized above and below the median.

**Statistical Analyses**

SPSS 12.0.1 was used for the following analyses. For clarity of interpretation and to capture nonlinear associations, we dichotomized all variables. Binomial logistic regression analyses were used to examine the relative significance of demographic factors and the four types of trauma exposure associated with three outcomes: mental health, substance abuse, and physical health problems. Odds ratios and 95 percent confidence intervals were calculated.

**RESULTS**

**Demographics**

The median age of the sample was 42 years (see Table 1). Only a small portion of the sample was married (5 percent), and nearly a quarter of the sample was white (23.4 percent). More than half the sample reported childhood physical abuse (68.2 percent), and 71.1 percent of the sample reported adulthood physical abuse. More than half the sample reported childhood sexual abuse (55.6 percent), and 53.1 percent reported adulthood sexual abuse.

**Binomial Logistic Associations**

The outcomes of interest in this study—mental health, substance abuse, and physical health problems—are either uncorrelated (Pearson $r = .04$ and .09, respectively, between mental health and physical health problems) or, at most, weakly correlated (Pearson $r = .19, p < .05$, between mental and physical health problems). Unadjusted associations between demographic and trauma variables and mental health, substance abuse, and physical health problems are presented in Table 2. Several variables were significantly associated with mental health problems. Specifically, participants older than 42 years of age were more than two times more likely to have mental health problems. In terms of trauma history, history of adulthood physical abuse, childhood sexual abuse, and adulthood sexual abuse were significantly associated with mental health problems. Each type of trauma exposure was associated with an approximately twofold increase in the risk of mental health problems.

No demographic or trauma variables were significantly associated with substance abuse problems. Finally, although demographic variables were not associated with physical health problems, childhood physical abuse was significantly associated with physical health problems. Unexpectedly, a history of childhood physical abuse was associated with a reduced risk of physical health problems.

We considered conducting a multivariate logistic regression to determine if the different types of trauma exposure were predictive of mental health problems when considered simultaneously. However, the substantial collinearity among the four types of trauma exposure (Pearson $r$ = -.28 to -.54, median = -.42) did not permit a multivariate analysis.

**DISCUSSION**

Results of the binomial associations suggest that among homeless men, trauma experiences are strong indicators of the presence of mental health problems but not of physical health or substance abuse problems. The finding of a relationship between childhood and adulthood trauma with mental health problems is consistent with prior research with homeless women (Bassuk et al., 2001) and a variety of high-risk populations of men and women (for example, incarcerated adults) (Jordan, Schlenger, Fairbank, & Caddell, 1996), combat veterans (Ford et al., 2004), and sex workers (Villano et al., 2004).

The absence of an association between trauma exposure and substance abuse problems is inconsistent with prior epidemiological and clinical studies (Chilcoat & Menard, 2003; Jacobsen et al., 2001). It is possible that factors other than trauma (for example, familial substance abuse, peer endorsement of substance use) may be more influential in

<table>
<thead>
<tr>
<th>Table 1: Sample Profile ($N = 239$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
</tr>
<tr>
<td>Age (older than 42 years)</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td><strong>Trauma history</strong></td>
</tr>
<tr>
<td>Childhood physical abuse</td>
</tr>
<tr>
<td>Adulthood physical abuse</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
</tr>
<tr>
<td>Adulthood sexual abuse</td>
</tr>
</tbody>
</table>
leading to or sustaining the high levels of substance abuse found among homeless men. The absence of a relationship between mental health problems and substance abuse problems in this sample suggests that trauma may play a relatively specific role related to mental health but not substance abuse problems in contributing to the psychosocial impairment associated with homelessness among men.

The absence of a relationship between trauma exposure and physical health problems also is inconsistent with substantial research literature linking trauma and physical illness (Ford et al., 2004). In further contrast with prior research, childhood physical abuse was associated with a reduced risk of physical health problems among this sample of homeless men. Several possible explanations for this finding warrant further study, including the tendency for childhood abuse to be related to a reduced awareness, minimization, or greater tolerance of physical pain and illness (Villano et al., 2004). For homeless men, it may be functional to use such psychological coping strategies or defenses to manage the mental health problems associated with traumatic abuse while surviving homelessness.

Although childhood physical abuse failed to achieve statistical significance in the logistic regression analysis, it had a virtually identical odds ratio to that found for childhood sexual abuse in its association with mental health problems. However, both childhood sexual and physical abuse were less strongly associated with mental health problems than were adult physical or sexual victimization trauma. Although we did not measure the recency of adult trauma, studies with similarly vulnerable populations (for example, adults with serious mental illness, many of whom are homeless) (Goodman et al., 2001) have suggested that victimization is a potential risk that confers additional psychosocial impairment over and above that accounted for by childhood victimization (that is, cumulative traumatization).

The failure to find statistically significant results for several associations may be due to the exploratory nature of this research and the small sample size. Also, given the need to make assessment as brief as possible, the measures could not address all aspects of the target constructs (for example, trauma was not assessed according to the full *DSM-IV-TR* criteria). The items used in this study to measure childhood and adulthood sexual and physical trauma were not as behaviorally specific or as comprehensive as those used in other studies of trauma and PTSD (for example, Kessler et al., 1995). PTSD symptoms also were not directly assessed, and this will be important in future studies in light of other research showing that PTSD may mediate the effects of trauma exposure on health outcomes and social functioning (for example, Ford et al., 2004). Also, because of the importance of assessing immediate risk and protective factors and the probable greater reliability of recall of recent rather than past factors, the study did not obtain as full an assessment of past risk and protective factors as desirable. This methodological limitation may be in part the reason why factors prior to homelessness do not appear to be as influential in predicting homelessness status as more contemporary factors.

With these limitations in mind, these findings should be viewed as providing a foundation on

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Mental Health</th>
<th>Substance Abuse</th>
<th>Physical Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Age (older than 42 years old)</td>
<td>2.11</td>
<td>1.23–3.63**</td>
<td>1.05</td>
</tr>
<tr>
<td>Married</td>
<td>0.82</td>
<td>0.25–2.67</td>
<td>1.05</td>
</tr>
<tr>
<td>White</td>
<td>0.61</td>
<td>0.33–1.11</td>
<td>0.69</td>
</tr>
<tr>
<td>Trauma history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood physical abuse</td>
<td>1.72</td>
<td>0.99–3.01</td>
<td>0.80</td>
</tr>
<tr>
<td>Adulthood physical abuse</td>
<td>2.03</td>
<td>1.15–3.60**</td>
<td>1.08</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>1.73</td>
<td>1.02–2.93*</td>
<td>0.98</td>
</tr>
<tr>
<td>Adulthood sexual abuse</td>
<td>2.45</td>
<td>1.43–4.19***</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Note: CI = confidence interval.

* *p < .05, ** *p < .01, *** *p < .001.
which future research on homeless men can be based, particularly through large sample, prospective studies beginning earlier in life (for example, with children or adolescents who are homeless or at risk of homelessness) and assessing the constructs from this study on a repeated basis. Along with its cross-sectional retrospective design, this study also is limited by potential sampling bias and use of self-report as the only data collection modality. By conducting large, random-sample, longitudinal studies, research may be able to better define and measure the specific pathways that lead homeless men to various psychosocial impairments. Furthermore, larger, longitudinal studies can more appropriately examine the development of specific risk and protective factors and other more behaviorally specific variables that are associated with male homelessness. Therefore, longitudinal studies beginning with boys or young men who are recently homeless or at risk of homelessness and following them over many years into adulthood, with assessments that capture the complex domains involved in homelessness, will be necessary to more clearly document the paths leading to and flowing from male homelessness.

**IMPLICATIONS FOR PREVENTION, RESEARCH, AND POLICY**

This study reinforces service providers’ perceptions that because many homeless men experience the long-term, deleterious effects of not only current stressors, but also abuse and victimization that often begins in childhood, homeless men are a subpopulation in need of proactive services that are preventive and emphasize long-term continuity of care rather than sporadic crisis-based services. Tools such as the brief instruments used in the present study can be used both to screen homeless men for behavioral or physical health problems and as a basis for primary or secondary prevention interventions to address mental health problems related to physical and sexual child abuse and neglect among boys and men before they become homeless or develop debilitating traumatic stress or psychiatric disorders. The design and validation of brief instruments should also be further explored in research to more precisely measure behaviors or characteristics that are associated with specific subpopulations of homeless men (for example, military veterans, men with different ethnocultural backgrounds, men living in rural rather than urban areas, men in different age cohorts).

Prevention specialists may begin to both universalize and individualize interventions for at-risk or homeless boys and men. Universal education about the nature and impact of trauma on mental health and physical health could enhance existing prevention programs by providing an additional perspective on psychological and physical self-care following traumatic stress. When working with boys or men who already are homeless and are experiencing mental health problems, secondary prevention should consider appropriate ongoing follow-up to prevent cyclical patterns of declining physical, mental, and social health and coping behaviors that may result due to the combination of traumatic events that began with abuse or neglect in childhood and continue with revictimization in adolescence and adulthood. This is also an important consideration for future research, because the examination of the long-term deleterious effects of adulthood trauma and childhood trauma could significantly inform the design of preventive services and the policies that guide treatment programs and their funding sources. A wide variety of evidence-based and evidence-informed treatment interventions have been developed for PTSD (Foa, Keane, Friedman, & Cohen, 2008) and complex traumatic stress disorders (Courtois & Ford, 2009), but these interventions have not yet been adapted for and empirically demonstrated to be effective with homeless men.

The absence of an association between traumatic victimization and substance use problems in this sample of homeless men suggests that although trauma may contribute to or result from substance abuse (Chilcoat & Menard, 2003), substance abuse prevention among homeless or at-risk men may need to focus on factors other than trauma exposure per se. Some homeless men may have substance abuse problems associated with the psychological or mental health distress associated with childhood or recent traumatic victimization, but the relationship between trauma, mental health, and substance abuse problems among homeless men should be identified empirically on an individual basis and not assumed to be a universal comorbidity.

Stable housing and financial solvency are necessary to the restoration of homeless men’s ability to lead productive lives. Supported housing (Fakhoury, Murray, & Shepherd, 2002) and employment (Bond, Resnick, & Drake, 2001) interventions that combine safe, affordable, and livable housing with a safety net of social and therapeutic activities and services
provide a promising approach to the provision of this kind of fully integrated recovery services for homeless men. The sparse literature on male homelessness suggests that these services will be most effective in preventing chronic homelessness or mental health problems if they are designed as a coordinated approach to simultaneously address recovery from the daunting set of challenges these men face. The present study’s findings further suggest that simultaneously addressing the impact of childhood trauma, adult victimization, and problems with mental health and physical self-care may be important in prevention of or recovery from chronic homelessness by men. Substantial policy changes, therefore, are needed (for example, universal health care, expanded victims’ compensation statutes, expansion of the McKinney-Vento Homeless Assistance Act of 1987 [P.L. 77–100]) to support the timely provision of accessible and effective services to prevent victimization of homeless and other at-risk children and to provide opportunities for housing and therapeutic services that address homeless adults’ mental and physical health needs in a trauma-informed manner (Fallot & Harris, 2008).

REFERENCES


Ware, J. E., Kosinski, M., Turner-Bowker, D. M., & Gandek, B. (2002). How to score version 2 of the SF-12 Health Survey (with a supplemental documenting version 1). Lincoln, RI: Quality Metric Inc.


**Mimi M. Kim, PhD,** is a research associate, Institute for Health, Social, and Community Research, Shaw University, Raleigh, NC. **Julian D. Ford, PhD,** is associate professor, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT. **Daniel L. Howard, PhD,** is professor of health policy and executive director of the Robert Wood Johnson Foundation Center for Health Policy, Meharry Medical College, Nashville, TN. **Daniel W. Bradford, MD, MPH,** is director, Psychosocial Rehabilitation and Recovery Center, VA Medical Center, Durham, NC, and Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC. This research was funded by the Department of Health and Human Services Agency for Healthcare Research and Quality grant R24 HS013353. Shaw investigators were also funded, in part, by the National Institutes of Health (NIH) National Center on Minority Health and Health Disparities grant P60 MD000239 and the NIH National Center for Research Resources, Extramural Research Facility Improvement Program grant C06 RR020139. This research was also funded by the National Institute of Drug Abuse (1 R03 DA15494-01; M. Kim, PI) and a career development K23 grant from the National Institute of Mental Health MH01889-01A1 (J. Ford, PI). Address correspondence to Mimi Kim, Institute for Health, Social and Community Research, 900 S. Wilmington Street, Raleigh, NC 27601; e-mail: mkim@shawu.edu.

Original manuscript received April 14, 2009
Final revision received July 9, 2009
Accepted August 31, 2009