

# Hard to Reach: Rural Homelessness & Health Care

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January 2002

This project was funded through a Cooperative Agreement with the Health Care for the Homeless Branch, Division of Programs for Special Populations of the Bureau of Primary Health Care, Health Resources and Services Administration.

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## Acknowledgments

The author gratefully acknowledges the contributions of the following individuals who provided information about rural homelessness, the health status of rural homeless people, and the service access barriers in rural areas that exacerbate poor health and contribute to chronic homelessness:

Sheri Adams, Homeless Healthcare Coordinator, Metro Development Council, Tacoma, Washington

Marie Alyward-Wall, MSN, PHN and Steve Schilling, Clinica Sierra Vista Homeless Program, Bakersfield-Kern County, California

Roberto Anson, Kathy Hayes, DMD, MPH, and Forrest Calico, MD, MPH, Federal Office of Rural Health Policy/HRSA, Rockville, Maryland

Minnie Bommer, Children and Family Services, Covington, Tennessee

Pat Berens, PA, Grand Avenue Clinic, Pueblo CHC, Pueblo, Colorado

Alex Conchola and Rosemary McKenzie, National Rural Health Association, Kansas City, Missouri

Robert Cox, MA, Hospitality House, Boone, North Carolina

Martha Craft-Rosenberg, PhD, RN, FAAN, and Susan Lehmann, MSN, University of Iowa College of Nursing, Iowa City, Iowa

Paul Dragon, Homeless Health Care Program, CHC of Burlington, Burlington, Vermont

Ed Friedman, PA, Redfield Medical Clinic, Redfield, Iowa

Lori Hartford, RN, Yellowstone City-County Health Department HCH project, Billings, Montana

Edith Iwan, CNP, Western New Mexico Medical Group, Grants, New Mexico

Brian Lane, PA, Beatty Medical Center, Nevada Rural Health Centers, Beatty, Nevada

Harvey Licht, Director Office of Rural Health, New Mexico Department of Health, Albuquerque, New Mexico

Marsha McMurray-Avila and Suzanne Zerger, National Health Care for the Homeless Council

Kevin McTeague and Catherine Scott, Terry Reilly Health Services HCH, Boise and Nampa, Idaho

Wendy Ring, MD, Mobile Medical Office, North Coast Clinics Network, Blue Lake, California

Gerry Roll and Jennifer Weeber, Hazard-Perry County Community Ministries, Hazard, Kentucky;

Fran Feltner, RN, SKYCAP program, Hazard, Kentucky

Mary Santineau, PA, Starting Point, Chippewa Falls, Wisconsin

Susan Schirott, North Woods Community Health (CHC), Hayward and Minong, Wisconsin

Ed Scully, MD, Greater Lawrence Family Health Center (CHC), Kingston, New Hampshire

Dave Williams, LSW, Family Health Care Center HCH, Fargo, North Dakota and Moorhead, Minnesota

Jan Wilson, FNP, Valley Health Systems, Inc., Harmony House homeless health care center, Huntington, West Virginia

**The National Health Care for the Homeless Council** is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness.

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## Executive Summary

This report examines obstacles to health care encountered by people who experience homelessness in small communities and remote rural areas of the United States. Information presented here was obtained from the research literature and from 32 service providers and others who are knowledgeable about rural poverty and homelessness in 17 states. The views expressed in this report are those of the author and the individuals cited, and are not necessarily the views of the Bureau of Primary Health Care/ Health Resources and Services Administration, or any other government agency.

The document summarizes what is known about the causes of rural homelessness, and how unstably housed people living in rural areas differ from their urban counterparts. In addition, it describes health problems often experienced by rural homeless clients, highlights strategies that homeless service providers are using to meet the challenges these clients present, and lists their recommendations for policy and practice to improve service access and reduce the incidence of rural homelessness. Sources cited in this report and additional resources about rural homelessness in particular states are included in the bibliography.

**The Problem:** Homelessness is a serious and growing problem in rural areas throughout the United States. While homeless persons are less numerous in rural than in urban areas, the proportionate incidences of homelessness in some rural counties are similar to or greater than those found in major metropolitan areas. For rural communities with few health and social services, the burden of homelessness is disproportionately heavy.

**Causes of Rural Homelessness:** Wherever it occurs, homelessness is inextricably linked to poverty. The same trends are responsible for its growth in both rural and urban areas: unemployment or falling incomes (low-wage, seasonal or temporary jobs), rising rents, and severe shortages of low-cost housing. These and other factors precipitating rural homelessness are illustrated by examples from rural California, Kentucky, North Carolina, Iowa, Colorado, Tennessee, North Dakota, and New Mexico.

**Characteristics of Rural Homeless Clients:** Here is what we know about rural homeless persons from the most recent national survey: 77% are male, most are White non-Hispanic, 64% are 35–44 years old, and 24% are under age 35. Nearly two-thirds have not graduated from high school, half are divorced or separated, and 14% of adults are in families with children. Of rural homeless people, 62% are homeless for the first time (44% for six months or less), 45% live temporarily in private housing, and only 16% spent the night on the streets or in other places not intended for human habitation during the past week. Almost two-thirds worked for pay during the past month, at a median monthly income of \$475; only 6% had no income, and 35% received some sort of government assistance. Only 25% were on Medicaid, and 63% had no health insurance at all. Nearly 50% of rural homeless persons needed but were unable to see a doctor or nurse within the last year. About two-thirds of these individuals reported having a mental health, drug or alcohol problem during the past month, and one-third reported having only an alcohol problem during the past year. Before reaching adulthood, 12% were physically or sexually abused; and 67% have spent time in juvenile detention, jail or prison.

**Rural vs. Urban Homeless Populations:** Persons experiencing homelessness in rural areas differ significantly from their urban counterparts in the following respects: They are less well educated but more likely to be employed, although in temporary jobs with no benefits. They have a higher average monthly income and are more likely to receive cash assistance from friends, but less likely to receive it from the government. They experience shorter and fewer episodes of homelessness, and are 2–4 times more likely to live with family or friends. Consequently, they are less likely to sleep in places not intended for human habitation. Rural homeless persons are as likely as other homeless persons to report having a mental health, alcohol or drug problem during the past month, but six times more likely than their urban

counterparts to report an alcohol-only problem during the past year. They are less likely to have been physically or sexually abused as children, and less likely to have either health insurance or needed access to medical care. According to clinicians, health problems seen in both rural and urban homeless populations tend to be more advanced in rural patients, who present with more untreated, chronic health problems. The highest rates of incarceration are among rural homeless people, who also suffer more stigmatization because the small communities in which they live are less socially diverse than more urban areas.

**Health problems:** Homeless service providers report that health conditions most commonly seen among their rural homeless clients include behavioral health problems, hypertension, heart disease, diabetes, obesity, chronic lung disease, hepatitis C, respiratory and intestinal infections, cognitive and physical impairments, and dermatological problems secondary to peripheral vascular disease, environmental exposure or parasitic infestations. Examples are presented from rural areas in California, Kentucky, Colorado, Montana, Iowa, Tennessee, Nevada, West Virginia, and New Hampshire.

**Health care access barriers:** Despite the severity and complexity of their health problems, access to health care for homeless people in rural areas is seriously limited by three primary obstacles, according to rural service providers: lack of transportation, lack of health insurance, and unavailable or inaccessible health services—particularly secondary and tertiary care, and behavioral health care. Lack of cultural competence and the criminalization of homelessness present additional barriers. Although these barriers are not unique to rural homeless people, they are often more severe, as examples from the field vividly illustrate.

**Service models:** Homeless assistance models in rural communities vary according to their size and distance from urbanized areas. In rural areas large enough to support health and social services, strategies include community partnerships linking formal and informal support systems, multi-service centers, and a hub-and-spoke model of outreach to, and referrals from, outlying rural and urban communities in one or more counties. In remote rural communities with only minimal capacity to provide services, two strategies are most frequently used: mobile outreach units and, as a last resort, referrals to more urbanized areas with established homeless services.

**Recommendations:** The service providers we consulted about rural homelessness and health care expressed a number of ideas about how these access barriers can be overcome, and how rural homelessness might be ameliorated or prevented altogether. Their recommendations fall within seven general categories:

- Provide transportation assistance;
- Expand health coverage and facilitate access to covered services;
- Stimulate the development of a comprehensive service delivery infrastructure in rural communities that is responsive to the needs of homeless people;
- Coordinate rural service delivery systems;
- Increase outreach to “hidden” homeless people in remote rural areas;
- Promote cultural competence among homeless assistance providers; and
- Focus on homelessness prevention.

**Conclusion:** Modern rural homelessness, like urban homelessness, is primarily a function of ongoing structural change in the American economy. Its causes are well understood. Lack of education, adequate incomes, and affordable housing must be addressed to remove the primary causes of rural and urban homelessness. Accessible, comprehensive health and social services are among the resources required to prevent, ameliorate or end homelessness. Vast distances, rugged terrain, lack of transportation, maldistribution of supportive services, and cultural disparities explain why rural homeless persons and homeless assistance providers are mutually hard to reach. Information presented in this report is intended to help homeless service providers and their clients bridge this gap.

In sparsely populated areas across America, growing numbers of impoverished people are struggling to meet the basic human need for shelter. Their struggle is mostly hidden from public view. Some live in makeshift shelters far from developed areas—in mountain hollows, forest campgrounds, desert canyons, and farmers' fields. In desperation, large numbers move from relative to friend to casual acquaintance, until their only option is sleeping in a vehicle or a dilapidated structure on the edge of private land. Proud people with a long tradition of self-reliance, those who experience homelessness in rural areas are reluctant to seek help, are far from established support services, and are hard to reach.

Homelessness in rural America has received far less attention than urban homelessness. Larger numbers of visibly homeless persons in metropolitan areas have caused some to conclude that homelessness is primarily an urban problem. On the contrary, it is also a serious and growing problem in rural areas throughout the United States. For rural communities with few health and social services, the burden of homelessness is particularly heavy.

### Definitions

**Homeless** A homeless person is defined in section 330(h)(4)(A) of the Stewart B. McKinney Homeless Assistance Act as

*an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing (Public Law 104-299-Oct. 11, 1996).*

The concept of homelessness presupposed in this discussion is the expanded definition used by the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration, according to which a homeless person is

*an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered homeless if that person is 'doubled up,' a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness. (BPHC, March 1999)*

**Rural** Urban and rural are matters of degree, based on relative population size, density, and proximity to highly populated areas. A number of definitions have been used to distinguish less populated areas of the United States from more highly populated areas for various purposes—to interpret census counts, distribute agricultural subsidies, and conduct epidemiological studies, among others. For the purposes of this discussion, we employ the National Rural Health Association's definitions, which distinguish rural from urban areas and among different types of rural areas. They are loosely based on 1990 Census Bureau definitions, which have been most widely used in the research cited in this monograph:

*A metropolitan (urban) area is a district of 50,000 population or more, and a non-metropolitan (rural) area is a district of less than 50,000 population that may contain "urban places" (more than 2,500 individuals) and "open countryside" (fewer than 2,500 individuals) (NRHA, 1996). Rural homeless people are found in both metropolitan and non-metropolitan areas (Nooe and Cunningham, 1992). Rural communities are of four types: rural adjacent (contiguous to or within a metropolitan area), rural nonadjacent (not contiguous to a metropolitan area), urbanized rural (with a population of 25,000 or more and not adjacent to a metropolitan area), and frontier (fewer than six people per square mile) (NRHA, 1996).*

Researchers wishing to investigate the comparative incidence and prevalence of homelessness or of particular health indicators among homeless people across areas of varied population size, density, and proximity to metropolitan areas are referred to more elaborate measures used in the 2000 Census, or to the rural-urban continuum code based on the classification scheme developed by the Department of Agriculture (U.S. Census Bureau, 2001; Ormond, et al, 2000).

## **Incidence & Prevalence of Rural Homelessness**

While homeless persons are less numerous in rural than in urban areas, the incidence of homelessness in some rural areas is similar to or greater than that found in major metropolitan areas. For example, reported incidences of homelessness per 1,000 population in some rural counties of Iowa are as great as ten times incidence rates in New York City, Los Angeles, or Washington, DC. (Lawrence, 1995). The prevalence of homelessness is especially high in rural areas experiencing economic distress (Ibid.; NRHA, 1996; First, et al, 1994).

According to the most recent national data, 9% of surveyed homeless clients live in rural areas (Burt, 1999). However, these data may underrepresent rural homeless people because they exclude unstably housed persons in rural areas who did not or could not access targeted homeless assistance services (Ibid.). Some statewide studies estimate a proportion of rural homelessness that is twice as high (NRHA, 1996). Because health and social services for indigent populations in rural areas are scarce (Aron and Fitchen, 1996; Bachrach, 1992), the proportionate burden of homelessness on rural communities is often greater than in more urbanized areas, where supportive services are more plentiful.

Less than 5% of all McKinney funds<sup>1</sup> go to rural communities, which often lack the staff and resources necessary to compete for federal grants (NRHA, 1994). Only nine of 139 Health Care for the Homeless grantees currently serve significant numbers of clients in rural areas, although homeless clients served by many HCH projects have rural origins. Migration of homeless people to more urbanized areas is primarily motivated by the search for jobs, services, and/or personal support from relatives or friends living there (Nooe and Cunningham, 1992).

## **Causes of Rural Homelessness**

Wherever it occurs, homelessness is inextricably linked to poverty (Aron and Fitchen, 1996; First, et al., 1994; Patton, 1998). The same trends are responsible for its growth in both rural and urban areas: unemployment or falling incomes (low-wage, seasonal or temporary jobs), rising rents, and severe shortages of low-cost housing (NRHA, 1994). Rural areas in which the prevalence of homelessness is especially high include:

- Regions with a history of persistent poverty that are economically dependent on declining extractive industries such as mining, timber or fishing;
- Economic growth areas with new or expanding businesses that attract more job seekers than can be absorbed and/or higher income residents, which drives up taxes and living expenses including housing costs;

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<sup>1</sup> Stewart B. McKinney Homelessness Assistance Act programs include those originally funded in 1987 to provide funding for housing, shelter, and services including education and health care to homeless people.

- Areas in which changing economic conditions, such as a lower demand for farm labor due to mechanized and corporate farming or a shrinking service sector from declining populations, have resulted in fewer employment opportunities; and
- Communities located on major transportation routes that attract transient people without resources, looking for work. (Aron & Fitchen, 1996)

These and other factors precipitating rural homelessness are illustrated by the following examples:

Unemployment is a major cause of homelessness in **Humboldt County, Northern California**, where the fishing and timber industries are in serious decline, reports Dr. Wendy Ring, Medical Director of the Mobile Medical Office in Blue Lake, California. Salmon is now an endangered species there because of the timber industry; felled trees cause erosion, rain washes soil into rivers causing them to fill up with silt, and salmon can't spawn. The timber industry is also slowing down because trees have been cut faster than new ones can grow. "Many of the people living in this area aren't prepared for this situation," observes Dr. Ring. "Lots of older and middle-aged folks without a college education are out of work. People used to be able to get work straight out of high school, buy a house, and have a good life. That's no longer true, but even kids now in high school aren't taking the need for higher education seriously; they don't understand that jobs in the salmon and timber industries won't be there for them." This problem is exacerbated by the migration of affluent people from Southern California, who are inflating the real estate market. They come with huge amounts of money and pay cash for houses, driving up the market price. People who would ordinarily be homeowners end up renting, reducing the supply of affordable housing for lower-income residents, many of whom end up homeless.

In Appalachia, the declining coal industry has long been a source of chronic poverty and homelessness. **Hazard, Kentucky**, is located in the coal fields where mining still goes on. Nevertheless, few young people are willing to do deep mining as their fathers did, because of the health hazards involved, according to Gerry Roll of Hazard-Perry County Community Ministries, Inc. The biggest new industry in Hazard today is a telemarketing pool that provides computer tech support, employing 600 people. Nevertheless, lack of transportation and childcare present serious barriers to employment for homeless families.

A classic example of an area that has experienced both an economic boom and rising homelessness is **Boone, North Carolina**. Boone is a mountain resort town in the western part of the state where a regional university with a growing reputation and an influx of second homeowners have attracted more affluent residents and reduced the stock of affordable housing. "People are selling off their family land for fairly decent prices to developers who make gated communities out of it," explains Robert Cox, MA, of Hospitality House, an area homeless shelter with a transitional living program. "The main purchasers are second homeowners who live there only seasonally. This drives up tax rates and the cost of living. As a result, Boone has the second highest *per capita* rental costs in North Carolina, in a service-based economy where the average wage is \$7.00 per hour." This hits female-headed households especially hard. The homeless shelter has seen a 28% increase in homeless families within the past year, he says, primarily due to low wages and unaffordable housing.

The population of Iowa grew by 5.4% between 1990 and 2000, compared to a national average of 13%. In general, rural populations declined, while metropolitan areas saw large increases, especially in Western Dallas County near Des Moines (US Census 2000). Increased employment opportunities partially explain this growth. Lots of companies moved to Des Moines and surrounding suburbs, increasing the number of jobs in insurance, real estate, and the service industry. But this didn't help the citizens of **Redfield, Iowa** (population 933), 35 miles away—especially those on the edge of homelessness. "Cities in Iowa with populations of 30,000–50,000 seem to be doing well, but smaller towns like Redfield are having a real struggle," says Ed Friedman, PA, the sole medical provider in the only clinic in town.

“Economic bad luck and domestic problems, sometimes exacerbated by spousal abuse, substance abuse and/or mental illness, often result in homelessness.” Family breakup and job loss are reported to be primary causes of homelessness in rural Iowa (MacDonald, et al., 2000). Friedman says he is seeing more homeless people who come to Redfield to move in with their grandparents. Others camp out or live in their cars, often parked in remote areas. “Relatives and friends used to take people in when they needed help,” he recalls, “but there isn’t as strong a support network any more, because more folks have moved to urban areas.”

**Pueblo, Colorado**, is a small city of 100,000 in a low-income area of the state, surrounded by a very rural area. The boom economy enjoyed by other parts of Colorado in recent years passed Pueblo by. Their major employer, a large HMO service center, went out of business. Many Spanish-speaking families have difficulty competing in the local job market, although some migrant workers do construction or landscaping. Low wages and high unemployment compound the shortage of affordable housing as factors that precipitate homelessness. A number of clients seen by the Pueblo Community Health Center’s homeless clinic are from small towns in the surrounding area. Recently, a very sick man with a gastrointestinal bleed was referred to a Pueblo hospital because a small rural hospital couldn’t take him, says Pat Berens, PA. The patient was discharged homeless. Many displaced persons originate in rural towns that lack the medical or financial resources to meet their complex health care needs. Transported to cities for emergency care, too many such persons have nowhere to go but the streets, once they are medically stabilized.

Children and Family Services in **southwestern Tennessee** serves low-income families in Haywood, Tipton, Lauderdale, and Fayette counties. About 15% of the families served are homeless, estimates executive director Minnie Bommer, who founded the agency 25 years ago. Most of their homeless clients are African American. “Typically, they are living with relatives and friends in housing that isn’t equipped for more than one family. They were either asked to leave their previous residence and can’t afford to go anywhere else, or they are sick. A couple of families were living in their cars, traveling from one county to another.” Only about half of her homeless clients are employed. “There aren’t many jobs available for people at their level or education or training,” explains Bommer. “The reading comprehension level of homeless parents is typically low; few have completed even a high school education.”

The prevalence of homelessness in this four-county area appears to be “about the same as it has always been,” says Bommer, although the particular causes have changed. “Economic and social circumstances force people into homelessness,” she says. For example, farm foreclosures increased the number of homeless persons in the area 5–10 years ago. No small farms remain; big farms replaced sharecroppers, who no longer exist in West Tennessee. But this is not a recent cause of homelessness. New laws governing the public housing authority are the main reason for homelessness her agency sees. “If an adult resident of Section 8 housing or a child is suspected of drug use, the family has to move. This rule is strictly enforced. Young families with teens or small children are often evicted for this reason,” she reports. Moreover, when residents’ wages increase, public housing authorities increase the rent, so people don’t have a chance to save money for unsubsidized rental housing or a mortgage. “We need to help these families on the front end instead of waiting until they are kicked out,” contends Bommer. “This would prevent homelessness.”

**Fargo, North Dakota**, is the largest city in a primarily rural state, close to the Minnesota border. Fargo experiences several kinds of homelessness. Located along a rail line that runs from Seattle to Chicago, Fargo attracts a fair number of homeless men who travel there by train (“the hot rails crowd”), especially in spring and summer. These transients lead a hobo lifestyle, living in camps on the outskirts of the city, observes Dave Williams, LSW, of the Family Health Care Center. They tend to travel in gang-like groups whose use of alcohol and other drugs results in a good deal of violence. About one-third of the clinic’s clients are Native Americans from several reservations within a three-state area (North Dakota, South Dakota, and Minnesota) who are intermittently homeless. They go back and forth between the

community and the reservation, or stay with family members until substance abuse and resulting violence make them no longer welcome. A few individuals with intractable substance dependence and/or untreated mental illness become chronically homeless. Unwelcome in shelters and often unable to obtain treatment, they live out of doors, even in sub-zero temperatures. Whether newly, intermittently, or chronically homeless, these people are in great need of both housing and support services.

Rural homeless populations in **New Mexico** tend to cluster along two borders, according to Harvey Licht, director of the state Office of Rural Health in Albuquerque, New Mexico. A significant homeless population resides in the northwest, four-corners area of the state, along the Arizona, Utah, and Colorado borders and near the Navajo Nation. Gallup and Farmington are two small communities in this area where homeless people congregate.

In the southern part of the state, foreign nationals in communities and surrounding rural areas along the Mexican border often live on the brink of homelessness. “In the town of Anthony, where a canning plant seasonally employs 600–1000 people per year with a population three times as large, living standards for migrant workers are similar to those seen 30 years ago. But today, people work in an industrial instead of an agricultural environment, and live in cars or trailers instead of camping in the fields,” says Licht. Some workers without green cards live around the plant for the season; others drive back and forth from Mexico. Similar employment situations are found throughout the lower tier of New Mexico.

These aren’t really seasonal farmworkers; typically they are in construction (foundation work, roofing, ditch digging) or agriculture-related industrial work (onion packing sheds). This homeless population has historical roots in the Bracero Program that began after World War II, which allowed Mexican workers to come to the US on a temporary work permit in agriculture-related industries, Licht recalls. This program legalized the status of Mexicans working in rural West Texas and Southern New Mexico. There are current efforts to revive this policy, to meet America’s labor needs.

The Wagner Act was passed to protect migrant workers when they were shipped interstate. For example, immigrants could come into the Employment Security Office in El Paso, Texas, to identify agricultural job opportunities in other areas of the country, explains Licht. Before companies could appear on the employment security listing, they would have to guarantee housing and appropriate services for the immigrants seeking jobs. But there is no limit on the number of referrals made, and individuals may arrive to find that the listed job opportunities have been filled. These workers may stay to fill other, non-listed positions that do not meet minimum standards. These individuals, far from home, are at high risk for homelessness. The result is increased homelessness in rural areas across the United States where migrant workers have been lured by sometimes elusive job opportunities, or seasonal employment without affordable housing or services.

“What differentiates ... rural folk who survive hard times from those who fall into homelessness is the number and severity of their structural problems, and the presence of personal and social resources with which to resolve them. Problems increase as resources decrease.”

— Yvonne Vissing, 1996

## Characteristics of Rural Homeless Clients

A statistical overview of rural homelessness is helpful to understand the scope of the problem and characteristics of the people who experience it. According to the Urban Institute's weighted analysis of client data (Burt, 1999) from the National Survey of Homeless Assistance Providers & Clients (NSHAPC) conducted in 1996, here is what we know about surveyed homeless people living in rural America who received targeted homeless services and acknowledged their homelessness:<sup>2</sup>

### Statistical Portrait of Rural Homeless Clients

**Gender:** 77% male, 23% female.

**Ethnicity:** Most are White non-Hispanic (42%) or Native American (41%).

**Age:** 64% are 35-44 years of age, 24% are under 35.

**Education:** 64% completed less than a high school education

**Family status:** 50% divorced or separated, 14% of adults in families with children.

**Homelessness:** 62% homeless for the first time (44% for 6 months or less)

**Habitation:** 45% live temporarily in private housing, 16% slept on street or in places not meant for human habitation during past week.

**Employment:** 65% worked for pay during past month, 12% in jobs lasting or expected to last at least three months.

**Income:** \$475 median income during past month, 36% received money from parents or friends, 6% had no income.

**Govt assistance:** 35% receive AFDC, GA, SSI, housing, or food stamps.

**Medical insurance:** 63% uninsured, 25% on Medicaid.

**Health care access:** 47% needed but were not able to see a doctor or nurse within last year.

**Behavioral health problems:** During the past year, 55% had an alcohol problem (33% alcohol-only), 30% had a mental health problem, and 21% had a drug problem; 64–67% had one or more of those problems during the past month.

**Victimization:** 12% were physically or sexually abused before age 18.

**Incarceration:** 67% have spent time in juvenile detention, jail or prison.

*1996 National Survey of Homeless Assistance Providers & Clients (Burt, 1999)*

When rural residents with permanent housing lose it, they typically use three strategies to cope with homelessness:

- *Move in* with a series of relatives and/or friends until they wear out their welcome;
- *Move out* of housing intended for permanent habitation into abandoned shacks, vehicles, or other temporary shelter on private property, in Forest Service campgrounds or other remote areas; or
- *Move on* to more urbanized areas in search of jobs, services, and/or personal supports from family or friends living there—beginning the cycle anew. (Aron and Fitchen, 1996)

<sup>2</sup> These and other data reported in this document may not be representative of all homeless people residing in rural America, because of limitations in survey design and/or the fact that many rural homeless residents live beyond investigators' reach.

## How Rural and Urban Homeless Populations Differ

Homeless people in rural areas of the United States have been reported to differ significantly from their urban and suburban counterparts in the following respects:

### What Distinguishes Rural from Urban Homeless Clients:

- Lower educational level; more than twice as likely to be high school drop-outs.
- More likely to be employed, but typically in temporary jobs with no benefits.
- Higher median income during the past month; half as likely to have no income.
- More likely to receive income assistance from friends but less likely to receive cash assistance from the government.
- More likely to be residing in their county of birth.
- Experience shorter and fewer episodes of homelessness during their lifetime.
- 2-4 times as likely to be living temporarily in private housing with family or friends.
- Less likely to sleep on the streets or in other places unintended for human habitation.
- Less likely to report having a mental health or drug problem during the past year but six times more likely to report having an alcohol-only problem during the past year.
- More likely to be without any health insurance, less likely to be on Medicaid.
- Have less access to medical care.
- Less likely to have been physically or sexually abused before age 18.
- Higher rates of incarceration.

*1996 National Survey of Homeless Assistance Providers & Clients (Burt, 1999)*

**Age & gender:** According to national averages, rural homeless clients tend to be somewhat older; larger percentages of rural homeless service users are between ages 35 and 44, and significantly fewer are under age 35 (Burt, 1999). In addition, women and children comprise a larger percentage of homeless clients living in rural areas than of those living in more urbanized areas (Ibid.; MacDonald, et al, 2000; Fitchen, 1992). Nevertheless, the demographics of rural homeless people may vary somewhat from region to region. A statewide study in Ohio (First, et al, 1994) and a seven-state study in Colorado, Delaware, Maryland, Minnesota, Ohio, Pennsylvania, and Washington (Craft-Rosenberg, 2000) found rural homeless populations to be younger than urban homeless populations.

**Ethnicity:** Nationwide, 42% of surveyed White non-Hispanic homeless people live in rural areas. In general, there are lower proportions of African Americans (9%) and Hispanics (7%), and higher proportions of Native Americans (41%)<sup>3</sup> among surveyed rural homeless residents than among homeless people living in more urbanized areas (Burt, 1999). Nevertheless, “the ethnic distribution of homeless people tends to mirror the distribution of poor people in a given location” (Bassuk, as cited in Wagner, 1995). Thus low-income people lacking stable housing are predominantly white in Appalachia and rural areas of the Northeast and upper Midwest, black in the Mississippi Delta, Native American in areas close to Indian Reservations, and Hispanic in parts of the country that attract migrant labor.

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<sup>3</sup> These data should be interpreted with caution, warns Burt. “Three Native American clients interviewed at the same emergency shelter comprise 1.3 percent of the unweighted homeless rural sample but constitute 34.4 percent of the weighted sample.”

**Education & employment:** Rural homeless clients have the lowest levels of educational attainment; 64% are high school dropouts—nearly twice the percentage reported by other homeless clients. Nevertheless, they are more likely than urban or suburban clients to be working, albeit at part-time, short-term or seasonal jobs without benefits. Although a higher proportion of homeless clients are employed in rural (65%) than in urban (40%) or suburban (49%) areas, rural clients are more likely to be working at jobs lasting less than three months (Burt, 1999). Geographic isolation and lack of transportation often block their access to better jobs and health services in more urbanized areas (Grant, et al, 2000).

**Income & resources:** On average, the financial resources of surveyed homeless people in rural communities appear to be significantly higher than those of homeless people residing in central cities, and slightly higher than those of homeless people living in suburban and urban fringe areas. Surveyed homeless clients in rural areas had a higher median income during the past month (\$475) than clients in suburban areas (\$395) or central cities (\$250); only 6–7% had no income, compared to 15% in urban areas. Rural homeless persons are more likely than those in more urbanized areas to receive income assistance from friends, and less likely to receive government assistance, except for Veterans’ benefits and food stamps (Burt, 1999).

It should be noted that the average income levels just reported are based on interviews of homeless clients in the few rural programs serving homeless people, either exclusively or as a primary part of their mission. These averages exclude rural homeless residents who did not or could not access these services, and service users who did not identify themselves as homeless. Thus reported data about income and resources must be understood as representing only a subset of homeless people living in rural areas of the United States. Homeless persons not surveyed may have fewer financial resources than those who were, particularly if they live in remote, frontier areas, far from homeless assistance resources. The National Survey of America’s Families (NSAF), conducted by the Urban Institute, found that “rural areas are poorer than urban areas, and the more isolated the rural area, the greater the degree of poverty” (Ormond, et al, 2000).

**Stigmatization:** There is less socioeconomic diversity in rural America, where more traditional values and bias against minorities can magnify the stigmatization of homeless individuals (Bachrach, 1992). A ‘blame the victim’ mentality may be more prevalent in small towns, where residents place a high value on individuality and self-sufficiency, and tend to attribute homelessness to individual failure rather than to structural problems (Lawrence, 1995; Wright, 2000). Although rural communities pride themselves on “taking care of their own,” economic pressures from rising unemployment, falling incomes, and continued decline in low-cost housing make it increasingly difficult for informal support systems to manage the burden of a growing rural homeless population (NRHA, 1996; Patton, 1988).

**Habitation:** Rural homeless people are more likely to be residing in their county of birth, and experience shorter and fewer episodes of homelessness during their lifetime than do homeless persons in urban and suburban areas (Craft-Rosenberg, 2000; Burt, 1999). A lower proportion of rural clients report having slept on the streets or in other places not intended for human habitation (16% rural, 23% suburban, 36% urban), although these data may not include homeless persons living in Forest Service campgrounds or vehicles in remote rural areas (Burt, 1999). A higher proportion of rural clients (45% rural, 22% suburban, 11% urban) are living temporarily in private housing (Ibid.), in part because of the lack of shelters in rural areas (Wagner, et al, 1995). Larger extended families compensate somewhat for the scarcity of temporary shelters in rural communities, where a higher proportion of residents who lose permanent housing “double up” or “couch surf” with a series of friends and relatives (Dail, 1997; NRHA, 1996; Wagner, 1995). While homelessness is therefore more “hidden” in rural America, it is also less anonymous, increasing the difficulty of preserving client confidentiality (Patton, 1988).

**Health status:** There is strong evidence that in many respects, the health status of rural US residents is worse than that of urban residents, regardless of housing status (Ormond, et al, 2000). Among the most notable discrepancies are these: In most rural counties, adults are 20% more likely to die from heart disease; death rates among men with chronic obstructive pulmonary disease are 30% higher, attesting to the high prevalence of smoking in rural areas; and suicide rates are nearly 80% greater for males age 15 and older. Limitation in activity due to chronic health conditions in adults is also more common in non-metropolitan counties than in large metropolitan counties, particularly in the Northeast and South. (NCHS, 2001) “[B]ecause of the higher proportion of people who live in rural poverty and the lack of medical facilities and health care practitioners in rural areas, [it is arguable that] children and families who are displaced there are at even greater risk for health problems than are those from urban areas” (Vissing, 1996).

Few statistical analyses have been done comparing the health status of rural and urban homeless populations. The most inclusive national analysis to date—the 1996 NSHAPC study (Burt, 1999)—indicates that self-reported health risks may be higher for rural homeless clients in some respects and lower in others. For example, acute non-infectious conditions are more likely to be reported by homeless service users in rural (11%) and suburban (10%) areas than by those in central cities (7%). Acute infectious conditions are just as likely to be reported by homeless service users in rural (25%) and urban (24%) areas, but significantly more likely to be reported by those in suburban areas (35%).

On the other hand, according to the same study, surveyed homeless clients in rural areas are one-half to one-third as likely as their more urban counterparts to report being physically or sexually abused before age 18 (12% rural, 24% central city, 33% suburban). What’s more, chronic health conditions are reported by a smaller percentage of rural clients (33%) than by urban (48%) or suburban (43%) clients. Moreover, the four medical conditions most commonly reported by all homeless service users—joint problems, respiratory infections, physical disabilities and high blood pressure—are reported by the smallest percentages of rural homeless clients.

These results seem to contradict previously cited research findings of higher health risks for rural populations. They are also contrary to clinicians’ perceptions reported in the next section that chronic health problems seen in both rural and urban homeless populations, such as hypertension and diabetes, are more complicated in their rural homeless patients. According to these health care providers, rural homeless clients tend to be sicker because their treatment has been delayed longer.

This discrepancy may point to the limited accuracy of self-reported health status, or to the limited inclusiveness of data collected in the 1996 NSHAPC study, or to the likelihood that homeless service users in general may be less aware of their health problems than are homeless clients seeking health services. Other studies, even more limited in scope, suggest that rural residents may have a “hardier,” more stoic attitude toward ill health, and correspondingly greater reticence to confide in researchers about their health problems (Wagner, et al, 1995; Weinert and Berman, 1994). Comparative diagnostic data from samples of rural and urban homeless health care recipients might help to resolve the discrepancy between client self-reports and clinician perceptions.

**Behavioral health problems:** Nationwide, adolescents and adults in the most rural counties are most likely to smoke, regardless of housing status (CDC, 2001). About two-thirds of surveyed homeless clients in both rural and urban areas report an alcohol, drug, or mental health problem occurring within the past month. The proportion of rural clients reporting only an alcohol problem during the past year (36%) is six times that of all other homeless clients. The percentage of homeless clients reporting other drug problems during the past year increases as urbanization increases: 20% rural, 35% suburban, 41% urban. Slightly more than one-third of rural respondents report ever having a mental health problem, compared to over one-half of other homeless clients. (Burt, 1999) Stigmatization of mental illness and substance

abuse, which is allegedly greater in rural than in urban areas (Wagner, et al, 1995), may compromise the accuracy of these self-reports. Other research studies report a similar incidence of mental illness in rural and urban homeless populations (Craft-Rosenberg, 2000; Patton, 1988).

**Health care access:** Despite their poorer health status, residents of rural areas are getting less professional medical attention than their urban counterparts, in part because fewer physicians practice there, and because a higher proportion of rural residents lack health coverage (Ormond et al, 2000). Rural homeless people have less access to medical care than homeless people in urban areas; 47% needed to see a doctor or nurse within the last year but were unable to do so, compared to 22% of other homeless clients (Burt, 1999). The supply of specialists and dentists decreases markedly as urbanization decreases, in all regions of the United States (CDC, 2001). Moreover, the vast majority of resources to treat mental illnesses are in urban areas (Wagenfeld, et al, 1997), and access to mental health services is even more limited for rural homeless people than for rural people in general. “The few rural agencies available to help people who are homeless or at risk of homelessness rarely have staff who are trained to assess and work with people with serious mental illnesses” (NASMHPD, 1995).

**Health insurance:** A higher percentage of surveyed homeless people in rural areas (63%) lack health insurance, compared to 52–55% in suburban/urban areas; and lower percentages have Medicaid coverage (25% versus 31%) or private insurance (1% versus 4–5%) (Burt, 1999). Among all US residents under age 65 with income below 200% of poverty, the average uninsurance rate in 1997–98 was 33% in non-metropolitan areas and 31–35% in metropolitan areas (CDC, 2001). Uninsurance rates among low-income Americans tend to be higher in the South and West (Ibid.). Lack of health insurance is linked to unmet health needs and higher rates of morbidity and mortality (Ayanian, et al, 2000).

**Incarceration:** Rural homeless clients have the highest rate of incarceration; 67% have spent time in juvenile detention, jail or prison, compared to 55% of clients in central cities and 44% of suburban clients (Burt, 1999). High rates of behavioral health problems experienced by homeless people and more limited access to mental health care and substance abuse treatment in rural areas may partially explain this excessive incarceration rate.

## Health Problems of Rural Homeless Clients

Despite their quantitative and qualitative differences, homeless people in rural and urban locations share many of the same health risks. Exposure to the elements, environmental pollutants, infectious disease, frequently overcrowded living conditions, and chronic stress inherent in finding food and shelter increase their risk for poor health. Lack of a permanent address complicates their access to entitlements. Financial and transportation barriers, prejudice and stereotyping limit their access to mainstream health services (Craft-Rosenberg, 2000). The geography of homelessness may vary, but its consequences are remarkably similar.

We asked homeless service providers for a clearer picture of the individuals they serve in a variety of rural settings across the United States. In particular, we asked them to describe the clinical conditions that seem to distinguish their rural patients from other homeless clients, and to specify obstacles that prevent these individuals from obtaining the health care and social supports they need.

Clinicians we consulted specified the following health conditions as those most frequently seen among their rural homeless clients:

- **Mental health and substance abuse problems** –*posttraumatic stress disorder (PTSD) secondary to childhood abuse, domestic violence or war experiences; substance abuse problems that vary by region and population (Alcohol, methamphetamine and prescription drugs are among those most often mentioned.)*

A number of research studies have confirmed that serious mental illness is reported by similar proportions of both rural and urban homeless populations (Burt, 1999). Nevertheless, because mental illness has more stigma attached to it in rural than in urban areas, there may be significant underreporting of mental health problems experienced by rural residents (Wagner, et al., 1995). This assumption is supported by the fact that suicide rates are nearly 80% higher for rural than urban males over age 14 (CDC, 2001).

Neither the research literature nor clinicians interviewed for this report indicate a significant difference in the incidence or prevalence of mental health or substance abuse problems in rural and urban homeless populations, only in the use of particular psychoactive substances. As we have seen, alcohol abuse alone is significantly more common in rural than urban areas (Burt, 1999). The abuse of other psychoactive substances varies according to region. For example, clinicians reported more heroin and cocaine use in areas near the east and west coasts. Methamphetamine, marijuana, and synthetic heroin were reported to be popular in some rural areas, but this evidence is primarily anecdotal. Methamphetamine use began in California in the early 1990s and spread eastward when users started manufacturing the drug in home laboratories and moved to rural areas in the South, Midwest, and beyond (Alligood, 8-26-01).

- **Chronic medical conditions** – *hypertension, heart disease, diabetes, obesity, and chronic lung disease (emphysema, asthma)*

As reported in the previous section, mortality rates from heart disease and COPD are higher in rural than in urban areas (NCHS, 2001). Moreover, heart and circulatory problems, diabetes and asthma are among the health problems most frequently mentioned by surveyed homeless persons in rural areas (First, et al., 1994; Craft-Rosenberg, 2000). Of homeless clients enrolled in the SKYCAP Rural Health Outreach program in Hazard-Perry County, Kentucky, in 2001, 21% had hypertension, diabetes or heart disease, reports Fran Feltner, RN. Nevertheless, there are few epidemiological data differentiating rural from urban homeless populations with respect to the comparative incidence or prevalence of hypertension, heart disease, diabetes, or obesity.

NSHAPC data indicate a lower rate (10%) of self-reported high blood pressure among rural homeless clients than among urban/suburban homeless clients (15–16%) (Burt, 1999). Clinicians report no appreciable difference between homeless patients from rural areas and those from more urban areas in the occurrence of chronic medical conditions such as hypertension or diabetes, but higher morbidity in their rural homeless clients because they tend to remain untreated longer than their urban counterparts. In addition, clinicians report (and epidemiological data confirm) that hypertension, heart disease, diabetes, obesity, and asthma are especially common among Latino/Hispanic, Native American, and African American clients, regardless of their housing status. Although asthma is more common in urban than in rural areas, acute asthma is a function of inadequate primary and preventive care. To the extent that fewer health services are available to homeless people in rural than in urban areas, rural residents are at higher risk for acute complications of asthma.

- **Infectious diseases** – *hepatitis C, respiratory and intestinal infections, some tuberculosis and HIV/AIDS*

Hepatitis C, which is associated with injection drug use, is reported by clinicians to be a significant and growing problem among rural homeless clients, although no statistical data are yet available to substantiate this observation. Bronchitis, the common cold, and pneumonia are among acute health conditions most commonly reported by rural homeless women and children (Craft-Rosenberg, 2000), and are even more common among surveyed homeless clients in more urbanized areas (Burt, 1999).

The frequency of upper respiratory infections among rural homeless clients was confirmed by the clinicians we interviewed. Most of these practitioners also indicated that they are seeing much less TB and HIV/AIDS among their rural clients than is reported in urban areas, although even a few cases present serious individual and public health risks.

Because tuberculosis is more prevalent among recent immigrants from Latin America and Southeast Asia, rural communities that attract these populations may see a higher incidence of TB than others. There is also the problem of access to TB screening and treatment, which varies by state and from community to community. In Iowa, for example, the incidence of TB is 3.5 active cases per 100,000 population (compared to the public health goal of 1.5/100,000), which is largely reflective of the homeless and international populations there, according to Susan Lehmann, MSN, University of Iowa College of Nursing. Nevertheless, TB eradication efforts including both screening and treatment are insufficient, she says.

Although the prevalence of HIV/AIDS is lower in rural than in urban practice settings (Weinert and Burman, 1994), rural patients with HIV infection tend to be diagnosed later “because HIV/AIDS is perceived to be an urban disease, and their physicians do not consider them at risk” (Song, 1999). Care for HIV-infected homeless persons in rural areas is further complicated by the lack of running water or refrigeration in facilities where they are temporarily housed, and by the fact that few rural providers are experienced in HIV care and/or have access to the latest diagnostic tools and treatments (Ibid.).

- **Disabilities** – *severe mental illness, orthopaedic impairments secondary to occupational injuries & trauma*

Rural areas have consistently higher rates of disabilities among working adults, ages 18–64 (Community Options, 1999). Of all residents of non-metropolitan counties, 23.3% have a disability, compared to 18.4% of metropolitan county residents (1990 Census). Clinicians serving rural homeless persons report a number of clients with disabling conditions, including serious mental illness (schizophrenia, personality disorders or affective disorders such as depression, bipolar disorder or posttraumatic stress disorder) and musculoskeletal disabilities secondary to trauma from physical abuse or injuries from manual labor.

- **Skin problems** – *foot problems, head lice and scabies, frostbite, poison oak*

Most of these dermatological problems are not unique to rural homeless persons, although poison oak is usually not found in urban areas. Among the most serious foot problems seen in homeless persons are ulcers associated with untreated peripheral vascular disease, often secondary to diabetes (Brickner, et al, 1994). Because homeless people living in rural areas have more limited access to medical care than those living in urban areas (Burt, 1999), they are likely to be at higher risk for these complications. Neither the clinicians interviewed nor the surveyed literature indicated more parasitic skin infestations, such as head lice and scabies, among rural than urban homeless persons. These infestations are more prevalent wherever congregate living occurs. Although there are fewer shelters in rural communities, more “doubling up” occurs there, with multiple families living in housing intended for one. Thus infestations, like infections, are as likely to be spread in rural as in urban habitats. Because there is less unsheltered homelessness in rural areas, the prevalence of skin problems secondary to exposure, such as frostbite, may be lower among rural than urban homeless persons, but statistical findings are not available to demonstrate this.

Although these health problems are characteristic of both rural and urban homeless populations, they are often more advanced and complicated in homeless persons living in rural areas, as the following examples illustrate:

Clinica Sierra Vista Homeless Program, based in **Bakersfield, California**, is one of the few Health Care for the Homeless projects that serves a large rural population. Although the HCH clinic is located in a metropolitan area of 400,000, its mobile health care unit goes all over Kern County—a vast, mostly rural county the size of Massachusetts, spanning more than 8,000 square miles of agricultural land, mountains, and desert. The average population density is 81 people per square mile, but much of the land is even more sparsely settled. Rural residents must travel long distances to jobs or services. The three largest industries are oil and agriculture in the Central Valley, and defense in the Mojave Desert. Despite this diversified economy, unemployment rates in some communities are as high as 20–30%. “A comfortable climate nearly year-round enables some homeless people to live unsheltered in most of the county, or in camper shells parked on someone else’s property,” says CSV executive director Steve Schilling. About one-third of their rural clients reside in the desert, one-third in a river canyon, and one-third in the mountains on Forest Service land when it’s not snowing, estimates homeless coordinator Marie Aylward-Wall, MSN, PHN. The HCH outreach team serves five distinct groups of rural clients:

**Transients:** This portion of the homeless population moves throughout the county, primarily between the mountains and the desert. “We lose 12–16 of these people each year to trauma alone,” she says. “They just disappear into the mountains.”

**Migrants:** About 40,000 mostly Hispanic farmworkers come to Kern County during the harvest season, May through October, although the migrant population is diminishing somewhat as agricultural workers move north to escape the drought that has destroyed crops and jobs. There is no housing for migrant workers in the area, although young Hispanic men have been coming up from Mexico for generations. Most live in orchards and fields or along canal banks; some live in more urban areas, doubled up in motels. These undocumented immigrants are very skittish about receiving services, says Aylward-Wall. One Sunday, the mobile van found a 47-year-old farmworker with diabetes, living in the desert with gangrene up to his knee. They transported him to the emergency room, where his leg had to be amputated.

**Homeless families:** Most homeless families live in small agricultural towns or more urbanized areas with support services. The county puts up hundreds of farmworkers’ families in a welfare motel, often 6–8 people to a room. Pockets of homeless families also live in more remote areas. In one isolated place in the desert they discovered 250 farmworker families, 110 miles (a two-hour drive) from Bakersfield. Victims of a land scam, someone had sold them property in the desert with limited access to water and no electricity. They live in shacks and trailers, far off the road.

Once, HCH clinicians discovered a 33-year-old undocumented pregnant woman in the desert, living in her car with two children. She was pre-eclamptic with very high blood pressure, a medical emergency. The baby died, but without their help, the mother and her other two children would have been lost as well. This woman wasn’t far from a rural clinic, but she knew she wasn’t welcome there. She was entitled to Emergency Medicaid but didn’t know it, recalls Aylward-Wall. “Isolated homeless people lack access even to services they are entitled to receive,” she says. “They need advocates—people who understand Medicaid benefits, to do outreach, educate them about available services, and make the system work for them.”

**Drug users & survivalists:** There is a large network of methamphetamine labs, mostly in the desert, that attracts small settlements of chronic drug abusers. “These can be dangerous people,” says Aylward-Wall. Outreach workers depend on reliable local contacts to let them know when it is safe to go into the area. “There have been some scary incidents involving outreach workers who have stumbled onto meth labs without knowing what they look like,” she says. A large number of Aryan Nation members (“skinheads and old Ku Klux Klan leftovers”) inhabit unincorporated areas visited occasionally by the mobile outreach team. Serving these people can be especially risky for caregivers who are black or Hispanic. They are careful not to bring volunteer clinicians who are members of ethnic minorities to these areas. One black family had to be escorted out of the area for their own protection. “Bigotry against ethnic minorities seen in Midwestern rural areas is far more benign than what we are experiencing,” says Aylward-

Wall. “Remaining in touch with indigenous contacts is essential if you have a mobile outreach program,” she advises.

**Vietnam veterans:** At least 600–700 veterans are estimated to be living in undeveloped areas in the desert and mountains, in mine shafts and canyons. The HCH serves about 350 of them at any given time. “This is the hardest group to reach and the most skittish,” says Aylward-Wall. They tend to be loners, but have a very good communication network. Many of these clients have posttraumatic stress disorder with overlying drug problems and other chronic health issues they have never dealt with, she says. “Most have never been treated for PTSD. Already on drugs when they returned from the war, they have been self-medicating ever since.” Many of these individuals also have diabetes and hypertension, but have been without medications for 15 years, living in the desert. Bad foot lesions are often seen in untreated diabetic alcoholics. There is also a very high incidence of hepatitis C among homeless veterans; in those they have tested, the average prevalence of HCV is 60–65%, compared to 30% in other homeless clients.

Although the prevalence of reported substance abuse among rural and urban homeless people is similar, substances abused often differ. As seen, alcohol abuse occurs in a higher proportion of surveyed homeless people in rural than in urban areas. Rural providers also report more abuse of prescription drugs and other addictive substances that are less commonly seen in urban areas.

**Hazard, Kentucky,** has the dubious distinction of being the “OxyContin abuse center of the world,” says Gerry Roll of Hazard-Perry County Community Ministries (HPCCM). OxyContin is a synthetic heroin that was developed to control pain in patients with terminal illnesses such as cancer. “Doctors have not done a good job of controlling prescriptions for this medication, which is easier and cheaper to obtain in this community than in some others,” says Roll. A high concentration of physicians in the area recruited by a rural hospital chain, and insufficient prescription monitoring of individuals seen by multiple providers results in a good deal of “doctor shopping,” she explains. Some patients pay cash for drugs and sell them for much larger amounts on the streets. This helps to explain the higher availability of prescription drugs for illicit use. HPCCM is working to educate community doctors about this problem. The site of a rural Kentucky psychiatric hospital, Hazard attracts a number of people with mental illness who are seeking prescription drugs, many of whom are self-medicating. Prescription drug abuse in this community is a problem primarily among White non-Hispanic persons, who account for over 97% of the population of Perry County, Kentucky.

Soma, a muscle relaxant that converts into methamphetamine in the body, is another prescription drug that is reported to be a growing problem in **Pueblo, Colorado,** reports Pat Berens, PA, of the Grand Avenue Homeless Clinic. The clinic sees a larger number of mentally ill homeless people than elsewhere because there used to be a state mental hospital in Pueblo that was converted to an ambulatory care facility. HCH clinicians keep “a very tight lid on prescription drug abuse,” says Berens. “Treatment for pain used by mainstream physicians is often inappropriate for homeless people; it exacerbates their substance abuse. Different prescription criteria are needed for this high-risk population.”

Methamphetamine is the first drug of choice among young homeless clients served by the Yellowstone City-County Health Department’s Health Care for the Homeless project in **Billings, Montana,** according to program manager Lori Hartford, RN. Older clients prefer alcohol. In addition, many Native American clients drink Lysol and hairspray, which are extremely damaging to the brain and the liver. In Montana and elsewhere, substance abuse is both a cause and a consequence of homelessness that is often linked to child abuse/neglect and the loss of children to foster care—which in turn are predictors of adult homelessness.

“Homeless people in rural areas have many of the same health issues as urban homeless populations,” asserts Susan Lehmann, MSN, of the University of Iowa College of Nursing in **Iowa City, Iowa.** Obesity,

diabetes, hypertension, malnutrition, acute upper respiratory and intestinal infections, and chronic respiratory infections such as TB are among the conditions most frequently seen among homeless people in both rural and urban Iowa, she says.

Health conditions experienced by homeless people often mirror health problems that are disproportionately represented in particular ethnic groups or among immigrants from countries where the prevalence of infectious disease is high. For example, African American homeless clients served by Family and Children's Services in **Covington, Tennessee**, reflect the disproportionately high prevalence of obesity, hypertension, diabetes, and asthma among African Americans in the general population, notes executive director Minnie Bommer. Edith Iwan, CNP, **Thoreau, New Mexico**, also sees lots of obesity and diabetes among the homeless clients she serves, reflecting the higher prevalence of these conditions among Hispanics and Native Americans.

"Homeless people usually come in with lots of problems that haven't been taken care of for years, if ever, observes Brian Lane, PA, of Beatty Medical Center in **Beatty, Nevada**. Alcoholism and drug abuse, untreated diabetes, and high blood pressure are the biggest problems he sees. "Rural and urban homeless populations don't differ in the kinds of health problems they experience, only in what has been done about them," concludes Jan Wilson, FNP, homeless health care coordinator at Valley Health Systems in **Huntington, West Virginia**. "Our homeless clients from rural areas have had little to no health care in the past. They tend to come in with more chronic health problems that have gone untreated." High blood pressure, diabetes, substance abuse, coronary artery disease, and obesity are all conditions that are common in West Virginia, she says, but they are more advanced in rural homeless clients because they have remained untreated for longer periods of time.

Clinicians at the Greater Lawrence Family Health Center in **Kingston, New Hampshire**, see "some tuberculosis, a fair amount of HIV, and a phenomenal amount of hepatitis C, diabetes and hypertension" among their homeless clients, reports Ed Scully, MD. Located in a city of 70,000 in a relatively rural area 30 miles north of Boston, the clinic draws homeless patients from both rural and more urbanized areas. The homeless population is primarily Anglo with a few clients from the Caribbean, Puerto Rico, the Dominican Republic, Haiti, Vietnam, Cambodia, and Africa.

Few of Dr. Wendy Ring's homeless patients are HIV-positive, although many are IV drug users. "This is a real period of opportunity for **Humboldt County, California**, to prevent the transmission of HIV/AIDS," says Ring. "Many rural areas, particularly in the Southeast, missed that opportunity. They failed to prevent or address the problem early." Four clinics in Humboldt County, including Ring's Mobile Medical Office, currently have a needle-exchange program. Nevertheless, most of her homeless patients who are injection drug users develop hepatitis C within a year of using IV drugs, which indicates that they are still sharing needles. Ring favors a combination of harm reduction, early intervention and prevention strategies to address these and other problems associated with homelessness.

Mental illness is the primary disabling condition Ring sees among her homeless clients, including schizophrenia, personality disorders, and affective disorders such as depression, bipolar disorder, and posttraumatic stress disorder—mostly secondary to childhood abuse or domestic violence. "Some mentally ill patients isolate themselves as an alternative to taking medications," she observes. "They cope with their illness by simplifying their lives and camping out in the woods. Many of these patients should be eligible for disability assistance but are not on SSI." Ring screens her clients routinely for domestic violence, and sees higher rates among homeless clients, "even among high school students." Many domestic violence victims were also abused as children, she notes. According to Ring, Humboldt County has the highest incidence of substance abuse and family violence of all rural counties in California. "There is a multi-generational culture of substance abuse and family dysfunction here that replicates itself exponentially."

## Health Care Access Barriers

Despite the severity and complexity of their health problems, access to health care for homeless people in rural areas is seriously limited by three primary obstacles, according to rural service providers: lack of transportation, lack of health insurance, and unavailable or inaccessible health services—particularly specialty care, mental health services, and substance abuse treatment. These access barriers are not unique to rural homeless people, but they are often more severe.

### Transportation

Limited or no access to public or private transportation makes healthcare access virtually impossible for many homeless rural residents. Severe geographic barriers, such as mountainous terrain or vast distances from available services, exacerbate this problem.

“Many rural areas don’t even have buses,” notes Jan Wilson, FNP, Valley Health Systems, **Huntington, West Virginia**. “Even if you are only ten miles away from a health center and don’t have a car, that’s a serious barrier.” Lack of transportation to distant resources aggravates health problems, warns Sheri Adams, Homeless Healthcare Coordinator for the Metropolitan Development Council, serving **Tacoma-Pierce County, Washington**.

### Health Insurance

Lack of health insurance is a well-documented barrier to health care, and nearly two-thirds of rural homeless people are uninsured (Burt, 1999). “Single homeless adults aged 30–55 fall through the cracks in Wisconsin,” says Mary Clay Santineau, PA, of Starting Point, **Chippewa Falls, Wisconsin**. “Most aren’t eligible for Medicaid, and general medical assistance, in the counties where it exists, isn’t enough to help,” she says. “The only clinic in Chippewa County that sees clients on a sliding scale is so full that it turns away one-third of the people seeking services. Many families need \$70–\$80 medications to treat ADHD [attention deficit hyperactivity disorder], diabetes or mental illness, but can’t afford them; so they get off their medications, crash and burn, and can’t maintain regular housing.”

Only 5–8% of all clients seen at the Redfield Medical Clinic in **Redfield, Iowa**, are on Medicaid, says Ed Friedman, PA. Lots of his clients lost Medicaid following welfare reform. “Welfare reform happened during a time when the economy was expanding, so many people in this area were able to find some kind of work. But jobs held by homeless people typically don’t come with insurance, or premiums are too high for them to afford.” Friedman says he sees more people who used to have health insurance but don’t now, even if they are still employed.

### Managed Care

Most clients served by Children and Family Services in **Covington, Tennessee** are eligible for TennCare, the state’s expanded Medicaid managed care program, says executive director Minnie Bommer, but not all are enrolled. “Homeless clients have greater difficulty obtaining TennCare coverage and gaining access to covered health services than others, in part because they have no stable address,”

#### Access Barriers for Rural Homeless Clients:

- **Lack of transportation**
- **Lack of health insurance** and other entitlements
- **Inaccessible/ inadequate mental health & substance abuse services**, dental care, TB/HCV screening and treatment
- **Limited access to secondary & tertiary care:** few specialists accepting indigent patients, hospital closures, limited access to medications
- **Primary care access barriers:** managed care, co-payments, language and cultural barriers
- **Other barriers impacting health care access:**
  - Lack of temporary shelter beds
  - Lack of respite/recuperative care
  - Lack of childcare
  - Community resistance to homeless service centers
  - Criminalization of homelessness

*(Author’s summary of responses from  
23 homeless service providers in 17 states)*

she says. Her agency tries to make sure that at least the children get enrolled in TennCare, virtually all of whom are eligible. “But even if they get on TennCare, there aren’t enough health care providers to meet their needs,” she says. Many practitioners in this rural area of West Tennessee haven’t contracted with TennCare managed care plans, or have limited the number of TennCare patients in their practice and aren’t accepting any new enrollees, explains Bommer. There is no rural health clinic in the area, and she is not aware of any free care for indigent people.

Managed care is a huge barrier for homeless people, particularly transients, remarks Edith Iwan, CN, of the Western New Mexico Group, which serves the tiny town of **Thoreau, New Mexico**. She recounts the experience of a Native American family that brought a two-month-old baby to the clinic last winter with respiratory syncytial virus, contracted from an older sibling. The baby had stopped eating, started to lose weight, and needed oxygen and medical care. Getting it was a logistical nightmare, even though the child was on Medicaid, because the family had moved around so much and didn’t understand how to access the managed care system. The baby ended up in the only available hospital, 30 miles away, after clinic staff had struggled to locate needed service providers within the appropriate managed care network. Native Americans—but not other homeless people—have since been exempted from Medicaid managed care in New Mexico.

### **Secondary & Tertiary Care**

An insufficient provider network exacerbates these financial and logistical barriers, according to homeless service providers. Even in rural areas with primary health care providers, there is a scarcity of specialists, says Jan Wilson, FNP, **Huntington, West Virginia**. What’s more, many local hospitals have closed or made large cuts in indigent care budgets because of lower Medicare reimbursements. In areas where specialists are available, accessibility is severely limited for homeless clients, even if they qualify for Medicaid; many specialists refuse to contract with Medicaid managed care health plans that reimburse physicians at lower rates than they were paid under fee-for-service arrangements.

In **Pueblo, Colorado**, despite higher payments by community health centers to private physicians, specialists are eliminating services to CHC patients and raising fees, reports Pat Berens, PA, at the Pueblo Community Health Center’s Grand Avenue homeless clinic. Client referrals to orthopaedists, neurosurgeons, rheumatologists and gastroenterologists are either refused or effectively inhibited by physician charges the clinic cannot afford. The CHC is doing everything it can to retain its linkages to specialists, but with little success, says Berens. As a result, the CHC must send patients to Colorado Springs (about 40 miles away) to see specialists, who will accept some patients on Medicaid but none who is indigent. “This is the result of a healthcare management problem nationwide, related to inadequate Medicaid/Medicare funding,” she suggests. “There’s only so much a low-income community can do to solve that problem.”

### **Alcohol & Drug Treatment**

Lack of available and adequate substance abuse treatment is another serious barrier for rural homeless persons, says Jan Wilson, FNP, **Huntington, West Virginia**. Alcoholism is the primary substance abuse problem her clients experience. “There aren’t enough medical detox beds for indigent patients—even for those who want treatment, which often lasts only 24 hours.” The only clients able to get long-term substance abuse treatment are those who are willing to wait as long as a month and who haven’t been in treatment too many times before with unsuccessful results, she says. Wilson doesn’t have much confidence that the long-term substance abuse care that is available is very effective. Less than 10% of clients receiving these services are sober after three months of care—a success rate that is “no better or worse than anywhere else,” she says. Abstinence is not required for initiation of treatment. “Our goal is to keep clients from harming themselves further, and hope that the small amount of sobriety that results

will protect the brain and liver at least temporarily.” Homeless service providers in several other states share Wilson’s concerns.

The effectiveness of publicly funded substance abuse treatment programs in Idaho is hampered by the shortage of medical detoxification services, according to Kevin McTeague, former Homeless Services Director at Terry Reilly Health Services, **Boise, Idaho**. “Some state-funded inpatient and outpatient substance abuse treatment is accessible to homeless people, but quick access is hindered by the state’s managed care gatekeeper system. In addition, there are only a couple of detox beds serving the entire Boise MSA. Treatment on demand is a critical element for homeless persons with substance abuse problems,” says McTeague. The City of Boise has received a grant from the Substance Abuse and Mental Health Services Administration to provide intensive outpatient treatment for methamphetamine addiction, reports Catherine Scott, the HCH project’s current director. However, the program does not include medical detoxification services, which are provided only by a local for-profit facility. “Social detox” alone is available through two faith-based programs. “The lack of medical detoxification services hampers all efforts to provide substance abuse treatment to our homeless clients,” says Scott.

Except for one AA group in town, there is no substance abuse treatment or therapy available for homeless people in **Beatty, Nevada**, says Brian Lane, PA, of Beatty Medical Center, located on the edge of Death Valley. “We deal with addictions through crisis management alone,” he says. Mentally ill clients must be referred to the HCH project in Las Vegas, 120 miles away. Most often, they are referred to the ER at the nearest hospital, also in Las Vegas. “If an emergency occurs, we use a volunteer ambulance service; if it’s a real emergency, we can get a helicopter from Vegas,” says Lane.

### **Mental Health Care**

Mental health care is virtually nonexistent in rural **southwestern Tennessee**, except for that provided by community mental health centers, says Minnie Bommer, Children and Family Services, Covington, Tennessee. “Not many low-income people go to these facilities except those who are mandated to go because of disruptive behavior,” she says. “CMHCs discourage use of their services by poor, uninsured people—not formally, just by being unwelcoming and intimidating.” Psychiatric referrals and psychotropic medications are hard to come by, even for clients who qualify for TennCare, Tennessee’s Medicaid Managed Care program. Psychiatrists are in short supply and few will accept TennCare enrollees. Two mental health practitioners from Memphis come to Bommer’s agency once a week to conduct psychological assessments, group sessions, and individual counseling. They refer clients to other practitioners for psychotropic medications.

There are serious financial barriers to psychotropic medications for uninsured homeless patients in rural **Chippewa Falls, Wisconsin**, according to Mary Clay Santineau, PA. “A bottle of Ritalin costs \$80, antidepressants cost over \$100, and there’s no free clinic in the community.” Homeless people in **Boone, North Carolina**, have to wait 4–6 weeks to get into a community mental health center, and another month to see a psychiatrist, reports Robert Cox, MA, of Hospitality House. There is also a long wait to get psychotropic medications. What’s more, few providers offer appropriate treatment for patients with co-occurring mental illness and substance abuse disorders; they treat one condition or the other, but not both simultaneously.

### **Dental Care**

Access to oral health care is also severely limited in many rural areas, including **Boone, North Carolina**, where there is no Medicaid-covered dental care for adults. Hospitality House, a homeless shelter there with a transitional living program, raised money to help a client get two wisdom teeth extracted that were growing through the side of her gum, reports associate director Robert Cox, MA. They had to pay full price (\$685) for the procedure, while athletes at the local university got discounts from the same

doctors. “Many mainstream health care providers don’t want to deal with patients who have co-occurring emotional and substance abuse problems,” he says. This compounds financial barriers to dental and other health care.

“Oral health care access for indigent people, homeless or not, is extremely limited in **Montana**, even for those on Medicaid,” says Lori Hartford, RN, HCH Program Manager for the Yellowstone City-County Health Department in Billings. The Health Care for the Homeless project and most community health centers have tried to address this barrier with a volunteer model, but they can serve only clients with severe dental emergencies, she says. “Public funding of oral health care for indigent populations has come very slowly to Montana. The other part of the problem is that a large proportion of the state’s dentists are nearing retirement, but not many dentists are moving to Montana to open practices,” she explains. “Lots of counties have no dentists at all, even for private patients. Even people with insurance have to travel 200 miles to see a dentist. Homeless people have virtually no access to oral health care unless they can get to a clinic staffed by volunteer dentists and manage to get through huge waiting lists of 500–1000 people.”

### **Lack of Cultural Competence**

Although the homeless population in **Kingston, New Hampshire**, is predominantly Anglo, clinicians also see a smattering of immigrants with limited English proficiency, reports Ed Scully, MD, of Greater Lawrence Family Health Center. Most of these clients are Latinos from the Caribbean, Puerto Rico, the Dominican Republic, Guatemala, and Colombia. Despite a large proportion of bilingual staff (Spanish and English), communication barriers can be formidable, says Scully. Clinicians often don’t understand what their patients are saying, even if they speak their language. Many of these clients are skeptical of Western medicine, attribute illness to supernatural causes, and use home remedies. Language barriers are even more difficult for clients who are of Vietnamese, Cambodian, or African origins, he says. “We also see a small group of Haitians who say they understand French, but clinicians who speak French sometimes can’t tell if they really do. A few staff members speak Creole, which seems to be more understandable, but they aren’t always there.” The communication challenge is even greater for clinics serving homeless people from different cultures in more rural areas with fewer resources.

Another kind of “cultural insensitivity” that experienced homeless service providers are seeing in rural as well as urban communities is reflected in the attitudes of many mainstream clinicians and faith-based service agencies toward homeless people. “Often there is only one issue that a homeless client is ready to deal with, not the 16 other serious health problems he or she may have. But some clinicians insist on addressing everything at once, and prescribe treatment that is often refused. This is a barrier to engagement with homeless people, particularly those with emotional problems and substance abuse disorders,” says Marie Aylward-Wall, MSN, PHN of the Clinica Sierra Vista Homeless Program in **Bakersfield, California**. A number of faith-based organizations serving rural homeless persons make access to shelter and health services contingent upon abstinence from alcohol or drug use and participation in religious services, she observes. “This is a significant health care access barrier, especially for homeless people with addiction disorders, who end up sleeping by the river where they are beaten up or driven out by police.”

### **Criminalization of Homelessness**

Prisons are located in many American communities in or near rural areas, and their numbers are increasing, report homeless service providers. **Kern County, California**, has six prisons, and two more are anticipated within a year. When people are released from prison, they go directly to the streets, says Marie Aylward-Wall, MSN, PHN, of the Clinica Sierra Vista Homeless Program. Last year, 32% of their homeless clients were young men under age 30, just out of prison, most following a felony drug conviction. “They aren’t eligible for any federal assistance, not even food stamps. They end up on the street, in motels or in shelters, where the average age of residents is 25, mainly because of the prison population.

Without skills, these young men are unable to obtain work.” Police routinely arrest homeless people around shelters for loitering and suspicion of drug use. Prisons are also one of the local industries in **Pueblo, Colorado**, says Pat Berens, PA, of the Grand Avenue homeless clinic, which serves a number of prisoners’ families and former prisoners.

## Rural Service Models

Homeless assistance models in rural communities vary according to their size and distance from urbanized areas. In rural areas large enough to support health and social services, strategies include community partnerships linking formal and informal support systems, multi-service centers, and a hub-and-spoke model of outreach to, and referrals from, outlying rural and urban communities in one or more counties. In remote rural communities with only minimal capacity to provide services, two strategies are most frequently used: mobile outreach units and, as a last resort, “Greyhound referrals”—providing the price of a bus ticket to cities with established homeless services.

### Community Partnerships

The SKYCAP program in **Hazard, Kentucky** provides case management for sheltered and unsheltered homeless people in Perry and Harlan counties, where much of the land is vertical. Three organizations coordinate a voluntary network of more than 80 agencies and service providers through a management information system that tracks social services, housing status, and clinical and environmental factors affecting the health of people who are homeless and at risk of homelessness. The database currently contains information about more than 3,000 clients. These efforts have resulted in a streamlined system of homelessness intervention and prevention, says Gerry Roll, executive director of Hazard-Perry County Community Ministries, Inc., one of the program’s three co-sponsors. “We are learning from the mistakes made in urban areas for the last 20 years about how to prevent increases in homelessness.” There is evidence that their work is paying off. The number of homeless people in Hazard has decreased by 68% since 1993.

### Multi-Service Centers

Access to behavioral health services is fairly good for clients served by the Homeless HealthCare program in **Burlington, Vermont**—the state with the highest percentage of rural residents (67%). One-third of HCH clients are from rural areas throughout the state. All mental health, substance abuse, case management, and primary care services are coordinated at a single point of access. The program has been particularly successful at integrating services for individuals with co-occurring mental health and substance abuse disorders, says director Paul Dragon. A *pro bono* network of private practitioners provides mental health services. To reach more homeless people, the project is expanding its services to smaller clinics and health centers within Burlington, and developing expansion sites around the state.

### Hub & Spoke Model

Montana is an entirely rural state, large parts of which are frontier areas. The Yellowstone City-County Health Department’s HCH project in **Billings, Montana** and its sub-grantees in Helena, Butte, and Missoula exemplify an interesting hub-and-spoke service model. Besides serving homeless people who migrate to these cities from outlying areas, the project uses a mobile van to reach out to unsheltered persons in remote areas without HCH services. All towns with homeless health care projects have specialists within their provider network, says HCH project manager Lori Hartford, RN. “Few specialists refuse referrals, regardless of a client’s ability to pay. There is lots of community support for providing care to homeless people in Montana, where the media play an important part in educating the public about client needs and often participate in solving problems associated with homelessness.” Overlapping respon

sibilities among public health workers at community health centers, health departments and HCH, Indian, and migrant health services foster a high degree of collaboration and service integration not often seen in more urban areas, says Hartford. “Public health workers in Montana are used to networking and collaborating; they have done this for years. Often there is one staff person who wears five different hats, working for multiple programs within the same agency. Public health workers from different agencies get together frequently for meetings, and have a personal relationship with everyone in the network, including mental health centers.”

### Referrals elsewhere

Quite a few homeless people are bused into rural towns from frontier towns in **Montana** because there are no services for homeless people there, says Hartford. They call it “Greyhound therapy.” Frontier towns just don’t have the resources needed to care for homeless people, she says. Much of the state of Montana is considered a frontier area, with fewer than six people per square mile.

Ed Friedman, PA, is the only full-time health care provider in **Redfield, Iowa**. A doctor visits his clinic once a week. Homeless people come there for medical services if they don’t have transportation; if they do, they travel 25 miles to Perry or 35 miles to Des Moines. Friedman faxes EKGs to a consulting cardiologist, but doesn’t use telemedicine because the clinic isn’t big enough to justify the cost. If his clients need a specialist, he says he just tries to help them find transportation to more urban areas.

**Minong, Wisconsin** has a high proportion of poor families, many of whom are transient; 33–50% of the school population changes each year. Nevertheless, with a total population of 521, the number of homeless persons, even including those who are “hidden” from public view, isn’t large enough to warrant targeted homeless services. The same is true in Hayward, where the year-round population of 2,000 swells to 30,000 in summer because of tourism. Susan Shirott, Executive Director of the North Woods Community Health Center that serves both communities, helped to start a Health Care for the Homeless project in the area ten years ago. It lasted only two years. One by one, the homeless services closed down. The Police Department gave homeless people bus tickets to larger towns where services were available. Even the mentally ill were sent out of the county then. Today there is a mental health center that Shirott helped to start, but mental health services are still insufficient. She used to work with police to keep homeless people in Hayward. Since then, she has come to agree that since adequate services are not available there, and since homelessness is considered a “minimal problem” in Hayward, where the majority of residents are more affluent, “shipping them out is probably the most cost-effective alternative.”

### Mobile Outreach

Wendy Ring, MD, is medical director and administrator of a mobile medical unit for the North Coast Clinics Network in **Blue Lake, California**, which serves homeless people all over Humboldt County. The van is 39 feet long, includes two exam rooms, an office lab, a dispensary for medications, and medical records—just like a stationary clinic, but smaller. In addition to providing medical services, they have a needle exchange program. Clients see a doctor every time they come in to exchange needles. Physicians screen them for hepatitis C, tuberculosis, human immunodeficiency virus, other sexually transmitted diseases, and mental illness. Ring maintains good electronic communications with other providers. “You can do a lot to connect people up to services with a laptop computer, a phone and a fax from a mobile unit,” she says. One advantage of mobile units is that they don’t arouse as many NIMBY (“not in my backyard”) sentiments, which often bar establishment of more permanent service facilities for homeless people, remarks Ring. “Because these clinics are on wheels, they don’t seem as threatening to neighborhoods.”

Mobile outreach does not always involve medical care. Some agencies, like the Yellowstone City-County Health Department’s HCH project in **Billings, Montana**, use their mobile unit to engage non-sheltered

homeless people in remote areas, provide food and clothing, and connect them to health and social services in more urbanized areas. The mobile unit in Billings is a converted bread delivery truck that was donated to the project. For many rural service providers, the cost of purchasing a mobile medical unit is prohibitive. The mobile clinic purchased by Clinica Sierra Vista Homeless Clinic cost \$250,000, says executive director Steve Schilling. “We decided to put our resources into expanding outreach to shelters instead,” says Kevin McTeague of Terry Reilly Health Services, **Boise, Idaho**. Many of their rural homeless clients must travel 100 miles to obtain dental and other health care in Boise or Nampa.

“The mobile unit helps, but is not a panacea,” says Marie Aylward-Wall of **Bakersfield, California**. “It’s like a false promise. Although our HCH project is in the vanguard with respect to primary care outreach to rural areas, follow-up care is very limited. Most clients don’t come back after the initial encounter. Mobile outreach will never be enough to meet the health care needs of these rural populations.”

### **Homelessness Prevention**

Dr. Ring and her colleagues in **Humbolt County, California** also deliver comprehensive medical care at school-based clinics. “Adolescence is the age to begin homelessness prevention,” she advises. “You can’t intervene as easily with younger children without parental permission, and parents often resist interventions because they are fearful of losing their child to state custody. Pregnancy prevention and substance abuse prevention are key,” she says. School-based clinics also foster early identification of mental illness, which often emerges in adolescence. “Early intervention can prevent cognitive impairment and encounters with the criminal justice system that can limit employment options and treatment access,” explains Ring.

“Early intervention to support families that are at risk of homelessness, particularly victims of domestic violence, is another important prevention strategy,” adds Martha Craft-Rosenberg, PhD, RN, FAAN, of **Iowa City, Iowa**.

### **Recommendations from Rural Service Providers**

The service providers who were consulted about rural homelessness and health care expressed a number of ideas about how the access barriers they identified can be overcome, and how rural homelessness might be ameliorated or prevented altogether. Here are their recommendations:

- 1. Provide transportation assistance.** Service providers agree that lack of transportation is a primary obstacle to employment and health care access for persons experiencing homelessness in rural areas. Given the scarcity of public transportation in non-metropolitan areas, they are at a loss to imagine how this gap might be filled, and request more information about how other rural areas are coping with this problem. One provider reported a church group in the Northeast that refurbishes used cars and gives them to homeless people as a possible solution that might be replicated.
- 2. Expand health coverage and facilitate access to covered services.** Lack of health insurance is a well-documented financial barrier to health care that is linked to increased morbidity and mortality (Ayanian, et al, 2000). Uninsurance is an even greater problem for rural homeless people than for those residing in more urbanized areas; 63% of the rural homeless are uninsured, and only 25% are on Medicaid (Burt, 1999). Some rural homeless people who are eligible for health coverage may not know it, or know how to obtain covered services. For these reasons, rural service providers strongly recommend the following:
  - Expand eligibility for health care entitlement programs to include all low-income persons who are homeless or at risk of homelessness.

- Restore eligibility for SSI-related Medicaid to persons with disabling substance abuse problems.
  - Allow presumptive Medicaid eligibility for homeless pregnant women and children, to promote early access to prenatal, primary, and preventive care.
  - Provide application and enrollment assistance to all persons likely to be eligible for public health coverage, and educate them about the services to which they are entitled.
  - Exempt homeless people from mandatory managed care.
3. **Stimulate the development of a comprehensive service delivery infrastructure in rural communities that is responsive to the needs of homeless people.** Lack of adequate health and social services that are available to indigent people is a serious barrier for homeless people described by rural service providers. To address this need, they recommend:
- More temporary shelter services that are accessible to homeless people;
  - Basic health and social services including school-based clinics, service centers for women, and services for undocumented immigrants;
  - Integrated mental health and substance abuse services;
  - Specialty care for indigent persons, including hepatitis C treatment and follow-up care;
  - Free or discounted pharmaceuticals that are readily available; and
  - More dental care.
4. **Coordinate rural service delivery systems:** Difficulties encountered by homeless people and by the practitioners who serve this transient population were noted by several providers. Primary challenges involve maintaining continuity of care and assuring appropriate care when clients see many different service providers in different locations. Providers that are meeting this challenge successfully advise practitioners in other rural areas to:
- Promote interagency collaboration and service coordination within and among rural counties.
  - Develop information systems to facilitate case management and continuity of care for persons experiencing residential instability.
  - Develop criteria for the prescription of pain medications to persons at risk of substance abuse, and monitor their use.
5. **Increase outreach to “hidden” homeless people in remote rural areas:** Outreach is an essential component of rural homeless assistance, according to homeless health care providers, who advise the following:
- Use community networks and indigenous workers to facilitate mobile outreach to homeless people in remote areas.
  - Decentralize rural health services by establishing more permanent clinic sites in remote areas.
6. **Promote cultural competence:** Experienced homeless assistance providers recommend the following strategies to address communication barriers with homeless immigrants or individuals long estranged from mainstream services by emotional problems and the stigmatization associated with homelessness:
- Provide an interpreter at every clinic site serving persons with limited English proficiency.
  - Focus on homeless clients’ immediate and perceived needs to facilitate engagement.
  - Educate faith-based agencies and mainstream service providers about the special needs of homeless people.

**7. Focus on homelessness prevention:** Preventing homelessness and arresting its rapid growth in rural areas requires addressing the structural causes of poverty and early intervention for youth and families who are newly homeless or at risk of homelessness. Specific strategies proposed by homeless service providers include the following:

- Advocate for adequate incomes and affordable housing in rural communities.
- Educate adolescents about pregnancy- and substance abuse prevention in school-based clinics.
- Foster early intervention to enable families living temporarily with relatives or friends to become self-sufficient.

## Conclusion

Unlike pioneers of the 19<sup>th</sup> century, most homeless people in rural America today are not seeking new frontiers; residential instability is not a circumstance of their own choosing. Modern rural homelessness, like urban homelessness, is primarily a function of ongoing structural change in the American economy (First, et al., 1994; NCH, 1999). However, as research has demonstrated and as service providers confirm, rural homelessness is not inevitable. Its causes are well understood (NRHA, 1996; Aron and Fitchen, 1996).

Lack of education, adequate incomes, and affordable housing must be addressed to remove the primary causes of rural and urban homelessness. Accessible, comprehensive health and social services are among the resources required to prevent, ameliorate or end homelessness. Vast distances, rugged terrain, lack of transportation, maldistribution of supportive services, and cultural disparities explain why rural homeless persons and homeless assistance providers are mutually hard to reach. Information presented in this report is intended to help homeless service providers and their clients bridge this gap.

This document cites significant differences between rural and urban homeless populations in the United States, traces the negative impact of rural homelessness on individual health, and reports access barriers that prevent rural homeless persons from obtaining the services they need to improve health and maintain residential stability. In addition, it describes strategies used and recommended by homeless assistance providers in rural communities across the United States to overcome these access barriers. The following bibliography provides additional resources for service providers who wish to learn more about the roots and branches of rural homelessness.

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