A descriptive study of formerly homeless mentally ill adults knowledge of AIDS

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The overall purpose of this study was to determine the level of knowledge of AIDS among formerly homeless mentally ill adults. Two constructs were addressed: (1) level of knowledge of AIDS by age, and (2) level of knowledge by race. A descriptive correlational study was conducted in this research. A questionnaire was administered to 30 individuals who are formerly homeless mentally ill adults living in a residential community. The findings of this research indicate that adults between the ages of 46 and over were more knowledgeable than other age groups; and white participants were more knowledgeable than other ethnic groups.
A DESCRIPTIVE STUDY OF FORMERLY HOMELESS MENTALLY ILL ADULTS KNOWLEDGE OF AIDS

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
CYNTHIA A. TRAYLOR

SCHOOL OF SOCIAL WORK

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CHAPTER ONE
INTRODUCTION

The concerns that determine the knowledge of the homeless mentally ill population, and the knowledge about Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have grown. The first discovery of AIDS came about in 1981. The Centers for Disease Control in 1987 determined that a revised definition for AIDS was needed. The new term is known as HIV. There could be at least 250,000-300,000 cases of HIV/AIDS diagnosed in the United States. This has put an extreme burden on the Health Care System. Education of HIV/AIDS and the ability to distinguish between the two will solve some of the uncertainties concerning HIV/AIDS for the general public. However, educational interventions and preventive methods must be geared to the specific needs of the homeless mentally ill population.

Background

Homelessness among the mentally ill is a major national problem; the homeless includes a variety of people such as street people, shelter users, and people applying for assistance, or those using services. Due to the limited
amount of low-income housing and the inadequacy of income, support for the poor has caused an increase of homelessness.

In a recent pamphlet prepared by the Mercy Mobile Health Program (MMHP), the homeless mentally ill are described as a heterogeneous, multi-cultural community, whose members engage in a wide variety of behaviors that place them at risk for HIV. The category "homeless in high risk situations" encompasses men who engage in sex with men; injecting drug users, who borrow or share their "works"; sex trade workers; individuals infected with STDs; individuals who are sex or needle sharing partners of the preceding groups; women in high risk situations (using sex as "Survival Tool"); runaway adolescents; and persons in the criminal justice system who are at risk for homelessness.¹

MMHP also reported that the epidemic of crack use in Atlanta is contributing to a rate of syphilis infection which is the second highest in the country which heightens the risk for HIV/AIDS, particularly among women who may engage in large numbers of casual, high-risk sexual encounters in exchange for the drug. A CDC-sponsored seroprevalence study, conducted in 1990, confirmed that the homeless population in Atlanta was disproportionately affected by the AIDS epidemic. Over a six month period, 678 homeless men and women were tested in a double blind study

¹Mercy Mobile Health Program, Atlanta Community Health Program for the Homeless, 1990.
of HIV infection. A total of 59 individuals (54/522 men and 5/156 women) showed positive antibody tests. Among men, this represents an alarming 10.34% with HIV infection, a level double the expected rate. Among African Americans and Hispanics the rates were even higher (11.11% and 14.7%).

In December 1990 it was reported by Centers for Disease Control in the "CDC HIV/AIDS Prevention Newsletter," by Dr. Gary R. Noble, (Assistant Surgeon General, Deputy Director (HIV)), that it is important for people to understand or be able to distinguish between AIDS and HIV. He also stated that "everyone needs to understand that HIV infection typically lasts for years before AIDS appears. . . . Personal knowledge of HIV infection can lead to individual changes in behavior that will prevent subsequent transmission to others through sex, shared drug needles, or pregnancy and will allow notification of previous sex or needle-sharing partners. If people don’t understand these concepts, how can they be expected to act on them? . . ."

"'AIDS' is obsolete -- The Presidential Commission of the HIV Epidemic stated "The term 'AIDS' is obsolete. 'HIV Infection' more correctly states the problem."

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Ibid.

American Red Cross, HIV/AIDS Instructor Update (Atlanta, GA: Metropolitan Atlanta Chapter, Health Services, American Red Cross, March 1991), 2.
Statement of the Problem

What is the level of knowledge of AIDS among a residential community of formerly homeless mentally ill adults, and does the level of knowledge vary with selected demographic and behavioral characteristics of a residential community of formerly homeless mentally ill adults?

In this current review of the literature about AIDS there are no descriptive studies of HIV/AIDS knowledge and beliefs among the formerly homeless mentally ill adults in a residential setting. This population may be excluded from general information surveys due to their lack of permanent address or telephone number. The characteristics of this population include an increased rate of chronic physical illness, mental illness, alcohol abuse and drug abuse. These characteristics may place them at risk for AIDS as well.

It is difficult to document a true proportion of formerly homeless mentally ill adults. It is felt that the proportion varies from city to city because the spread of AIDS among the homeless has grown beyond street people. Many homeless eventually get off the streets to join the ranks of the employed, and general population, where they are at risk for becoming infected.

The chronically mentally ill may be at high risk of contracting HIV/AIDS, because of their cognitive impairments. They have poor judgement and may be
emotionally unstable which is likely to result in behaviors that often involve unsafe sexual practices. They are certainly a target population in need of becoming more knowledgeable of AIDS.4

Education is the primary key to prevention of AIDS. Before an effective educational program can be developed to decrease the risk of AIDS infection and spread, data is needed on the pre-existing level of knowledge and beliefs about AIDS.5 Educational programs must be designed to meet specific needs of individual target populations.

The overall purpose of this study is to determine the level of knowledge about AIDS in a residential community of homeless mentally ill persons living in long-term, supportive housing.

"Stephen M. Brady and Elaine (H.) Carmen, "AIDS Risk and Prevention for the Chronic Mentally Ill," Hospital and Community Psychiatry 41, no. 6 (June 1990): 652-657.

CHAPTER TWO

REVIEW OF THE LITERATURE

AIDS has claimed the lives of thousands and has caused significant emotional stress for millions. Community Mental Health Centers (CMHC) are beginning to realize the enormity of this situation and the treatment response required. AIDS is likely to become the major mental health problem of the 1990s. Therefore, the potential roles for CMHCs will eventually be identified.¹

The incidence of the AIDS virus has increased to 20% among the homeless people in New York. The AIDS virus has infected the nation's homeless at rates that are two to 40 times as high as those of the national population, according to a new study by the Centers for Disease Control.²

CDC reported that the highest rates of HIV infection have been found in New York, Atlanta, Miami, and Washington. Denver, Houston and Memphis had the lowest rates of HIV infection. These high rates to some extent reflect use of intravenous drugs and risky sex practices of many homeless


people. In addition, as people infected with the virus exhaust their financial resources paying for treatment, an increasing number fall into the ranks of homelessness.

Little is being done to stop the spread of AIDS among the homeless. The homeless have little access to education on AIDS or condoms. They also rarely receive treatment for HIV infection, since medications for such treatment are costly and limited; however, this problem is not just a homeless problem.¹

There are programs established to reach the homeless. This population traditionally waits until they are extremely sick/ill before seeking care or treatment. In some areas programs have been set-up to help this population to make some changes in their lives and access medical care at an earlier stage. The clinics were introduced to reach people who might be infected with the AIDS virus but who have been alienated from the community services. A support system is essential in assisting the homeless mentally ill.

It is understood that behavioral change to reduce risk of AIDS is a slow and complex process even within a healthy population. For mentally ill patients, impulsivity

¹Ibid.
²Ibid.
and severe disturbances of self are prominent co-factors in noncompliance with recommendations for risk reduction.\textsuperscript{5}

One should not underestimate the difficulty of changing long-standing sexual or drug-use behaviors that place mentally ill patients at risk. It has been proven in group and individual treatment settings that patients can make changes in HIV risk behaviors.\textsuperscript{6}

Through efforts to assess and reduce patients' risk for AIDS, it has been learned that many mentally ill patients are inadequately prepared to manage the wide range of health and life-style issues that confront them. Clinicians in many mental health settings have not educated these vulnerable individuals about sexuality, contraception, child care, health maintenance, drug abuse, and AIDS.\textsuperscript{7} In some cases, clinicians have actively opposed such education.\textsuperscript{8} Institutional barriers to health education and AIDS prevention for mentally ill patients can be formidable. These barriers include lack of administrative support and staff resistance and denial. Among the obstacles that

\textsuperscript{5}Stephen Brady and Elaine (H.) Carmen, "AIDS Risk and Prevention for the Chronic Mentally Ill," Hospital and Community Psychiatry, 4 (June 1990): 656.

\textsuperscript{6}Ibid.

\textsuperscript{7}Ibid.

contribute to a milieu in which patients who are at risk for HIV infection may not receive necessary services are repeated requests by administrators for recommendations regarding AIDS prevention without their implementation, staff attitudes of blaming patients for "bad" or "immoral" behaviors, and clinicians' preoccupation with the issue of confidentiality rather than treatment.' Despite such barriers, prevention efforts can be effective if they are directed to patients themselves either through individual outreach or through patients' self-referral to a drop-in group.

At present the only way to prevent the spread of AIDS is through health promotion directed at preventing high-risk behaviors. Although specific high-risk groups (homosexual and bisexual men, intravenous [IV] drug users, women with infected partners, and infected pregnant women) were earlier identified and targeted for education, it has been suggested that chronic psychiatric patients living in urban centers may constitute another high-risk group.10

"Brady and Carmen, "AIDS Risk and Prevention for the Chronic Mentally Ill," 656.

Chronic homeless mentally ill persons are a potential risk for the spread of AIDS for several reasons. They do not maintain stable relationships but instead participate in a series of brief sexual encounters. They are vulnerable to sexual encounters. They are vulnerable to sexual abuse because of poverty and passivity. As a group, they engage in excessive use of substances, including IV drugs. They interact with other high-risk populations in community psychiatric facilities, prisons, and forensic units. And finally, due to social isolation, they may possess a limited understanding of AIDS risk behaviors. For these reasons, it is important to assess the level of AIDS awareness in the chronic homeless schizophrenic population.\textsuperscript{11}

In a recent study, Aruffo and Associates examined the extent of knowledge about AIDS among 80 female psychiatric outpatients, 49 of whom had a diagnosis of schizophrenia.\textsuperscript{12} They found that, when compared with a control group of patients from medical clinics, the psychiatric group knew significantly less about AIDS and about behaviors associated with transmission. The patients with a diagnosis of


\textsuperscript{12}Aruffo, Coverdale, and Chacko, "Knowledge About AIDS Among Women Psychiatric Outpatients," 326-328.
schizophrenia scored the lowest and accounted for the difference between the two groups.\textsuperscript{13}

In a study by Sacks and Associates, HIV risk factors were rated by therapists for a psychiatric sample of 205 patients.\textsuperscript{14} As many as one in five reportedly belonged to high-risk groups. The proportions of those who were homosexual (8.8 percent) and those who were IV drug users (6.3 percent) were twice as high as in the general population of the city where the study was conducted. They also reported the extent of knowledge about AIDS risk behaviors among subjects (N = 45) in the Toronto Schizophrenia Registry, a group of community outpatients with DSM-III-R diagnoses of schizophrenic disorders. When compared with a group of university student controls (N = 106) on the AIDS Knowledge Test, it was found, not surprisingly, that the schizophrenia group scored significantly lower (t = 2.40, df = 149, p > .05). More interestingly, however, three-fourths of the schizophrenia sample scored correctly on 80 percent of the questions, indicating a very good overall knowledge of risk behavior. For the most part, incorrect answers arose out of the ambiguity of certain questions in the scale.\textsuperscript{15}

\textsuperscript{13}Ibid.
\textsuperscript{14}Seaman, Lang, and Rector, "Chronic Schizophrenia," 765-768.
\textsuperscript{15}Hospital and Community Psychiatry 43, no. 2 (February 1992): 181.
Community Mental Health Centers (CMHC) should consider developing a strong and coordinated prevention and treatment response, working closely with colleagues in medicine and public health. Mental health professionals must prepare themselves by becoming more knowledgeable about AIDS-related psychological dysfunctions and more skillful in therapeutic techniques appropriate to this new population of clients.16

There is clearly a need for the development of community mental health interventions to help these infected and affected to deal with the psychological trauma that is confronting thousands of Americans each day. A clinician might be made available for one or more days per week to accept referrals, provide mental status evaluations, assess risk of suicide, offer crisis intervention or short-term individual or group therapy, organize support groups, and refer for psychotropic medication when necessary.17 Day treatment opportunities, respite care, and residential placements might also be necessary. At least, each center should identify one "AIDS Specialist" who will keep abreast of the rapidly changing information. There is also an important role for centers in training of health care providers, community education, outreach to high-risk

16Ibid, 27.

groups, consultation, and other prevention strategies designed to change attitudes and behavior.\textsuperscript{18}

\textbf{Theoretical Framework}

The model chosen for the basis of this study is the Community-as-Client by Anderson, McFarlane, and Helton. It is a helpful model for assessing health status of the community. The community-as-client model is an adaptation of the Neuman Health Care Systems model and expresses an effort to put into practice the definition of public health nursing as a synthesis of public health and nursing.\textsuperscript{19}

Health education is a primary preventative effort that aims at strengthening the lines of defense so that stressors cannot penetrate to cause a reaction or aims at interfering with a stressor by taking action against it.\textsuperscript{20} The goal of the model is to achieve system equilibrium. In this case, the equilibrium can be improved by providing this population with adequate, appropriate knowledge of AIDS. This knowledge will serve to strengthen the normal line of defense of the community.

\textsuperscript{18}Ibid, 30.


The analysis of a community includes the assessment of areas such as recreation, physical environment, education, safety and transportation, politics and government, health and social services, communication, and economics. The results of this descriptive study, assessing the homeless mentally ill's knowledge of AIDS, will contribute to this community analysis in the area of education.

The analysis of the homeless mentally ill adults' knowledge of AIDS will help to determine potential stressors, as well as the degree of reaction, that results in disequilibrium within the community system. This disequilibrium may be caused by inadequate or inappropriate health knowledge regarding AIDS. It may also be interpreted as a normal line of defense providing the knowledge level is adequate.

This analysis may be used directly in the formulation of a community nursing/health/mental health diagnosis, which is then followed by planning and intervention. The results of this descriptive study may prove to be useful in health education planning for this population.

**Assumptions**

The assumptions for this study are:
residence during the night is a supervised public or private facility that provides temporary living accommodations.23

2. **Knowledge** -- the range of one's information or understanding.24

3. **Mentally Ill Person** -- impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, social, or environmental. Mental illness is extremely variable in duration, severity, and prognosis, depending on the specific type of affliction. The major forms of mental illness include psychosis, neurosis, affective disorders, personality disorders, organic mental disorders, and psychosexual disorders.25

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1. Health Knowledge (of some kind) is probably necessary before a personal health action will occur.\textsuperscript{21}

2. It will be possible to obtain baseline knowledge about AIDS by administering the survey.

3. The health of a community is influenced by the knowledge of its members.\textsuperscript{22}

**Research Questions**

1. What is the level of knowledge about AIDS among the homeless mentally ill adult population?

2. Does the level of knowledge about AIDS among the homeless mentally ill adult population vary with race?

3. Does the level of knowledge about AIDS among the homeless mentally ill adult population vary with age?

4. Does the level of knowledge about AIDS among homeless mentally ill adults vary with level of education?

**Definition of Terms**

1. **Homeless Person** — an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary


\textsuperscript{22}Anderson, McFarlane, and Helton, *Community-as-Client*. 
CHAPTER THREE
METHODOLOGY

Research Design

This is a descriptive correlational study. The researcher will be unable to assign participants to groups or perform experimental manipulation. The aim of this study is to describe the relationship among variables rather than to infer cause-and-effect.\(^1\) This study will describe the knowledge of AIDS in a sample of homeless mentally ill adults in a residential community. In addition, as a correlational study, the relationship between the responses and demographic variables will also be addressed.

Setting

The study was conducted during the Summer of 1992 at a residential community which has medical services provided by Mercy Mobile Health Service of the South (MMHSS). Although currently living in a residential community, this clientele, by the definition provided by the McKinley Act,

are still considered homeless.\textsuperscript{2}

The Mercy Mobile Health Unit provided medical services on a monthly basis to the residential community. Interview times in the residential community were prearranged with the director. The director of the residential community served as an intermediary and introduced the researcher to the residents. A small interview area was set up at the main office. The area was designed to provide as much privacy as possible.

Population and Sample

The population selected for this particular study are formerly homeless mentally ill adults who live in a residential community in Atlanta, Georgia. A non-probability sampling technique utilizing a convenience sample was conducted among individuals who reside in a Residential Project for homeless mentally ill adults located in Atlanta. The design and setting of this study diminish the possibility of surveying a random sample. Another limitation of this sampling technique is that homeless people utilizing medical services may not be representative of Atlanta's total homeless population.

A sample size of 30 was chosen for this study. Thirty surveys were administered in the community. This sample provided for approximately a 63\% representation of

the 48 residents of the residential community known to utilize health care services.

**Instrument**

The instrument chosen for this study is the Modified AIDS Information Survey (MAIS) developed by the Nell Hodgson Woodruff School of Nursing Center for Nursing Research (Appendix A) and adapted from a questionnaire developed by DiClemente, Zorn, and Temoshok. This 34-question survey assesses basic knowledge regarding AIDS. This particular instrument was chosen because it has been tested among the homeless women/men population. The responses will be coded as true, false, and don’t know.

The reliability of this instrument was assessed by using the Kuder-Richardson formula. The reliability of a measuring instrument is a major criterion for assessing its quality and adequacy. The Kuder-Richardson index of reliability produces a coefficient reliability that can be interpreted by a numerical value derived from the formula. The normal range of values is between 0.0 and 1.00, and higher values reflect a higher degree of internal consistency. The Kuder-Richardson value computed was .76.

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The content validity was also assessed by the Research Center. The survey was sent to four persons considered experts in AIDS research. The content validity was measured by a Content Validity Index computed by the Research Center. The experts were asked to rank each question for its degree of relevancy. The ranking scale consisted of four items, ranking least to most relevant.

The Content Validity Index can be calculated to determine the degree of agreement regarding how well the items address the objectives of the tool and how adequately they represent the domain of interest. The experts rate items on a 4-point scale ranging from 1 = not relevant to 4 = highly relevant. The CVI = the proportion of items given a rating of 3 or 4 by the experts.5 The calculated CVI for the Modified AIDS Information Survey was .94.

Data Collection

Participants were selected from a sign-up sheet requesting volunteers to be involved in this survey. The selection for the study included those who were willing to answer the survey. These residents were introduced to the researcher by the director of the program. The explanation of the study and the consent form (see Appendix C) were read to each individual. If the individual agreed to participate in the study, the consent was signed.

During each scheduled appointment the questionnaire was read to the individuals by the researcher. The researcher explained to the participants that they could ask specific questions about AIDS after the survey was completed. At the end of the questionnaire all questions were answered by the researcher. This was done to prevent any bias in response due to questions answered by the researcher during the interview. Each interview was completed in approximately 15 minutes. This process was repeated several times during the day until an adequate sample of 30 was obtained.

The data was coded at the top of the demographic sheet by month, date, and year. The participants were coded by exact birthdate and race.

**Data Analysis**

The data from this study was analyzed and is presented in Chapter 4. The responses were coded and analyzed for means, frequencies and percentages to describe the level of knowledge about AIDS among the formerly homeless mentally ill adults.

**Limitations**

The limitations of this research may be altered due to the high rate of psychiatric impairment in the homeless population. The lowest rate appearing in the literature is
15% and the highest approximately 90%." Some bias may occur due to the sensitive nature of the topic. Sampling of nonprobability accidental design does not control for bias of self-selection."

**Informed Consent**

The cover sheet of the survey served as a consent form. The researcher reviewed both the consent and the survey with the participant. This was done to provide clear explanations to participants who may have some difficulty reading. The explanation and consent form assured the participant that lack of participation would not affect their use of the services of the program. After the consent was signed, the survey was administered.

**Confidentiality and Anonymity**

Every precaution was taken to give full confidentiality to the individuals who volunteered to complete the survey. The participants were told not to place their name or identifying marks on any of the forms. Each form was coded as described in the methodology section of this proposal. The consents were filed separately. The results of the survey will be made available to the director of the program as well as to Clark Atlanta University.

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"Polit and Hungler, *Nursing Research*. 
Release of any other results will be at the express consent of the researcher.

**Protection of Human Subjects**

An intermediary was utilized in the residential community for the purpose of explaining the study and introducing the researcher. This introduction were conducted by doing door-to-door knocking and having face-to-face contact with the participants.

The purpose of the study was explained to the director of the program. The researcher was introduced to potential participants by the staff employed at the program after which the researcher was able to obtain consents and administer all questionnaires.
CHAPTER FOUR
PRESENTATION OF RESULTS

This chapter represents the statistical analysis and discussion of data for this study. Two constructs were addressed: (1) level of knowledge of AIDS by age, and (2) level of knowledge of AIDS by race.

Demographic Data

Table 1 represents the thirty (N=30) participants in this study who ranged from ages 20 to above; 43% ranged from ages 20 to 35, 30% ranged from ages 36-45, and 27% ranged from ages 46 to above. In the area of education 23% attended sixth through the 12th grade, 30% were high school graduates, 30% had some college, 13% were college graduates and 4% attended Technical School. In the area of residency, 97% lived in an apartment and 3% lived outside periodically. In the area of Ethnic background 47% are white and 47% are black and only 6% were of another nationality.

Age Group

In the construct of the Modified AIDS Information Survey (MAIS) on Table 1, there were 30 respondents who were grouped by ages 20-35, 36-45, and 46 to above; who responded with the correct answers. Ninety-two percent responded that
at the present time there is no cure for AIDS, 100% respondent to AIDS is a disease caused by a virus, 87% responded to AIDS is a disease in which your body cannot fight off, 89% responded to stress causes AIDS, 87% responded to only gay men can get AIDS, 92% responded to a person who has AIDS can look and feel healthy, 87% responded to you can get AIDS by giving blood, 85% responded to AIDS can be cured if treated early, 100% responded to having sexual intercourse with someone who has AIDS is one way of getting it, 100% responded to people who get AIDS usually die from the disease, 92% responded to using a condom during sex can lower the risk of getting AIDS, 100% responded to AIDS is a life-threatening disease, and 87% responded to there is a vaccine available that protects a person from getting AIDS.

From an analysis of the results, the formerly homeless mentally ill adults in the age group from 46 to above appear to be more knowledgeable of AIDS.

**Ethnic Background**

Table 2 represents the thirty (N=30) participants in this study whose Ethnic background is white (N=14), Black (N=14), and other (N=2).

In response to the construct of race (N=30), the correct responses to the MAIS was as followed: 100% responded correctly to Lesbians are at high risk for getting AIDS, 100% responded to you can get AIDS from hugging
someone with the disease, 100% responded to you can avoid getting AIDS by exercising regularly, 64% responded to you get AIDS by giving blood, 100% responded to anybody get AIDS, 93% responded to AIDS is not a serious health problem. It is like having a cold, 100% responded to there is a blood test that shows the presence of the AIDS virus, 100% responded to I am less likely than most people to get AIDS, 100% responded to you can get AIDS by sharing a needle with a drug user who has the disease, and 100% responded to AIDS cannot be transmitted from women to men.

The responses to this construct would indicate that the white participants among the formerly homeless mentally ill adults living in a residential community have more knowledge of AIDS.
Table 1
Percent of Correct Responses to the MAIS by Age Group

<table>
<thead>
<tr>
<th>Items</th>
<th>20-35 (N=13)</th>
<th>36-45 (N=9)</th>
<th>46-above (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At the present time there is no cure for AIDS. (N=30)</td>
<td>92%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>2. AIDS is a disease caused by a virus. (N=30)</td>
<td>92%</td>
<td>100%</td>
<td>87%</td>
</tr>
<tr>
<td>3. AIDS is a disease in which your body cannot fight off. (N=30)</td>
<td>77%</td>
<td>67%</td>
<td>87%</td>
</tr>
<tr>
<td>4. Stress causes AIDS. (N=30)</td>
<td>85%</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>5. Only gay men can get AIDS. (N=30)</td>
<td>85%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>6. A person who has AIDS can look and feel healthy. (N=30)</td>
<td>92%</td>
<td>67%</td>
<td>87%</td>
</tr>
<tr>
<td>7. You can get AIDS by giving blood. (N=30)</td>
<td>61%</td>
<td>22%</td>
<td>87%</td>
</tr>
<tr>
<td>8. Having sexual intercourse with someone who has AIDS is one way of getting it. (N=30)</td>
<td>92%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>9. People who get AIDS usually die from the disease. (N=30)</td>
<td>92%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>10. Using a condom during sex can lower the risk of getting AIDS. (N=30)</td>
<td>92%</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>11. You can get AIDS by sharing a needle with a drug user who has the disease. (N=30)</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 1 (cont.)

<table>
<thead>
<tr>
<th>Items</th>
<th>20-35 (N=13)</th>
<th>36-45 (N=9)</th>
<th>46-above (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. AIDS is a life-threatening disease. (N=30)</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>13. There is a vaccine available that protects a person from getting AIDS. (N = 30)</td>
<td>85%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>Items</td>
<td>White (N=13)</td>
<td>Black (N=9)</td>
<td>Other (N=8)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1. Lesbians are at high risk for getting AIDS. (N=30)</td>
<td>78%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>2. You can get AIDS from hugging someone with the disease. (N=30)</td>
<td>93%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>3. You can avoid getting AIDS by exercising regularly. (N=30)</td>
<td>93%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>4. You can get AIDS by giving blood. (N=30)</td>
<td>64%</td>
<td>57%</td>
<td>50%</td>
</tr>
<tr>
<td>5. Anybody can get AIDS. (N=30)</td>
<td>93%</td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td>6. AIDS is not a serious health problem. It is like having a cold. (N=30)</td>
<td>93%</td>
<td>86%</td>
<td>50%</td>
</tr>
<tr>
<td>7. There is a blood test that shows the presence of the AIDS virus. (N=30)</td>
<td>86%</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>8. I am less likely than most people to get AIDS. (N=30)</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>9. You can get AIDS by sharing a needle with a drug user who has the disease. (N=30)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>10. AIDS cannot be transmitted from women to men. (N=30)</td>
<td>93%</td>
<td>78%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 3
Demographic Data

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residence (N=30)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Apartment</td>
<td>29</td>
<td>97%</td>
</tr>
<tr>
<td>Outside</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Age (N=30)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 35</td>
<td>13</td>
<td>43%</td>
</tr>
<tr>
<td>36 - 45</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>46 - Above</td>
<td>8</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Ethnic Background (N=30)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>14</td>
<td>47%</td>
</tr>
<tr>
<td>Black</td>
<td>14</td>
<td>47%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Education (N=30)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6th - 12th</td>
<td>7</td>
<td>23%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Some College</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>College Graduate</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>Technical School</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>
CHAPTER FIVE
SUMMARY AND CONCLUSION

The researcher began this analysis by thinking about some frequently asked questions among the formerly homeless mentally ill adults in a residential community. In order to answer these questions, the researcher recognized that an educational program is needed among this population. These questions consisted of should we interact with a person, knowing the person has AIDS? How does a person really get AIDS? How can one prevent himself/herself from catching AIDS?

AIDS has caused many problems among this population and people in society. This should encourage everyone to reexamine his/her knowledge of AIDS. AIDS is a deadly disease and education is needed now to prevent high-risk behaviors that contribute to the spread of the disease.

The results of the analysis of the formerly homeless mentally ill adults knowledge of AIDS surveyed indicate that participants between ages 20 to above are knowledgeable about AIDS. The ages of 46 and above were most knowledgeable about AIDS. The survey also indicates that participants between the ages 36 to 45 were least knowledgeable about AIDS. This age group needs more
educational training about AIDS, and should be offered preventive counseling to increase their knowledge and to reduce or eliminate the probability of high-risk behaviors.
CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

There are many implications for social work practice with the homeless mentally ill. Professional social workers who deliver services to homeless mentally ill adults should become aware of the services which are provided for this population and have an understanding of patient's rights versus patient's needs. Social workers should be cognizant of the isolation and alienation experienced by a homeless mentally ill person which may be caused by social, political, and economic discrimination.

Social workers should develop intervention strategies for working with this population. They must be knowledgeable of psychiatric disabilities and conditions on the streets for the homeless mentally ill. Efforts must be made to increase the satisfaction and successful functioning in the living environment of their choice. These strategies would allow the individual to make choices, to develop skills and supports. Social workers must develop and implement programs in the community in order to educate the homeless population about medical issues within our society. Counseling about AIDS prevention and other deadly diseases which an individual may come in contact should be readily
available. Social service agencies should provide support and guidance for the homeless population.

Additional research examining the extent of AIDS knowledge within psychiatric populations, the association between knowledge of AIDS and extent of risk behaviors, as well as the benefits of educational training is needed to assess the vulnerability of this population group to contracting and spreading AIDS.

The work of those who advocate, educate, mediate, and counsel the homeless mentally ill population should also include implementing plans which will rehabilitate an individual into an environment that is comfortable for him and society.
BIBLIOGRAPHY


Hospital and Community Psychiatry 42, no. 2 (February 1992): 181.


Mercy Mobile Health Program. Atlanta Community Health Program for the Homeless. 1990.


APPENDICES
**APPENDIX A**

**MODIFIED AIDS INFORMATION SURVEY**

**DIRECTIONS:** Please read each item below and respond by indicating whether the statement is true (T), false (F) or that you don’t know (DK). Circle the appropriate letter.

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At the present time there is no cure for AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>2. A pregnant woman who has the virus that causes AIDS can infect her unborn baby with the virus.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>3. AIDS is a disease caused by a virus.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>4. Lesbians are at high risk for getting AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>5. You can get AIDS from hugging someone with the disease.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>6. You can avoid getting AIDS by exercising regularly.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>7. AIDS is a disease in which your body cannot fight off.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>8. Stress causes AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>9. Only gay men can get AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>10. A person who has AIDS can look and feel healthy.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>11. You can get AIDS by giving blood.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12. Anybody can get AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>13. AIDS can be cured, if treated early.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>14. AIDS is not a serious health problem. It is like having a cold.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>15. Having sexual intercourse with someone who has AIDS is one way of getting it.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>16. People who get AIDS usually die from the disease.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>17. People with AIDS usually have other diseases as a result of AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>18. Receiving a blood transfusion can infect a person with the virus that causes AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>19. There is a blood test that shows the presence of the AIDS virus.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>20. You can get AIDS from food handled by someone who has the disease.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>21. I am less likely than most people to get AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>22. Using a condom during sex can lower the risk of getting AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>23. You can get AIDS by sharing a needle with a drug user who has the disease.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>24. AIDS is a life-threatening disease.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>25. AIDS is caused by the same virus that causes herpes.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>26. There is a vaccine available that protects a person from getting AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>27. The virus that causes AIDS can damage the brain.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>28. Some drugs have been developed for the treatment of AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>29. AIDS cannot be transmitted from women to men.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>30. I am not worried about getting AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>31. You can get AIDS by using the comb or brush of someone with AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>32. There is no cure for AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>33. You can get AIDS by shaking hands with someone who has the disease.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td><strong>34. I am not the kind of person who is likely to get AIDS.</strong></td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
</tbody>
</table>
APPENDIX B
DEMOGRAPHIC CHARACTERISTICS

1. Where do you usually sleep at night?

- My own apartment/house
- Friend’s apartment/house
- Shelter
- Outside

2. Date of birth?

Month______ Date_______ Year_______

3. Ethnic background?

- White ____  Hispanic ____
- Black ____  Other ____
- Asian ____

4. Years of school?

- 1 - 6 ____
- 7 - 11 ____
- High school graduate ____
- Some college ____
- College graduate ____
- Technical school ____

5. Have you ever attended a presentation about AIDS?

- Yes ____  No ____  Don’t Know ____

6. Indicate where you get most of your education about AIDS. Select three and number them by priority by letting 1 being most.

- Television
- Newspapers/Magazines
- Brochures/Fliers/Program Booklets
- A Medical Facility or Clinic
- Radio
- Relatives/Friends
- Blood Bank
- AIDS Hotline
- Other _______________________

7. Preference for a sexual partner?

- Male ____  Female ____  Either ____
8. Have you ever used drugs? If yes, check types.

_____Yes  _____No  _____IV  _____Cocaine
        _____Pills  _____Marijuana
        _____Alcohol
My name is Cynthia Traylor, I am a graduate student at Clark Atlanta University. I am conducting a survey to the formerly homeless mentally ill adult population in a residential community about knowledge of AIDS. This study consists of a 34 question survey and demographic data sheet which will require 15 minutes to complete. This study will benefit the formerly homeless mentally ill adult population by helping to determine their educational needs in the prevention of AIDS. Your name will not be used and there will be no way to identify you. You may refuse to complete this form, or decide to stop at any point and know that you will not be penalized in any way.

Please sign below if you agree to participate.

________________________________________________________________________
Date                         Signature of Research Subject

________________________________________________________________________
Date                         Investigator
APPENDIX D
CLARK ATLANTA UNIVERSITY
SCHOOL OF SOCIAL WORK

Agency or Individual memorandum of agreement concerning Social Work study

Title of Study: Knowledge of HIV/AIDS: A Residential Community of Formerly Mentally Ill Adults

Name of Agency: Phoenix House

Study discussed with and explained to

Jean Toole, Executive Director
Name of Representative, Title

and

Ben Burton, Director
Name of Representative, Title

a.) Description of Study: Knowledge about AIDS will be assessed among the formerly homeless mentally ill adults.

b.) Description of activities the representative agrees to do: Allow space and time for the researcher to administer the questionnaire. Allow the staff to approach potential participants to complete the questionnaire and offer a meal after completion of the questionnaire.

c.) Description of safeguards taken to protect identity of agency: Demographic sheets will be coded by numbers known only to the researcher. Agency will be identified by number. Name of agency will not be identified when reporting the data.

d.) Description of concurrent or later review procedure within the agency: None planned at this time. If
problems or questions arise, the researcher can be reached at 755-2685. A report of this study will be made available upon request.

Date

Signature of representative if written consent indicated

Date

Investigator