Distal Stressors and Depression among Homeless Men

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Depression is a common problem among homeless men that may interfere with functional tasks, such as securing stable housing, obtaining employment, and accessing health services. Previous research on depression among homeless men has largely focused on current psychosocial resources, substance abuse, and past victimization. Guided by Ensel and Lin's life course stress process model, the authors examined whether distal stressors, including victimization and exposure to parent problems in childhood, contributed to men's depression above and beyond current (or proximal) stressors, such as substance abuse and health problems, and social resources. The sample consisted of 309 homeless men who had entered a federally funded emergency shelter. Using the Burns Depression Checklist, the authors found that one out of three men met the threshold for moderate to severe depression during the past week. The logistic regression showed that past exposure to parent problems was related to depression after accounting for current stressors and social resources (number of close adult relationships and whether their emotional support needs were met). Past victimization was not related to depression. To address men's depression, workers should concurrently provide services that meet men's basic needs (for example, housing) and address their relationship needs, including their need for emotional support.

KEY WORDS: *adverse childhood experiences; depression; homelessness; men; social support*

Each year an estimated 1.5 million people enter homeless shelter services, although many more people experience homelessness (U.S. Department of Housing and Urban Development [HUD], 2012). Men comprise the largest proportion of the adult, sheltered homeless population: approximately two-thirds of all sheltered adults (National Coalition for the Homeless, 2009; HUD, 2012). Depression appears to affect a large number of homeless men. Using standardized measures, researchers consistently find that between 40 percent and 47 percent of homeless men meet criteria for mild to severe depression (Nyamathi et al., 2011; Rhoades et al., 2014; Weiser et al., 2006).

Previous research on depression among homeless men has largely focused on current psychosocial resources, substance abuse, and past victimization. In this study, we adopted a longer view and argued that it is important to take a life course perspective to understand depression among homeless men. Specifically, we relied on Ensel and Lin's (1996) life stress process model, which conceptualizes events or experiences that occurred in the distant past as distal stressors. Their research suggests that distal stressors can

make an independent contribution to our understanding of depressive symptomatology during adulthood above and beyond more recent or proximal stressors, and social resources.

We hypothesized that distal stressors, including past victimization and exposure to parent problems during childhood (compare adverse childhood experiences [ACEs]), would increase the variance explained in homeless men's depressive symptoms above and beyond the variance explained by more recent stressors—such as substance abuse, physical health, and length of homelessness—and by fewer social resources. We conceptualized substance abuse, physical health problems, and greater duration of homelessness as proximal stressors because they are current conditions, generally viewed as undesirable, and are likely to create a sense of being out of control with a high potential to contribute to stress. After testing the direct effect of distal stressors, proximal stressors, and social resources, controlling for several demographic factors, on depressive symptoms, we determined whether social resources have a buffering or moderating effect on the relation between distal stressors and depression.

LITERATURE REVIEW

Stressors

Substance abuse problems are prevalent among homeless adults. In Dietz's (2010) national sample of homeless adults, 44 percent of adults reported an alcohol problem and 41 percent reported a drug problem in the past year. Researchers have investigated the relationship between substance abuse and mental health among homeless men and found a bivariate relationship between hard drug use, severity of alcohol use, and severity of drug use and homeless men's mental health problems (Rhoades et al., 2014; Stein & Gelberg, 1995; Weiser et al., 2006). Among homeless adults with a substance abuse problem, the severity of the substance use problem was related to poorer mental health in Kertesz et al.'s (2005) and Nyamathi et al.'s (2011) studies. Although it seems likely that having a substance abuse problem is related to depression among homeless men, this relationship, to our knowledge, has not been examined in the context of other potentially important factors.

Physical health problems are also common among homeless adults; 49 percent report a chronic illness (Dietz, 2010). Having a physical health problem may be more salient for homeless adults than for non-homeless adults, because, in addition to the stress that poor health places on their bodies, homeless adults may have less access to quality, affordable health care (Baggett, O'Connell, Singer, & Rigotti, 2010). Worrying about their health and whether they will receive care is likely to increase homeless adults' level of stress. Two research teams tested whether homeless adults' perception of poorer health was related to depression. LaGory, Ritchey, and Mullis (1990) did not find a relationship between these two conditions, but Nyamathi et al. (2012) did. Because of these mixed findings, and because exposure to parent problems during childhood (Nyamathi et al., 2011; Nyamathi et al., 2012) and being victimized (Kim, Ford, Howard, & Bradford, 2010) are related to poorer physical health, it is important to account for physical health when predicting men's depression.

Homelessness is not a uniform experience. Men who are homeless, for example, differ in terms of the length of time they have been homeless. Men who are homeless for longer periods of time are likely to experience a constellation of stressors related to their survival—including an ongoing need to find food, shelter, and medical care—and stressors related to living on the streets or in a shelter, including exposure to inclement weather and harassment. It

seems reasonable, then, that men who are homeless for a longer period of time may experience a greater demand on their coping resources and be more likely to report depression than men who are homeless for less time. We are unaware of any studies on the relationship between length of homelessness and depression among men; however, a few studies have found a relationship between length of homelessness and greater emotional distress among adults who have experienced homelessness (Kertesz et al., 2005; Stein, Dixon, & Nyamathi, 2008; Stein, Leslie, & Nyamathi, 2002); LaGory et al. (1990) did not find such a relationship in their research.

Being a victim can be a very difficult and stressful experience that may have lasting negative consequences for men's mental health. Among men in the general population, victimization is related to depression (Arnold, Blasey, Hunkeler, Lee, & Hayward, 2011). Researchers have also found a relationship between victimization and mental health among homeless men, but the results are not entirely consistent. Controlling for demographic variables only, Kim et al. (2010) found that sexual abuse during childhood, sexual abuse during adulthood, and physical abuse during adulthood were related to mental health impairment among men in a shelter. Childhood physical abuse was not related to mental health impairment. Nyamathi et al. (2011) found the opposite result: Childhood physical abuse was related to depression among homeless men in substance abuse treatment; however, childhood sexual abuse was not. North and Smith (1993) studied a broader range of traumas among men in shelters. A history of trauma—including combat, rape, assault, sudden injury/accident, or other traumatic event—was related to major depression among homeless men in North and Smith's bivariate analysis.

A growing body of research suggests that exposure to ACEs—which include childhood exposure to a household member with a substance abuse problem, with mental illness, or involved in the criminal justice system; and childhood victimization—is related to adult mental health (Lowell, Renk, & Adgate, 2014; Mallers, Charles, Neupert, & Almeida, 2010). Despite research suggesting the importance of childhood experiences in understanding adults' psychological distress, we were unable to identify any studies that tested the direct relationship between homeless men's exposure to parent problems during childhood and their mental health during adulthood. Nevertheless, it seems likely that exposure to a parent or parents

who had a significant issue with a substance, mental health, or criminal behavior could trigger a cascade of stressors and stress responses that over time adversely affect a man's mental health.

Social Resources

Social resources are an important component in life stress process models. [Ensel and Lin \(1996\)](#) presented several models describing how social resources may be related to depression. We test two models: the independent model and the buffering model. The independent model states that social resources will have a beneficial effect (for example, less psychological distress) irrespective of a person's exposure to stressors. The buffering or moderating model states that stressors will be related to depression, but only under the condition of low social resources.

Evidence from the literature on adults experiencing homelessness suggests that the quantity and quality of adult relationships are directly related to psychological distress. Four studies found that homeless adults who had more relationships or who received more support were less likely to report symptoms of depression ([Kertesz et al., 2005](#); [LaGory et al., 1990](#); [Stein et al., 2008](#); [Wong & Piliavin, 2001](#)). However, [Nyamathi et al.'s \(2011\)](#) study—which appears to be the only study on relationships during adulthood and depression among homeless men—did not find a relationship between the quality and supportiveness of men's relationship with their parents, family, and friends and depression.

Very little is known about the potential moderating effect of social resources on depression among homeless adults. In [Schutt, Meschede, and Rierdan's \(1994\)](#) study on homeless adults, social support did not moderate the relation between stressful events and psychological distress. We think there could be a moderating relationship, however, for homeless men exposed to parent problems during childhood: They may not be as close to their parents and to other adults during adulthood. According to [Bowlby \(1988\)](#), experiences with attachment figures in childhood predict internal working models, models that adults rely on to maintain close relationships and receive adequate emotional support. Therefore, we hypothesize that depression will be more likely to occur among men who were exposed to more parent problems and who have fewer close relationships or who have a greater unmet need for emotional support than among men who have more social resources.

METHOD

Participants

We conducted a secondary analysis using a sample of homeless men who entered a federally funded emergency shelter and who were interviewed at intake between January 2009 and December 2010. The shelter was centrally located in a metropolitan area in the Midwest with a population of about 380,000 residents. If a man entered the shelter more than once during this time period and had completed the intake interview, including measures used in this study, then we selected one of his intake interviews randomly. After excluding 32 duplicate cases, the sample consisted of 309 men.

The [Centers for Disease Control and Prevention \(2010\)](#) reported that middle age, less than a high school education, a previous marriage, unemployment, and race or ethnicity are related to major depression. The average age of the participants was 41.5 years old ($SD = 11.7$); 77 percent of the men were 50 years old or younger. Over 70 percent of the participants had obtained at least a high school diploma or GED. Most of the men were divorced, separated, or never married (88.6 percent); 62 percent were fathers. The majority of the men had been employed during the past three years; however, most of them reported a pattern of part-time employment (59.2 percent). We created a dichotomous variable for race or ethnicity: white and nonwhite. Nonwhite included men who self-identified as African American, Hispanic/Latino, other nonwhite racial or ethnic group, or more than one racial or ethnic group (0 = nonwhite, 45.1 percent; 1 = white, 54.9 percent). Chi-square analyses were used to test whether the demographic variables were related to depression. Being white was the only variable related to depression.

Measures

An experienced mental health counselor interviewed the men during the intake process at the shelter. The counselor had a master's degree and was licensed by the state to diagnose and treat mental health and substance abuse disorders. The intake included the administration of the Burns Depression Checklist (BDC) ([Burns, 2006](#)) and the Addiction Severity Index (ASI) ([McLellan, Luborsky, O'Brien, & Woody, 1980](#)). The ASI is a structured clinical interview that has been used extensively for treatment planning and in a wide variety of clinical trials. The psychometric properties of the ASI have been thoroughly tested in several reliability and validity studies (see [Allen & Wilson, 2003](#),

for review). The interview lasted about 120 minutes. The authors' institutional review boards approved this study.

Depression. Symptoms of self-reported depression were assessed using the 25-item BDC, which asks participants to rate the intensity of symptoms of depression in four areas—thoughts and feelings, activities and personal relationships, physical symptoms, and suicidal urges. The men were asked how much they experienced each symptom within the past week, with 0 = not at all, 1 = somewhat, 2 = moderately, 3 = a lot, and 4 = extremely as possible answers (theoretical range = 0–100). Scores higher than 25 indicated moderate or severe depression (25 or less = minor or no depression). About one-third of the men (32.4 percent) met the threshold for moderate or severe depression and were classified as depressed (met the threshold = 1; did not meet threshold = 0). The BDC had good internal consistency, strong content validity, well-established discriminant validity, and excellent concurrent validity with the Beck Depression Inventory and other standardized measures of depression (Hargrave & Sells, 1997).

Substance Abuse Problem. The ASI included several questions related to drug and alcohol use, including type of substances used, frequency of use, and the consequences of using. Based on responses to these questions, the counselor rated the severity of the man's current drug problem and the severity of his current alcohol problem. If the man did not have a problem, he received a score of 0. If he did have a problem, the counselor rated the severity of the problem on a scale ranging from 1 to 9. Because there was no established cut point for these scales, and because the distribution of values was skewed, we coded the man as having a substance abuse problem (1) if he received a score greater than 1 on either the alcohol or the drug scale.

To evaluate health problems, each man was asked, "Do you have any chronic medical problems which continue to interfere with your life?" Response options were yes = 1 or no = 0. The majority of the men (57 percent) reported a health problem that interfered with their life.

We based our measure of length of homelessness on HUD's definition: first-time homeless, chronically homeless (continuously homeless for over one year or had four or more episodes of homelessness in the last three years), and episodically homeless (neither first-time nor chronically homeless).

Past Victimization and Multiple Victimization.

Each man was asked the following questions: "In your life, were you physically abused?" and "In your life, were you sexually abused?" *Physical abuse* was operationalized in the ASI as "caused you physical harm" and *sexual abuse* was operationalized as "forced sexual advances, non-consensual sexual acts, or rape." We created one dichotomous variable to measure victimization (was either physically *or* sexually abused) and one dichotomous variable to measure multiple victimization (was physically *and* sexually abused). Because almost all of the men who had been sexually abused (16.6 percent) also reported physical abuse, we were unable to test the relation between type of abuse and depression.

Past Exposure to Parent Problems during Childhood. Eight dichotomous items on the ASI were used to evaluate whether the men were exposed to parental addiction, psychiatric problems, and criminality in childhood. Respondents were asked whether their mother and their father had a significant problem with alcohol, a significant problem with drugs, a significant psychiatric problem, and a significant criminal problem. Table 1 lists the types of problems by mother and by father. The number of parent problems were added together to create an index (theoretical range: 0–8).

Social Resources. We included two measures for social resources from the ASI: (1) the number of close adult relationships and (2) the need for more emotional support. For number of close adult relationships, the men were asked to evaluate whether they have "a close, long-lasting, personal relationship with five different types of people": "mother," "father," a "sibling," an intimate "partner/spouse," and a "friend." Response options were yes = 1 or no = 0. We added these five types of relationships together to create an index for number of types of close adult relationships (theoretical range: 0–5 close adult relationships). "Need for emotional support was unmet" was measured with one question from the ASI: "To what degree do you feel you need more emotional support?" using a four-point scale, with 1 = not at all, 2 = a little, 3 = somewhat, and 4 = a lot. Higher scores indicated the man's need for emotional support was unmet (theoretical range: 1–4).

Data Analysis

Our analysis proceeded in three steps. First, we tested the bivariate relationship between the potential predictors and depression (see Table 1). Second, to test whether the distal stressors, victimization, and exposure

Table 1: Bivariate Relationship between Potential Predictors and Depression						
Variable	Depressed				Total	
	No		Yes		%	M
	%	M	%	M		
Stressors						
Alcohol or drug problem**	52.5		69.1		57.8	
Health problem*	53.6		65.0		57.0	
Length of homelessness						
First time	45.9		43.3		45.1	
Episodic	28.7		29.9		29.1	
Chronic	25.4		26.8		25.8	
Physically or sexually abused***	38.3		57.6		44.5	
Multiply victimized: Physically and sexually abused**	10.5		20.4		13.7	
Exposure to past parent problem during childhood						
Mother had a significant problem with						
Alcohol**	13.9		25.0		17.5	
Drugs*	5.3		11.0		7.1	
Mental health†	8.1		14.0		10.0	
Criminal activity	1.9		3.0		2.3	
Father had a significant problem with						
Alcohol*	23.4		36.0		27.5	
Drugs	5.7		10.0		7.1	
Mental health†	4.3		9.0		5.8	
Criminal activity	6.7		9.0		7.4	
Number of parent problems exposed to***		0.69		1.17		0.85
Social resources						
Have a close adult relationship with						
Mother**	74.6		59.2		69.7	
Father**	53.4		37.9		48.2	
A partner	71.5		63.3		68.9	
A sibling†	64.3		58.2		62.3	
A friend*	53.1		42.0		49.5	
Number of close adult relationships***		3.15		2.56		2.96
Need for emotional support unmet*		1.10		1.41		1.20

† $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

to parent problems during childhood increased the variance explained in men's depression above and beyond the variance explained by proximal stressors and by fewer social resources, we used hierarchical logistic regression (see Table 2). Because race/ethnicity was related to depression in the bivariate analysis, we entered this variable into the first block of variables along with proximal stressors and social resources. Because length of homelessness was not related to depression in the bivariate analysis, we excluded it from the multivariate analysis. We reverse coded number of close relationships, so that all of the odd ratios were positive and, therefore, more comparable. In the second block, we added the distal stressors: past victimization and exposure to parent problems. We were interested in whether being victimized or being multiply victimized was related to

depression in the multivariate analysis; however, neither variable was significantly related to depression. Moreover, regardless of which victimization variable was entered into the model, the significance level for each potential predictor was the same or almost identical (the p value did not change more than one-hundredth of a percent). Therefore, we included the dichotomous variable for multiple victimization in the final model. Third, to test whether social resources buffered the relationship between distal stressors and depression, we entered each interaction term into the final model separately. For example, we tested whether men who were exposed to more parent problems and had a greater number of close adult relationships were less likely to be depressed than men who were exposed to more parent problems but had fewer close relationships.

Table 2: Predictors of Depression (Hierarchical Logistic Regression)

Variable	Model 1					Model 2				
	B	SE	Wald	p	OR	B	SE	Wald	p	OR
Race/ethnicity										
White	.72	.29	6.25	.01	2.01	.63	.29	4.60	.03	1.88
Proximal stressors										
Alcohol or drug problem	.74	.29	6.40	.01	2.10	.66	.45	4.93	.03	1.94
Health problem	.49	.29	2.88	.09	1.63	.52	.30	3.12	.08	1.68
Social resources										
Number of close adult close relationships ^a	.23	.10	6.32	.02	1.26	.22	.10	4.55	.03	1.24
Need for emotional support unmet	.29	.14	4.45	.04	1.33	.27	.14	4.01	.04	1.32
Distal stressors										
Physically and sexually abused						.47	.39	1.46	.23	1.59
Number of parent problems exposed to						.25	.12	4.13	.04	1.28
Chi-square test			31.98*					38.29*		
−2 log likelihood			306.64					300.33		
R ²			.11–.15					.13–.18		

^aReverse coded so all odds ratios are positive.

* $p < .0001$.

RESULTS

Men who were depressed were more likely to have a substance abuse problem and were more likely to report a health problem than men who were not depressed (see Table 1). Both measures of prior victimization were related to depression. Men who were depressed were more likely to report that they had been physically or sexually abused than men who were not depressed. Depressed men were also more likely to report that they had been multiply victimized. The bivariate results indicated that the number of parent problems that the man was exposed to during childhood was related to depression. Of the men who were depressed and not depressed, 61 percent and 39.4 percent, respectively, reported at least one significant parent problem. Men who were depressed had fewer close adult relationships and a greater unmet need for emotional support than men who were not depressed.

Table 2 shows that race or ethnicity was related to depression in model 2. Compared with nonwhite men, white men were 88 percent more likely to report moderate to severe depression. Having an alcohol or drug problem was related to depression. Men who reported having an alcohol or drug problem were nearly twice as likely to be depressed. Having a health problems also appeared to be related to depression. Men with health problems were 68 percent more likely to be depressed than men with no health problems; however, this relationship was not significant at the .05 level ($p = .08$). Having fewer close adult relationships (odds ratio [OR] = 1.24) and

needing more emotional support (OR = 1.32) both increased the likelihood that men were depressed.

Proximal stressors and social resources explained between 11 percent and 15 percent of the variance in depression, depending on the statistic used, in model 1. To determine whether distal stressors, past victimization, and past exposure to parent problems added to the variance above and beyond proximal stressors and social resources, we entered these variables into model 2 and calculated the change in R^2 . Past victimization was not related to depression; however, the number of parent problems was. For each additional parent problem reported, men were 28 percent more likely to be depressed. The change in the variance, 2 percent to 3 percent, from model 1 to model 2 was statistically significant [$\chi^2(2) = 6.31$, $p = .04$].

Finally, we tested whether the number of close adult relationships would moderate the relationship between being exposure to parent problems during childhood and depression and between multiple victimization and depression, and whether having a greater unmet need for emotional support would moderate the relationship between being exposed to more parent problems during childhood and depression and between victimization and depression. These four interactions were not significant in model 2.

DISCUSSION

The purpose of this study was to determine whether distal stressors could make an independent contribution to our understanding of depressive symptomology

during adulthood after accounting for recent stressors and social resources. Despite the large proportion of men (44.3 percent) who reported a history of physical or sexual abuse, our results showed victimization was not related to depression. This finding is inconsistent with two studies on victimization and mental health among homeless men. It is possible that in the context of a broader range or a different set of variables, victimization may be less important than other factors in predicting depression. In the stress process model, the impact of some factors may “disintegrate” over time, reducing their impact on current levels of depressive symptomology (Ensel & Lin, 1996). Alternatively, the type and timing of the victimization (during childhood, adulthood, or both) may be important, as suggested by Kim et al.’s (2010) and Nyamathi et al.’s (2011) research. To clarify the relation between victimization and depression, future studies should use a more nuanced approach to measuring not only the type and timing of the victimization, but also the man’s perception of its influence on his life.

Exposure to parent problems during childhood was related to an increased risk of depression. Research on nonhomeless adults has shown a relationship between parental factors during childhood and psychological distress later in adulthood (Lowell et al., 2014; Mallers et al., 2010). Our study extends this line of research to homeless men, demonstrating the potentially long-lasting effects of exposure to parental problems on homeless men’s mental health. Although more research is needed to replicate this finding, it appears that exposure to parental problems may be important to our understanding of homeless men’s depression.

Consistent with the literature on homeless men (Rhoades et al., 2014; Stein & Gelberg, 1995; Weiser et al., 2006), we found that having an alcohol or drug problem increased the odds of being depressed. Homeless men who have a substance problem may experience depression due to physiological issues related to the substance abuse itself (for example, withdrawal). Alternatively, their substance abuse may interfere with their attempts to realize their goals (for example, secure employment), leading to stress, disappointments or setbacks, and depression.

We also found a relationship between men’s report of having a health problem that interfered with their lives and depression in our bivariate analysis; however, it was not related to depression in our multivariate analysis at the .05 level. This finding may be related to how we measured men’s health

problems and, clearly, given the high percentage of men who reported a health problem (60 percent), requires additional investigation.

Fewer close adult relationships and an unmet need for emotional support were also related to men’s depression. Social resources had a main effect on men’s depression regardless of their exposure to stressors, providing evidence for the independent, not the buffering, model. This finding adds to the existing literature on the importance of relationships in understanding homeless adults’ mental health (Kertesz et al., 2005; LaGory et al., 1990; Stein et al., 2008; Wong & Piliavin, 2001). Whereas the number of close relationships is an indicator of the structure of one’s social network, the need for more support assesses what the man received or his perception of its adequacy. Both the number of close relationships and whether their need for emotional support was met appear to be important predictors of men’s depression. It is possible that many homeless men who are depressed suffer from unmet socioemotional needs and are lonely. Although we did not find support for the buffering model, social resources may, as described in Ensels and Lin (1996), mediate the relationship between stressors and depression. Stressors and social resources are likely to be related to depression in complex ways that we were unable to test with these cross-sectional data.

Our study had both strengths and limitations. For example, we used standardized measures with a relatively large sample of homeless men in a shelter and controlled for variables that have not been controlled in previous studies. However, our results must be viewed within the context of some limitations related to our design, the variables we had access to, and the characteristics of our sample. First, because our design was cross-sectional, we cannot conclude that our predictors caused depression, and we were unable to test the mechanisms or pathways underlying, for example, the relationship between exposure to parent problems in childhood and depression. Second, although we tried to include a broader range of factors that might explain depression, we undoubtedly excluded important internal resources (for example, coping, attributional and attachment styles) and external resources (for example, accessibility to health care and employment). Finally, although our sample of homeless men was not limited to men in treatment and was, therefore, more heterogeneous, we cannot generalize our results to homeless men living on

the streets or to other geographic regions of the United States.

Despite these limitations, the results suggest some implications for practice. First, we were struck by the high percentage of men who met the threshold for moderate to severe depression. Depression is likely to interfere with many aspects of homeless men's daily lives, such as securing and maintaining employment, housing, and relationships. We urge community leaders to develop an integrated approach to homeless services that will meet men's mental health, socioemotional, and survival needs concurrently. Whereas offering safe, affordable, and permanent housing, for example, provides foundational support for men, inattention to their depression, substance use, and need for greater emotional support may chip away at that foundation and undermine men's efforts to meet their goals.

Second, given the high percentage of men who report depression, and the relation between depression and suicide among homeless men, shelters should screen for depression. The assessment can be very brief, such as [Rost, Burnam, and Smith's \(1993\)](#) three-item suicide screener. For men who score positive on a brief screen, shelter workers can administer a more in-depth assessment for depression and suicidal thoughts and refer men for further assessment and treatment, if it is not provided on-site.

Third, because men present with many urgent problems, childhood issues may be relegated as secondary issues or "nice to know but not needed." Our results suggest distal factors, or ACEs, may be relevant to service providers who are working with men to address their depression. Accordingly, workers should consider collecting information on men's exposure to parental problems during childhood and men's perception of whether those problems are related to their depression.

Finally, it is easy to recommend that shelter workers refer men to services if services exist and if men are willing and able to use them. [Stergiopoulos, Dewa, Durbin, Chau, and Svoboda \(2010\)](#) found that half of the homeless adults in their study did not have their mental health needs met despite on-site health services. The factors associated with mental health services utilization are poorly understood, especially among homeless men. To effectively serve this population, more research is needed to understand the circumstances under which men experiencing homelessness will use services. **HSW**

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