Homeless Families and Children

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Abstract

Debra Rog and John Buckner report that since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of families and children who become homeless, especially in understanding the heterogeneity within the population and whether a “typology” of families can be created (i.e., distinguishing families with greater needs for services and housing from those with lesser needs.) The authors review the findings from recent studies on homeless families and children and summarize the descriptive and outcome findings from evaluations of housing and service interventions and prevention efforts. With respect to children, research has focused on understanding and documenting the impact of homelessness on children. Rog and Buckner emphasize that that many of the challenges homeless families and children confront are also experienced by families that are very poor but not homeless, pointing to the need for further research on how to target assistance most efficiently to minimize the incidence and duration of homelessness for low-income families and children in general.

Introduction

The Current Context of Homelessness for Families and Children

Homelessness among families continues to be an all too common occurrence in our nation. Beginning in the early 1980s, families with young children began to appear at shelters intended for single adults and quickly became a fast-growing segment of the homeless population. The best estimate is that families comprise 34 percent of the homeless population (23 percent children and 11 percent adults) on any given night (Burt et al., 1999). In a given year, this translates to about 420,000 families, including 924,000 children, experiencing homelessness in the United States. By extrapolation, about 1.8 percent of all families in this country spend at least one night homeless over the course of a year (Urban Institute, 2000). Among just low-income families, about 8 percent of households and 9 percent of children have been homeless during the past year. It is also believed that many more families are precariously housed, in doubled-up situations or in substandard housing.

It is important to recognize that there is a structural imbalance creating homelessness that helps to explain both geographic and temporal differences in rates of homelessness. The nature of the crisis in affordable

for viable solutions. New approaches to service delivery and provision of housing targeted at this population have been developed. Some of these interventions are becoming widely recognized as “evidence-based.” In the last 5 to 10 years, there has been a convergence of opinion among advocates and policymakers at all levels of government that chronic homelessness need not exist in the United States. Momentum around this issue started to build in 2000 when the National Alliance to End Homelessness (NAEH) released a plan to end homelessness in 10 years. Shortly afterward, Secretary

housing varies from place to place. For example, the examination of worst case housing needs indicates that the suburbs experienced the greatest losses in units affordable to extremely low-income families in the 1990s as a consequence of growth in population and jobs (U.S. Department of Housing and Urban Development, 2000). Shortages in affordable housing and differences in fair market rents also vary geographically. Fair market rents, even averaged across entire states, are over twice as high in some states as in others; local variation is much greater (Pitcoff et al., 2003). In addition, the extent to which public housing and other housing assistance is available may have a role in explaining this variation. Recent analyses of the Fragile Families database, which comprises an at-risk sample of families from communities across the country whose mothers have recently given birth, reveals that among families living below 50 percent of the poverty level, homelessness is related to having no housing assistance or having lost that assistance or public housing. Residential stability among those in the poverty sample is strongly predicted by having or gaining public housing (Rog & Holupka, unpublished). Families living at the bottom rung of the income ladder have inadequate incomes to pay the fair market rents in literally all communities. Therefore, the role that the lack of affordable housing plays in creating the structural backdrop for why homelessness occurs points to its fundamental importance in creating long term solutions for preventing homelessness among families as well as individuals.

Even within the same locale, the characteristics of homeless families can change over time. Weinreb et al. (2006) recently compared the characteristics of two samples of similarly enrolled homeless families in Worcester, Massachusetts, based on studies conducted in the early 1990s and early 2000s. Demographic characteristics were fairly similar between the two samples. However, compared to the 1993 sample, homeless families in the 2003 study were poorer (adjusted for the effects of inflation) and reported more physical health limitations; psychological distress; and mental health disorders, especially major depression and posttraumatic stress disorder (PTSD). The most noteworthy finding was a fourfold higher rate of current depression in the 2003 study as compared to the earlier investigation. Reasons for this increase are unclear and the finding merits replication in other settings to determine whether it is part of a broader trend.

Recent Research and Evaluation Activity

Since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of families and their children who become homeless, especially in understanding the heterogeneity within the population and whether a “typology” of families can be created (i.e., distinguishing families with greater needs for services and housing from those with lesser needs). With respect to children, research has focused largely on understanding the impact of homelessness.

At federal and state levels, there also has been increased attention to the types of housing models needed by the array of families who become homeless (including transitional, permanent supportive housing, and permanent housing), the services that are needed to assist families and their children while they are homeless and after they exit, and strategies for preventing family homelessness and facilitating more rapid exits.

In this paper, we synthesize what we know in each of these areas, highlighting the relevant research studies and policy analyses that have been conducted since 1998 that shape our understanding. We begin with a methodological overview of the more recent research studies on the characteristics and needs of families and children, followed by a summary of the main findings. We then provide a more in-depth synthesis of the literature on the characteristics and needs of homeless families overall, and then on the

impact of homelessness on children. We follow with summaries of the descriptive and outcome findings from evaluations of various housing and service interventions and efforts to prevent homelessness. The final section outlines the research that is indicated to fill the gaps in knowledge that remain.

Research on the Characteristics and Needs of Homeless Families and Children: Summary of the Methodological Context and Key Findings

The body of research on homeless families has grown, though not dramatically, since the mid-1990s. More has been learned about the size and characteristics of homeless families, especially compared to equally low-income families who remain domiciled. Several key studies (Shinn et al., 1998; Rog et al., 1995a; Bassuk et al., 1996) had begun reporting results prior to the 1998 Symposium, though analyses continued. Two additional large studies were conducted following the Symposium: (1) the National Survey of Homeless Assistance Providers and Clients (NSHAPC), directed by Burt and colleagues (1999), which has contributed to our knowledge of basic characteristics of homeless families across the nation, and (2) analyses of administrative data sets in New York City and Philadelphia by Culhane and colleagues (1999), which have improved our understanding of families' use of shelter and the interconnection of homelessness with involvement in other services and systems.

Several more recent studies that are adding to the literature on the characteristics of families (some with publications underway or in press) include the evaluation of the five-year CMHS/CSAT Homeless Families Program (Rog, Rickards et al., in press); a secondary analysis of the Fragile Families and Child Well-Being dataset (Reichman et al., 2001) focused on comparing families at different levels of residential instability (Rog et al., 2007); and examinations of housing problems experienced by recipients of child welfare services (Courtney, McMurtry, & Zinn, 2004; Park et al., 2004).

With respect to homeless children in particular, the first studies were conducted in the mid- to late 1980s, not long after the issue of homelessness among families became apparent. The findings from these initial studies helped spawn a second generation of research studies on homeless children that were conducted in the early to mid-1990s (cf. Bassuk, Weinreb et al, 1997; Buckner & Bassuk, 1997; Buckner et al., 1999; Buckner, Bassuk, & Weinreb, 2001; Garcia Coll et al., 1998; Masten et al., 1993; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Schteingart et al., 1995; Weinreb et al., 1998; Zeismer, Marcoux, & Marwell, 1994). These studies were funded by the federal government (e.g., the National Institute of Mental Health), private foundations, and other agencies. A chief aim of many of these investigations was to further clarify the impact of homelessness on children. Compared to the earlier studies, these latter projects enrolled more study participants, included a greater breadth and quality of assessment instruments, and employed more advanced statistical techniques with which to analyze data.

The studies on homeless families and children have varied in definitions used, study designs, participant selection, and geographic context, all of which have contributed to differences and inconsistencies among the studies. In addition, examining and synthesizing the findings of studies over time is confounded by historical and structural changes in housing, improvements in shelter conditions over time (especially when examining the effects of homelessness on children), and effects of programs implemented through the McKinney-Vento Act (such as the educational programs serving as a buffer for children). Few studies have been longitudinal, only several have used comparison groups of other low-income families to contextualize the results, and the geographic areas have been limited.

Despite these limitations, the small body of emergent research has provided insights into the risk factors associated with family homelessness, the housing and service needs of homeless families and children, and the impact of homelessness on children. Among the most consistent findings are:

- The most common profile of a homeless family is one headed by a single woman in her late 20s with approximately two children, one or both under 6 years of age; those at greatest risk belong to ethnic minority groups.
- In the Northeast the vast majority of homeless families are headed by single-parent females (Bassuk et al., 1996), while in other parts of the country there is a greater mix, with a modest percentage being two-parent families or families headed by a single father (U.S. Conference of Mayors, 2005).
- The residential histories of homeless families typically reveal high mobility and instability, including living in a variety of doubled up and own housing arrangements.
- Family separations are a common occurrence, both before and after the homelessness episode.
- Homeless families are typically extremely poor, and mothers who are homeless lack human capital—useful skills and abilities—with respect to both education and employment.
- Conflict, trauma, and violence figure prominently in the lives of homeless families, as they do with equally poor but domiciled families.
- The health of mothers who are homeless is often poorer than the health of mothers who are domiciled, but mothers who are homeless typically report high rates of access to health care; in contrast, their mental health problems are comparable in rate and nature (e.g., typically depression) to poor women in general, and are typically unmet.
- Reports of substance abuse, though likely underestimates, are higher for mothers who are homeless than for other women in poor families, but lower than for single adults who are homeless.
- Both homeless and low-income housed children experience the negative effects of broad poverty-related adversities. Study findings suggest that although homelessness itself can have an additional detrimental impact on children's mental health, physical health, and school performance, particularly in the short term, the effects tend to dissipate over time once children are rehoused.

What Have We Learned About Families Who Become Homeless?

Factors That Place Families at Risk of Homelessness

Ethnicity. Homeless families are more likely than poor families, and both are substantially more likely than the general population, to be members of minority groups, in particular African Americans (Lowin et al., 2001; Rossi et al., 1987; Susser, Lin, & Conover, 1991; Rog et al, 2007; Rog & Holupka, unpublished; Whaley, 2002). This is also true of single adults who are homeless. For example, in the NSHAPC, 62 percent of families and 59 percent of single adults, compared to 24 percent of the general population, were members of minority groups (Burt et al., 1999). However, the particular minorities represented vary from city to city. Their race and ethnicity reflect the composition of the city in which

they reside, with minority groups invariably disproportionately represented (Breakey et al., 1989; D'Ercole & Struening, 1990; Rog et al., 1995a; Shinn, Knickman, & Weitzman, 1991; Lowin et al., 2001).

Resources. The incomes of mothers who are homeless are significantly below the federal poverty level (Bassuk, Buckner et al., 1996, 1997; Rog et al., 1995b; Shinn & Weitzman, 1996). Homeless families' incomes are slightly higher than homeless single adults' due to families having greater access to means-tested benefit programs such as TANF and more help from relatives and friends. Nonetheless, homeless families' incomes are almost always too low for the families to obtain adequate housing without subsidies (Burt et al., 1999). In the Worcester Family Research Project (WFRP), a study of 436 homeless and low-income housed single-parent female-headed families, more than half earned less than $8,000 per year, placing them at 63 percent of the poverty level for a family of three (Bassuk et al., 1996). Similarly, in the NSHAPC the median income in 1996 for a homeless family was only $418 per month, or 41 percent of the poverty line for a family of three (Burt et al., 1999).

In a recent reanalysis of the Fragile Families and Child Well-Being dataset focused on families living at 50 percent or below of the poverty level conducted as part of a larger project designed to inform a typology of homeless families (Rog et al, 2007), those families who remained residentially stable over three years without experiencing risk factors for homelessness (e.g., having utilities shut off) were more likely to have relatively higher incomes and have received housing assistance and to be living with a partner who was working. Having other adults living in the household appears to increase a mother's likelihood of remaining in stable housing.

Findings about the role of social networks of homeless families are mixed. Several studies have found that mothers in the midst of an episode of homelessness, compared to low-income housed women, have less available instrumental and emotional support, less frequent contact with network members, and more conflicted relationships (Bassuk & Rosenberg, 1988; Bassuk et al., 1996; Culhane, Metraux, & Hadley, 2001; Passero, Zax, & Zozus, 1991). One qualitative study found that the lack or withdrawal of support was a key factor in families becoming homeless (McChesney, 1995), but another study (Goodman, 1991) found no differences in support between homeless and housed mothers. In contrast Shinn, Knickman, and Weitzman (1991) found that newly homeless mothers report *more* recent contact with network members than low-income housed mothers, and over three-quarters had stayed with network members before turning to shelter. Moreover, more recent analysis of that dataset (Toohey, Shinn, & Weitzman, 2004) found that five years later the social networks of the (now) formerly homeless mothers in this sample were quite similar to those of their housed counterparts. Differences in study findings may be related to the timing of interviews of the mothers—in the months prior to a homelessness episode, a mother's contact with network members may increase, whereas by the time a mother and her children enter shelter, she may have depleted most of her social network resources.

There is some evidence that conflict in social support networks may be related to poorer symptoms and outcomes for families. In the WFRP, homeless mothers had smaller social networks that comprised nonprofessionals and reported more conflicted relationships in their networks than did housed women. Therefore, large social networks emerged as a protective factor for homelessness, but having a network marked by interpersonal conflict was a risk factor for homelessness (Bassuk, Buckner et al., 1997). Conflict with family and friends, especially sibling conflict, was related to impaired mental health (Bassuk et al., 2002). Similarly, in the recent CMHS/CSAT Homeless Families Program involving mothers with psychiatric and/or substance abuse issues, mothers reporting conflict in their networks over

the course of a 15-month follow-up showed less improvement in a number of outcomes—including mental health symptoms and functioning, trauma, and substance abuse, regardless of the type of intervention they received (Rog, Buckner et al., in press; Sacks et al., in press; Pearson et al., in press).

Young Children and Pregnancy. Not only are homeless families overwhelmingly headed by women, but they are disproportionately families with young (pre-school) children. The risk for homelessness is highest—and higher than the general population rate—among families with children under the age of six. Furthermore, the risk increases for younger children, with the highest rate of risk among families with children under the age of one year ("infants"), as approximately 4.2 percent of infants were homeless in 1995 (Culhane & Metraux, 1999). Having young children may place parents at a competitive disadvantage in terms of holding a job and being able to afford housing.

Pregnancy itself is a risk factor for homelessness (Shinn et al., 1998). In a comparison of homeless public assistance families in New York with a sample of housed families on public assistance, 35 percent of the homeless women were pregnant at the time of the study and 26 percent had given birth in the past year, while only 6 percent of the housed group were pregnant and 11 percent had given birth recently (Weitzman, 1989).

Other Needs and Problems Facing Homeless Families

Family separations and influence on family composition. In recent years, the extent to which families experience the temporary or permanent separation from a child when homeless or at various stages in their residential history has become more apparent (Cowal et al., 2002; Hoffman & Rosencheck, 2001). Parent-child separation among homeless families is part of a much broader issue. Because residents of family shelters must include at least one parent and at least one child, parents who are separated from their only child or all of their children are not welcome at family shelters and instead must find shelter in facilities meant for "single" adults. The NSHAPC reported that 60 percent of all homeless women in 1996 had children younger than 18 years, but only 65 percent of those women lived with any of their children (and often not all of their children); similarly, 41 percent of all homeless men had minor children, yet only 7 percent lived with any of them (Burt et al., 1999). Other studies yield similar findings (Cowal et al., 2002; Maza & Hall, 1988; North & Smith, 1993; Rossi, 1989; Zima et al., 1996). The residents of shelters intended for single adults include some individuals who would be in a family shelter if they were presently caring for their child(ren). This is borne out in a study conducted in Alameda County, California by Zlotnick, Robertson, and Wright (1999), who interviewed 171 homeless women drawn from a countywide probability sample. Of these women, 84 percent were mothers and 62 percent of these homeless mothers had a child under the age of 18 living either in foster care or some other out-of-home placement.

Among families with children, parent-child separation is sometimes the choice made by a parent, usually the mother, in deciding the best interests of a child; at other times, it can be a decision forced upon her by the child welfare system, shelter staff, or relatives (Cowal et al., 2002; Park et al., 2004). Cowal et al. (2002) conducted the most comprehensive investigation to date on this issue. Their study, conducted in New York City during the early 1990s, involved 543 low-income families, 251 of which had experienced homelessness at some point in the five prior years. They found that 44 percent of the homeless families had experienced a child separation, compared to only 8 percent of low-income never homeless families. Even when accounting for histories of mental health and substance abuse problems as well as domestic violence (directed at the mother), homelessness was strongly associated with a family experiencing such a

separation (Cowal et al., 2002). The reasons why the risk of parent-child separation increases when a family becomes homeless is not entirely clear, but it is likely due to multiple factors. The "fishbowl hypothesis" posits that parenting practices are under closer scrutiny when a family is in a shelter than when housed, posing a risk for child welfare placement (Park et al., 2004). Alternatively, in some cases, a soon-to-be-homeless mother will ask that a relative care for her child so that the child can continue attending the same school. In other instances, shelters may not allow adolescents, especially males, to stay in their shelter, thereby forcing a family-child separation.

Homelessness is not only a major factor in family separations; it also makes the reunification of separated families more difficult. Cowal and colleagues (2002) found that only a subset (23 percent) of the separated children were living with their mothers at the five-year follow-up (Cowal et al., 2002). In most studies, the majority of separated children lived with relatives, but a substantial minority were in foster care or had Child Protective Service (CPS) involvement (26 percent, Cowal et al., 2002; 6 percent, DiBlasio & Belcher, 1992; 15 percent, Zlotnick, Robertson, & Wright, 1999). In a five-year follow-up of a birth cohort of children in Philadelphia, being in a family that requested shelter was strongly related to CPS involvement and to foster care placement (Culhane et al., 2003). The risk for CPS involvement increased as the number of children in a family increased. Similarly, in another Philadelphia study there was a greater risk for child welfare involvement for those families with longer shelter stays, repeated homelessness, and with fewer adults in the family (Park et al., 2004).

The link between child homelessness and foster care is even more disturbing in light of the preponderance of research that has found childhood separation—and especially foster care involvement—to be a predictor of homelessness in adults (Bassuk, Buckner et al., 1997; Bassuk, Rubin, & Lauriat, 1986; Knickman & Weitzman, 1989; Susser, Lin, & Conover, 1991; Susser, Conover, & Struening, 1987) as well as future separation from one's own children (Nunez, 1993).

Human capital: Education, employment, and income. Adults in both homeless and other poor families generally have low levels of educational attainment and minimal work histories. Compared to the national average of 75 percent of adults having a high school diploma or GED, for example, high school graduation or GED rates for mothers in homeless families range from 35 percent to 61 percent across a number of studies (Bassuk et al., 1996; Burt et al., 1999; Lowin et al., 2001; Rog et al., 1995b; Rog, Rickards et al., in press; Shinn & Weitzman, 1996). Overall, the rates of educational attainment for homeless families are lower than for homeless single adults (47 percent versus 63 percent in the NSHAPC) (Burt et al., 1999) but similar to other low-income families.

Not surprisingly, most homeless mothers (84–99 percent) upon entry into shelter are not working (Bassuk et al., 1996; Lowin et al., 2001; Rog et al., 1995b; Rog, Rickards et al., in press.) The majority of homeless mothers have had some work experience, however, ranging from 67 percent in the Worcester study (Brooks & Buckner, 1996) to over 90 percent in the RWJF/HUD Homeless Families Program and the recent CMHS/CSAT Homeless Families Program (Rog et al., 1995b; Rog, Rickards et al., in press). Among homeless and housed low-income mothers in the Worcester study, becoming pregnant before the age of 18 significantly lowered a woman's chances of having been employed (Brooks & Buckner, 1996).

Partner violence and childhood abuse. Homeless mothers, like poor women in general, have experienced high rates of both domestic and community violence (Bassuk et al., 1996; Bassuk, Perloff, & Dawson, 2001; Browne & Bassuk, 1997). Many women report having been both victims and witnesses of violence over their lifetimes. In the WFRP, almost two-thirds of the homeless mothers had been severely

physically assaulted by an intimate partner and one-third had a current or recent abusive partner (Browne & Bassuk, 1997). More than one-fourth of the mothers reported having needed or received medical treatment because of these attacks (Bassuk et al., 1996). Supporting these findings, Rog and her colleagues (1995b) reported that almost two-thirds of their nine-city sample of homeless women described one or more severe acts of violence by a current or former intimate partner. Not surprisingly, many of these women reportedly lost or left their last homes because of domestic violence.

In addition to adult violent victimization, many homeless mothers experienced severe abuse and assault in childhood. The WFRP documented that more than 40 percent of homeless mothers had been sexually molested by the age of 12 (Bassuk et al., 1996). Women participating in the CMHS/CSAT study reported similar findings, with 44 percent reporting sexual molestation by a family member or someone they knew before the age of 18 (Sacks et al., in press). Sixty-six percent of the women in the WFRP experienced severe physical abuse, mainly at the hand of an adult caretaker. Other studies have found similar results (e.g., Rog, Rickards et al., 1995b; Sacks et al., in press; Rog et al., in press).

Health and dental needs. Homeless mothers and their families face a number of health challenges and problems, some that may stem from homelessness and others that may have contributed to becoming homeless. Mothers who are homeless, for instance, have more acute and chronic health problems than the general population of females under 45 years of age. Bassuk et al. (1996), for example, found that 22 percent of the mothers reported having chronic asthma (more than four times the general population rate), 20 percent chronic anemia (ten times the general population rate), and 4 percent chronic ulcers (four times the general rate). These rates among homeless mothers in Worcester were comparable to those found in a comparison group of low-income housed, never homeless mothers (Bassuk et al., 1996).

In the RWJF/HUD Homeless Families Program (Rog et al., 1995b), 26 percent of the mothers reported having two or more health problems in the past year, and 31 percent characterized their health as poor or fair. Likewise, in the more recent CMHS/CSAT Homeless Families study, 44 percent of the women reported their health as being only fair, poor, or very poor when they entered the study, and 43 percent indicated that they had needed some sort of medical services in the prior three-month period (Rog, Rickards et al., in press; Rog, 2004). Despite the reported poor health, in both of these studies most women report having had some access to health services while homeless: 75 percent in the RWJ Homeless Families Program, typically through Medicaid (Rog et al., 1995b), and 81 percent in the CMHS/CSAT Homeless Families Project (Rog, 2004).

A significant unmet health need among homeless families is dental services. The RWJF/HUD Homeless Families program found that 62 percent of the families needed dental services at baseline, while only 30 percent reported receiving services prior to entering the program (Rog & Gutman, 1997). Similarly, in the more recent CMHS/CSAT Homeless Families project, 44 percent of the families reported needing dental services at baseline, and only 28 percent of these families reported receiving dental services in the three months before entering the program (Rog, 2004).

Substance abuse and mental health. Studies differ on overall prevalence of substance abuse and mental health problems among mothers who are homeless and the extent to which these problems may function as risk factors, largely due to how they are defined and measured (including both the actual measure and the time period being assessed) (Shinn & Bassuk, 2004). Whatever the measurement, it is clear that the nature of the problems is far different than for single adults who are homeless.

Data from the WFRP indicates that homeless families are more likely than other low-income families, but less likely than individuals who are homeless, to report abusing substances (Bassuk, Buckner et al., 1997; Burt et al., 1999). Rates of reported lifetime use of substances range from 41 percent (Bassuk et al., 1996) to 50 percent (Rog et al., 1995b). Rates are much lower for current use as exemplified by a reported illicit drug use of 5 percent in the WFRP (Bassuk et al., 1996) and a 12 percent rate of illicit drug use in the past year in the Rog et al. 1995b study. Heavy use of alcohol or heroin over the prior two years was found to be a risk factor for homelessness in the WFRP (Bassuk, Buckner et al., 1997). Similarly, recent reanalyses from the Fragile Families dataset (involving low-income mothers who have recently given birth) suggest that substance abuse is a risk factor for homelessness, with families who report experiencing recent homelessness having higher rates of substance use than families who remain stably housed (Rog & Holupka, unpublished).

Depression among mothers who are homeless is relatively common, as it is for low-income women generally, while psychotic disorders are rare (Bassuk et al., 1998; Shinn and Bassuk, 2004). In the reanalysis of the Fragile Families data, reports of mental health issues were related to becoming homeless and their absence related to stability (Rog et al., 2007). Forty-six percent of families experiencing homelessness in Year 1 of the study reported feeling sad or depressed two or more weeks in a row, compared to 12 percent of the families who remained stably housed during that time. Comparable percentages were found at the Year 3 follow-up.

Given the high levels of stress and the pervasiveness of violence, it is not surprising that mothers who are homeless have high lifetime rates of posttraumatic stress disorder (PTSD) (3 times more than the general female population), major depressive disorder (2.5 times more than the general female population) and substance use disorders (2.5 times more than the general female population) (Bassuk et al., 1998). Bassuk and colleagues (1996, 1998) found, however, few differences between homeless and low-income housed mothers. Thirty-six percent of homeless mothers and 34 percent of low-income housed mothers had lifetime prevalence of PTSD and 18 percent of homeless mothers compared to 16 percent of low-income housed mothers reported current PTSD.

In addition, between one-quarter and one-third of mothers who are homeless report at least one lifetime suicide attempt (Bassuk et al., 1996; Rog et al., 1995b). In fact, Rog and Gutman (1997) reported that a majority of the mental health hospitalizations reported by women in the RWJF/HUD nine-city evaluation were related to suicide attempts.

Finally, it is important to recognize that many women who are homeless face multiple problems and issues. In the WFRP, the most common current co-occurring disorders found were major depression, substance use disorders, anxiety disorder, and PTSD (Bassuk et al., 1998; Shinn & Bassuk, 2004). In addition, Rog and her colleagues (1995b) noted that 80 percent of the homeless women had current needs in at least two of three areas examined: human capital (poor education or lack of a job), health, and mental health (including substance abuse and trauma-related issues). One-quarter of the women had issues in all three areas.

Residential instability. Family homelessness is perhaps most aptly described as a pattern of residential instability. Homeless episodes are typically part of a longer period of residential instability marked by frequent moves, short stays in one's own housing, and doubling up with relatives and friends. As an illustration, in the 18 months prior to entering a housing program for homeless families in nine cities, families moved an average of five times, spending 7 months in their own place, 5 months literally

homeless or in transitional housing, 5 months doubled up, and 1 month in other arrangements. Overall, one-half (53 percent) had been homeless in the past. It is important to note, however, that this sample of families was not random, but consisted of families selected for a variety of service needs, with prior homelessness a selection criterion at some of the study sites (Rog & Gutman, 1997).

Other studies document the lack of stability that the families experience both before and after experiencing homelessness. For instance, Shinn and colleagues (1988) documented that many families on the precipice of homelessness for the first time had never established themselves in stable permanent housing. Before entering shelter, doubling up with other families was common as were moves from one overcrowded living arrangement to another. At-risk families who had been able to obtain a housing subsidy were much more residentially stable and less likely to enter shelter. In a more recent study of newly homeless families in eight sites across the country who were screened as having mental health and/or substance abuse problems, the families spent less than one-half of the prior six months in their own homes (Rog, 2004). Staying with relatives or friends is often found to be the most common living situation prior to entering shelter (Lowin et al., 2001; Rog, 2004). The length of time families stay homeless is a function, in part, of shelter limits on stay and the availability of affordable housing. Families with limited incomes have few housing choices. As discussed later in this paper, there is substantial evidence that subsidized housing plays a major role in reducing homeless stays and in ending homelessness for a majority of families.

To date, there have not been any conceptual models developed, or research conducted, that help to explain the manner in which risk and protective factors for homelessness among families interrelate. Presumably, there is a class of distal as well as a class of proximal mediating variables that can be delineated in efforts to explain pathways into homelessness. Distal variables for a homeless mother could include history of childhood abuse, foster care placement, and other disruptive experiences early in life. These distal factors could affect mediating variables such as recent substance abuse, mental health issues, and conflict within the social network, which in turn play roles in affecting a person's vulnerability to becoming homeless. In addition, recent research (Rog & Holupka, unpublished) suggests that the absence of protective factors (e.g., having housing assistance, having another adult living in a household) combined with having mental health and substance abuse concerns makes it difficult for vulnerable families to stay residentially stable and heightens their risk of homelessness.

What is the Toll of Homelessness on Children Living With Their Families?

The year 1987 marked the beginning of published studies that focused on homeless children living with their families. Four years later, a sufficient amount of research had been conducted to warrant a review article by Rafferty and Shinn (1991). This "first generation" of research on homeless children called attention to a growing number of youngsters who were living in shelters and clearly at risk for developing problems. Unlike the studies of families that sought to understand what placed certain families at greater risk of homelessness, the focus of these studies was to determine the impact of homelessness on children. The early investigations documented demonstrable problems that children were having in various areas of functioning, such as health, developmental status, mental health and behavior, and academic performance (cf. Alperstein, Rappaport, & Flanigan, 1988; Bassuk & Rubin, 1987; Miller & Lin, 1988; Rescorla, Parker, & Stolley, 1991; Wood et al., 1990).

As noted earlier, the findings from these initial studies helped spawn a second generation of studies on homeless children, funded by a variety of public and private sources, conducted in the early to mid-1990s (cf. Bassuk, Weinreb et al., 1997; Buckner & Bassuk, 1997; Buckner et al., 1999; Buckner, Bassuk, & Weinreb, 2001; Garcia Coll et al., 1998; Masten et al., 1993; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Schteingart et al., 1995; Weinreb et al., 1998; Zeismer, Marcoux, & Marwell, 1994). As a group, these studies were stronger due to greater sample sizes and improved methodology. Again, their dominant focus was to further an understanding of the impact of homelessness on various dimensions of child functioning.

This second wave of studies on homeless children did not generate as clear a pattern of results as the first set of investigations. The most consistent and uniform finding across these studies was the detection of elevated problems among both homeless and low-income housed children compared to children in the general population (using normative data). This appears to be due to the effects of poverty-related risk factors that low-income children, whether currently homeless or in housing, have in common. What was not consistently found across this second wave of studies was an additional elevation in problems among homeless children in comparison to low-income housed children. In other words, these latter studies seldom found negative effects in children that could be attributable to the experience of homelessness, per se.

Impact on mental health and behavior. At least seven publications since 1993 have examined the impact of homelessness on the mental health and behavior of children. Of these studies, Masten et al. (1993) in Minneapolis, Ziesemer et al. (1994) in Madison, Wisconsin, and Schteingart et al. (1994) in New York City reported *no* differences between homeless study participants and their low-income housed counterparts on various indices of mental health, principally the Child Behavior Check List (CBCL) and the Children's Depression Inventory.

In the WFRP, Bassuk, Weinreb et al. (1997) found that homeless preschool-age children had higher elevated "externalizing" problem behaviors (e.g., aggressive behavior) as measured by the CBCL than low-income housed children, but did not find significant differences on the "internalizing" (e.g., depressive, anxious, and withdrawn behavior) subscale. Conversely, Buckner et al. (1999) found the opposite among school-age children in the Worcester study (significantly worse scores for homeless children on the internalizing subscale of the CBCL but not on the externalizing subscale). Assessing mental health problems in a diagnostic manner using DSM-III-R criteria, Buckner and Bassuk (1997) found that homeless and low-income children age 8 years and older in the Worcester study had nearly identical current prevalence rates for psychiatric disorders (about 32 percent), a rate much higher than the 19 percent prevalence found among children in the general population (Shaffer et al., 1996). So, while these second-generation studies of homeless children documented a poverty-related effect on children's mental health/behavior (i.e., data on low-income children, whether homeless or housed, looked worse than normative data), effects due specifically to homelessness-related factors were much harder to detect.

Impact on education-related problems. There has been a somewhat more consistent pattern of findings across studies in the realm of education-related problems and outcomes. When the crisis of family homelessness emerged in the 1980s, most school systems were unprepared to deal with the complex needs of homeless children. Many homeless children were denied access to education, with school districts claiming that families living in shelter did not meet permanent residency requirements and therefore were not eligible for enrollment (Rafferty, 1995). Other impediments to school attendance included immunization requirements, availability of records, and transportation to and from school

(Stronge, 1992). If homelessness causes children to miss school, such absence will likely be detrimental to their academic performance. As part of the Stewart B. McKinney Homelessness Assistance Act, which Congress passed in 1987, the Education of Homeless Children and Youth (EHCY) program was established to ensure that homeless children had the same access to public education as other children.

Studies of homeless children conducted prior to and shortly after the creation of the EHCY program have consistently documented disrupted school attendance and academic underperformance (Bassuk & Rubin, 1987; Masten et al., 1993; Masten et al., 1997; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Zima, Wells, & Freeman, 1994). Since then, the EHCY program has provided formula grants to state educational agencies to review and revise policies that may act as barriers to school enrollment and attendance in addition to funding direct services such as transportation and tutoring.

Anderson, Janger, and Panton (1995) conducted a national evaluation of the EHCY program and found that over 85 percent of homeless children and youth were regularly attending school, indicating a marked improvement in school access compared to pre-EHCY program attendance rates. Similarly, Buckner, Bassuk, and Weinreb (2001) found no evidence of higher school absenteeism or lower academic achievement scores among homeless school-age children in the Worcester study as compared to low-income housed children. Children in each group had missed an average of six days of school in the past year and scores on a composite measure of academic achievement were identical for both groups. Rates of school suspension, grade retention, and special classroom placement were actually higher in the housed comparison group. This lack of differences in the Worcester study on school- and education-related variables suggests that the EHCY program has been successfully implemented in that city, as evidenced by similar absenteeism rates between the homeless and housed school-age children. What this study illustrates is that the ability of researchers to detect an effect of homelessness on children may depend in part on the historical context; that is, the timing of the study in relation to the societal response that has arisen to address the problem.

Impact on development. This inconsistency in study results concerning the impact of homelessness extends to findings on the cognitive and motor development of young homeless children. Two of the three studies that have addressed this domain are first-generation studies and the third, a second-generation project. The first two studies (Wood et al., 1990: Bassuk & Rosenberg, 1990) found a greater proportion of developmental delays among the homeless preschool children than comparison groups of low-income housed children. Both used the Denver Developmental Screening Test, an instrument that focuses on reports about the child by a parent or guardian. The third study (Garcia Coll et al., 1998) employed the "gold standard" measure of developmental status in infants and young children, the Bayley Scales of Infant Development, which involves direct observation and interaction with a child by a tester who has undergone specialized training. In contrast to the earlier two studies, Garcia Coll et al. found no differences in developmental status between homeless and low-income housed infants/toddlers on the Bayley. Moreover, scores on the Vineland Screener (a measure of adaptive behavior that asks a parent about a child's communication, daily living, socialization and motor skills) were almost identical between the two groups.

Impact on health. The studies of Alperstein, Rappaport, and Flanigan (1988) in New York City and Miller and Lin (1988) and Wood et al. (1990) in Los Angeles represent the earliest studies of homeless children that assessed health outcomes. Each of these investigations found a higher prevalence of health-related problems compared to low-income housed children or children in the general population. A second-generation study (Weinreb et al., 1998) with more methodological rigor than prior studies

compared 293 homeless children ranging from 2 months to 17 years of age to 334 low-income housed (never homeless) children and also found greater frequency of health problems among homeless children. Only one study, Menke and Wagner (1997), did not show differences on health-related outcomes between homeless and low-income housed groups of children.

Summary of impact of homelessness. Past studies have been somewhat mixed in their findings on the impact of homelessness on children, especially when comparing homeless to low-income housed children. While the magnitude of severity of problems found among homeless (and low-income housed) children tends to be in the mild to moderate range in the short term, in virtually all instances these two groups of low-income children look worse on various outcome measures compared to children in the general population. Very little research has gauged the impact of homelessness over the longer term, but the evidence suggests that any short-term impact dissipates after several years. A two year follow-up of homeless children in the WFRP indicated that exposure to violence had a much more pronounced negative effect on school-age children's mental health than did history of homelessness (Buckner, Beardslee, & Bassuk, 2004). Similarly, Shinn et al. (in press) found, across a broad age range, that formerly homeless and housed children in New York City looked quite similar to each other on indices of health, mental health, IQ, and academic achievement approximately 55 months after the initial shelter entry of the homeless group. These investigators, however, did find elevated internalizing and externalizing behavior problems at follow-up among a subgroup of children who were homeless when they were infants and toddlers as compared to their housed counterparts.

Due to the lack of consistency across the studies that have been conducted, all that can be reasonably concluded from the scientific evidence at this stage is that homelessness (when meant as a stay in a family shelter) can have a detrimental short-term impact on children, but not in all instances. Homelessness can function as a "marker of risk" for children, meaning that children who are homeless are likely going to have a higher prevalence rate of problems than similar age youths in the general population, but not necessarily higher against a comparison of similarly poor, but housed children.

Differences among the studies from the first to second generation also suggest that some of the improvement in children's outcomes may be due to the much greater societal response to the problem of homelessness than was the case when the earliest studies were undertaken. The McKinney-Vento Act programs and improvements to family shelters have likely buffered some of the negative impact of homelessness.

In addition, the structural backdrop of homelessness, as noted, likely complicates what can be attributed to the impact of homelessness on children. Because homelessness among families is largely due to a structural imbalance between the supply and the demand for affordable housing, those most vulnerable to homelessness are those least able to compete for the scarce supply of available affordable housing (Buckner, 1991, 2004a; Shinn, 1992). In the beginning stages of a protracted housing shortage, it is likely that the most vulnerable families will become homeless first—those with significant problems or issues such as a mental health, substance use, or physical health disorder. As a structural problem worsens over time regarding the demand for affordable housing in relation to the supply, studies of homeless families would likely find differences in rates of problems between homeless and low-income housed families compared to findings of investigations conducted in the early stages of a tightening housing market. The implication this has for homelessness research is that, all other things being equal, in a gradually worsening housing market that takes many years to unfold, early studies may reveal greater problems among shelter residents (adults and children) than do later studies. In addition, if there are other factors

that determine which families entered shelter, these also could have a role in influencing children's mental health (or other aspects of child functioning). As a result, the status of being homeless, itself, may not be the reason or only reason for the heightened problems seen among children living in shelter.

Researchers who have examined the impact of homelessness on children have also had to grapple with the difficulty of trying to demarcate where the effects on children of poverty-related sources of risk end and homelessness-specific risks begin. Children from low-income families, whether homeless or housed, face an array of chronic strains (e.g., hunger, feeling unsafe) and acute negative life events (e.g., exposure to community and domestic violence) that stem from the broader conditions of poverty. In terms of exposure to such risk factors, homeless and low-income housed children differ far more from children in the general population than they do from one another. Despite their current housing status being dissimilar, homeless children and low-income housed children have many more similarities than differences in terms of the extent and nature of adversities to which they have been exposed (cf. Masten et al., 1993; Buckner et al., 1999). Even regarding housing status, it is important to note that homelessness is a temporary state through which people pass, not a permanent trait emanating from individual deficits (Shinn, 1997). Moreover, housed low-income children can often be found living in rundown and decrepit dwellings, thereby reducing the contrast between them and children living in shelter. When viewed in the context of a much broader range of adversities, it is apparent that *homelessness is but one of many stressors that children living in poverty all too frequently encounter*.

Ending Homelessness for Families: Evaluations of Different Housing Approaches

The research directly focused on housing interventions for homeless families has been largely limited to several descriptive evaluations, including evaluations of:

- housing and supports for families with histories of homelessness and other difficulties, such as the nine-city RWJF/HUD demonstration of services-enriched housing (Hambrick & Rog, 2000; Rog & Gutman, 1997; Rog et al., 1995a, 1995b), the Minnesota Supportive Housing and Managed Care Pilot (National Center on Family Homelessness, 2006, 2004a, 2004b), and the Charles and Helen Schwab Foundation Family Supportive Housing Initiative (Nolan, Magee, & Burt, 2004; Nolan et al., 2005);
- rapid housing programs for first-time or at-risk homeless families, including the Charles and Helen Schwab Foundation's Housing First Collaborative (LaFrance Associates, 2005); and
- transitional housing, including a descriptive review of a sample of transitional housing programs across the country (Burt, 2006) and an evaluation of the Gates Foundation's Sound Families Initiative (Northwest Institute for Children and Families, 2005).

In addition, findings that inform our understanding of how to improve the residential stability of families have emerged from longitudinal studies that examine factors related to increased stability. In this section, we highlight the main findings that emerge from these evaluations and research efforts.

The Role of Subsidies

Increasing the affordability of housing by affecting the supply and cost of housing or increasing disposable income by increasing wages or subsidizing costs of housing, childcare, food, and other

essentials would likely prevent homelessness among low-income families as well as end it for the majority who enter shelters. The findings of studies conducted during the 1990s with respect to the role of subsidies and affordable housing in ending family homelessness provide undeniable evidence for the role these supports can play.

In the WFRP, Bassuk, Buckner et al. (1997) found that, controlling for other explanatory variables, cash assistance in the form of AFDC and housing subsidies in the form of Section 8 vouchers or certificates were important protective factors. Ninety-three percent of low-income housed families had received cash assistance in the past year as compared to 72 percent of homeless families in the year prior to their homeless episode. For housing subsidies, these respective figures were 27 percent and 10 percent.

Other studies have indicated that the strongest predictor of exits out of homelessness for families is subsidized housing (Shinn et al., 1998; Zlotnick, Robertson, & Lahiff, 1999). In a longitudinal study of first-time homeless families and a comparison random sample of families on public assistance, residential stability five years after initial shelter entry was predicted only by receipt of subsidized housing (Shinn et al., 1998). Eighty percent of the formerly homeless families who received subsidized housing were stable (i.e., in their own apartment without a move for at least 12 months), compared to only 18 percent who did not receive subsidized housing (Shinn et al., 1998). Additional studies have found that families receiving subsidized housing upon discharge from shelter are less likely to return to shelter than families receiving some other type of placement (Stretch & Krueger, 1992; Wong, Culhane, & Kuhn, 1997). Similarly, after a policy of placing homeless families in subsidized housing was adopted in Philadelphia, the number of families entering shelter who previously had been in shelter dropped from 50 percent in 1987 to less than 10 percent in 1990 (Culhane, 1992).

Demonstration initiatives studying supportive housing with different intensities of services also found high stability rates, regardless of the intensity of the services received. In the nine-city RWJF/HUD study in which homeless families received both Section 8 certificates and various intensities of case management services across the nine sites, 88 percent of the families accessed and remained in permanent housing for up to 18 months (based on 601 families in six sites where follow-up data were available) (Rog & Gutman, 1997). This finding was replicated in a 31-site study of families in the Family Unification Program who received Section 8 certificates and child welfare services. Eighty-five percent or more of the families in each site were still housed after 12 months, despite different eligibility criteria and services across the sites, among other differences (Rog, Gilbert-Mongelli, and Lundy, 1998). Weitzman and Berry (1994), in a smaller study in New York City in the early 1990s, examined an intervention very similar to the RWJF/HUD intervention, involving subsidized housing coupled with short-term intensive case management compared to a group that received subsidized housing but no special services. At the end of a one-year follow-up period, the vast majority of families in both groups were housed, and less then 5 percent had returned to shelter. The type of subsidized housing received was the strongest single predictor of who would return to shelter, with families in buildings operated by the public housing authority more stable than those in an alternative city program (Weitzman & Berry, 1994).

The evaluation of the Welfare to Work Voucher Program (HUD, 2004; 2006) provides additional evidence for the effects of tenant-based rental assistance on self-sufficiency. Although the program is not specifically targeted to homeless families, it is targeted to families living on welfare who have a similar demographic profile. The study found that the program resulted in small but significant improvements in the quality of neighborhoods where people lived and that the vouchers greatly reduced a family's probability of becoming unstably housed or homeless.

Finally, examinations of transitional housing suggest that subsidies play an important role in successful transitions for many families. The preliminary evaluation of the Sound Families Initiative in the greater Seattle area indicated that 70 percent of families exiting did so with a Section 8 voucher (Northwest Institute for Children and Families, 2005). Moreover, the report concluded that nearly all families needed some type of housing subsidy to secure permanent housing, and in some cases families needed to stay in the transitional housing longer when there were reductions in voucher availability. In a review of 53 transitional housing programs across five communities, Burt (2006) found that, on average, 35 percent of those leaving transitional housing left with a subsidy (about half of those going into permanent housing). The percentage ranged by community, with the highest percentage being in Seattle/King County, coinciding with the Sound Families evaluation findings (Northwest Institute for Children and Families, 2005).

Although housing subsidies appear to be a critical resource for exiting or preventing homelessness, a small percentage of families go back to shelters after receiving subsidized housing. In the New York City follow-up study, 15 percent of 114 families who obtained housing subsidies returned to shelters at some point during the five-year follow-up period (Stojanovic et al., 1999); in the RWJF/HUD nine-site evaluation, 11 percent of the families entering shelter had previously received a subsidy. In the New York City study, reasons for leaving subsidized housing included serious building problems—safety issues, rats, fire or other disaster; condemnation; or the building's failure to pass the Section 8 inspection. In the RWJF/HUD study, informal discussions with city officials suggested that families may return to shelter because of failure to renew Section 8 certificates for a variety of reasons.

Need for More Information on Matching Interventions with Need

There have been no studies that compare the effectiveness of different types of housing approaches—transitional housing, permanent supportive housing, or permanent housing—for homeless families. The descriptive studies conducted to date focus on one approach and universally note the importance of affordability in housing. Almost all evaluations also describe the variability of implementation of the housing model. For example, as Burt (2006) notes, there is no standard model of transitional housing—the programs vary greatly with respect to who is served, services provided, the configuration of the housing, and the length of the programs, among other variables. Similarly, Rog and colleagues (1995a) found that even in a demonstration program that stipulated a services-enriched housing model, there was great variation among and within service sites as to the intensity of the case management provided. To date, there have been no studies examining the type of housing and service mix best suited to families with different needs. There have been no comparative studies of models, or studies that systematically varied the intensity of services. What does exist are descriptive evaluations of different housing models for specific subgroups of families, generally families with prior episodes of homelessness and other needs who may need supports. The most recent and current evaluations are described below.

The Minnesota Supportive Housing and Managed Care Pilot, a demonstration project funded by the state of Minnesota and administered by the Hearth Foundation, serves single adults and families with histories of homelessness exacerbated by other difficulties. The housing provides a range of supports to those living in the subsidized housing. A multi-pronged evaluation is being conducted by the National Center on Family Homelessness, and includes a multi-year qualitative study, a cost study, an adult outcome study, and a study on the children in the families. Preliminary data indicate dramatic increases in days spent in their own housing despite struggles with deep-seated problems (National Center on Family Homelessness, 2006, 2004b).

Similarly, in a descriptive evaluation of the Family Permanent Supportive Housing Initiative funded by the Charles and Helen Schwab Foundation (Nolan et al., 2005; Nolan, Magee, & Burt, 2004), which also targets families with substantial prior homelessness (an average of four prior episodes and four years homeless), families realized substantial subsequent residential stability, having lived in their current supportive housing residences for an average of 2.2 years at the time of the evaluation.

Finally, the Charles and Helen Schwab Foundation Housing First Initiative was designed to rapidly house and help maintain the stability of at-risk families who did not have a prior history of homelessness or significant barriers to housing (including active substance abuse, recent domestic violence experience). The evaluation of the initiative (LaFrance, 2005) found that 88 percent of the families targeted had been successfully housed in Section 8 or market rate housing, and the time it took to become housed had been significantly reduced. Year 1 outcomes indicated that only one family housed had lost the housing. This program also provided housing search assistance, move-in and other financial assistance, and home-based case management.

In sum, the evaluations to date of housing interventions all note improvements in housing stability, and often improvements in other outcomes (e.g., income; child school attendance), for the families they serve. However, without comparative information, we still lack knowledge of what level of housing and assistance is needed by whom to acquire and remain in housing.

Ameliorating the Problems Homeless Families Face

The major examination of services for homeless families that has occurred since 1998 is the Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) Homeless Families Program, a five-year, two-phased, multisite study initiated in 1999 to advance knowledge about the effectiveness of interventions for homeless mothers with psychiatric and/or substance abuse disorders who are caring for their dependent children (Rog, Buckner al., in press). It was specifically designed to be the first multisite evaluation of the effectiveness of innovative interventions, compared to services as usual or alternative interventions, in addressing the particular treatment and service needs of homeless families.

The focus of the target intervention in each site in the CMHS/CSAT Homeless Families Program was to be a time-limited (i.e., no more than a nine-month period of intensive services) intervention aimed at meeting the psychiatric, substance abuse, and/or trauma services needs of homeless women with children. The interventions were to be existing programs in the community, but could be enhanced. All target interventions were to be multifaceted, involving a combination of services focused on mental health treatment, substance abuse treatment, trauma recovery, securing and maintaining housing, parenting skills, household and money management, and goal setting.

Despite having a common set of core parameters, the target intervention models varied widely across the eight sites. Most sites involved some form of "intensive case management," but combined that approach with other services in various settings. Three sites used more comprehensive service approaches, including (1) a multidimensional family assistance intervention in which families were provided with multisystemic therapy both in the shelter and in their residence (Henggeler et al., 1998), (2) multiple services (i.e., family-centered case management, home-based parent support, education and skills training, and child-focused interventions such as primary care) through a Comprehensive Family Health

Practice within a community health center, and (3) a family therapeutic community in a residential substance abuse treatment program that was enhanced with trauma recovery and aftercare components.

Results from the CMHS/CSAT initiative are currently being analyzed and reported. Overall, the study did not find any effects of the target interventions on a range of outcomes for the homeless families compared to services as usual (e.g., Pearson et al., in press; Rog, Buckner et al., in press; Sacks et al., in press). However, for substance abuse and mental health outcomes, having more on-site services in these areas was associated with greater improvements for all families, and especially for families with clinical-level need for substance abuse and mental health services (Pearson et al., in press; Rog, Buckner et al., in press) Homeless mothers in programs that provided more on-site mental health services, such as having a psychiatrist or psychologist on site and having designated mental health providers who could provide an array of mental health services in the shelter or other setting where the families resided (e.g., residential treatment), experienced a greater decrease in their mental health symptoms than mothers who were in programs that had fewer on-site services and/or relied on referral services. Similarly, homeless mothers in programs with on-site substance abuse services reported less substance use over time than mothers in programs with fewer on-site services.

In addition, because of the multisite study's longitudinal design, it was possible to examine trajectories of change over time and to examine the role of other time-varying conditions on families' outcomes. On most outcomes, families in both the target and comparison conditions on average had a positive rate of change. However, for each outcome, there was a substantial segment of families who started with mental health problems severe enough to warrant treatment and who did not show improvement over 15 months. Across outcomes, reports of ongoing trauma and network conflict were associated with less improvement, whereas employment was associated with more improvement (e.g., Pearson et al., in press; Rog, Buckner et al., in press; Sacks et al., in press). These findings suggest the need for not only understanding the history of problems families have as they enter shelter and other settings, but also the struggles they continue to experience that may be interfering with their ability to progress.

Interventions Focused on Homeless Children

There continue to be a limited number of evaluations of interventions that target homeless children (or their mothers) in an effort to improve their well-being. A few studies have evaluated school-based or summer program interventions for homeless children (Nabors, Weist et al., 2004; Nabors, Sumajin et al., 2004). More recently, Buckner et al. (in press), examined the effectiveness of multifaceted, mother-focused interventions on improving the behavior of children who participated in the eight-site CMHS/CSAT Homeless Families Program Initiative. Data were collected at four time points (an initial assessment followed by three similar assessments 3, 9, and 15 months later) on 1,103 children, ranging from 2 to 16 years of age, who were living with their mothers. Hierarchical linear modeling was used to examine whether intervention status, programmatic emphases, and other factors predicted rate of change in behavior problems over time. While the results indicated that, overall, children's problem behaviors improved over time, neither treatment status (target intervention versus comparison intervention group) nor programmatic emphases were associated with change in problem behaviors either within or across the eight sites. Consistent with previous research, measures of the mother's psychological distress as well as parenting practices were found to be good independent predictors of child behavior problems. Results from this study indicate that further research and program development are needed to identify effective strategies for addressing the mental health and behavioral needs of homeless and low-income children.

Preventing Homelessness

Targeting Families for Prevention

The importance of subsidies in reducing the risk of family homelessness among poor families strongly suggests that increasing the amount and access to these benefits to such families would likely result in a lower incidence rate of family homelessness. Policies to reduce the cost of housing, thereby making it more affordable, are also important. Broad-based efforts to help families pay the cost of housing and to lower such costs are needed to prevent family homelessness.

However, preventing family homelessness in a more targeted fashion by selecting low-income families who are most at risk to be recipients of a preventive intervention remains difficult at this time. This is due both to the difficulty of selecting families who have a very high risk of homelessness and the challenges of ameliorating those risks enough to substantially lower the probability of their becoming homeless.

Trying to broadly identify families who are most vulnerable to homelessness—even among extremely low-income people—may be inefficient. In the recent reanalysis of the Fragile Families study (Rog et al, 2007), a longitudinal study of a nationally representative birth cohort of new parents and their children, we found that even among women who are extremely poor (at or below 50 percent of the poverty level), the risk of being homeless is not as large as one might expect. Using a very broad definition of homelessness, fewer than 1 in 10 (8 percent) of the women in this poverty sample indicated that they had been homeless for even one night over a one- to three-year period. This number, however, is tempered by the fact that attrition could account for greater difficulty in locating homeless families or families experiencing residential instability at the time the interviews were being conducted. Despite at least 20 telephone or in-person attempts made with each eligible woman (Knab, personal communication), the study lost 11 percent of their baseline sample at Year 1, and 14 percent in Year 3, with only 6 percent missing both follow-ups. Approximately half of the missing cases were due to women refusing to be interviewed, being too ill to be interviewed, being incarcerated and unavailable to be interviewed, or being no longer eligible to be interviewed (e.g., parent or focus child was now deceased), while the rest were missing because they could not be located or had moved out of state[1]. If the assumption is made that the group of respondents who could not be located were all homeless, the upper bound for the percentage of women homeless increases to 23 percent for those who are in the poverty sample (Rog and Holupka, unpublished). Attrition analyses also indicated that among the factors that were significant predictors of missing data, several factors, including greater likelihood of reporting baseline substance use and domestic violence and less likelihood of receipt of TANF and/or Food Stamps at baseline, may suggest some level of vulnerability among those missing in Year 3 to being homeless. There are other factors, however, such as one site having greater attrition, that may have more to do with methodology and less with the personal characteristics of the individuals. Even with this upper bound of homelessness, however, fewer than one in four families living at 50 percent of the poverty level or less would be expected to experience homelessness within a three year period.

Similarly, Shinn and colleagues (1998), in their New York City study, needed 20 predictors to distinguish new applicants for shelter from the public assistance caseload in 1988. They were able to build a model

[1] For the Year 1 interview, 50 percent of the missing interviews were due to problems locating the respondent; in Year 3, 56 percent were missing for these reasons.

that correctly identified 66 percent of shelter entrants while targeting 10 percent of the public assistance caseload. With a large public assistance caseload, however, even 10 percent misidentified as needing services means that four families who would not become homeless would be identified for every family who would receive homeless services; thus 80 percent of services would be wasted. In addition, any model based on a single risk factor would do more poorly and a complicated model such as the one used by Shinn and her associates would be impractical.

Bassuk, Weinreb, Dawson, Perloff, & Buckner (1997), in their multivariate analyses of risk and protective factors that distinguished homeless from low-income housed families, also relied on a number of different variables. Their findings indicate that there are multiple sources of risk for family homelessness (in the realms of mental health, substance use, social supports, housing history and lack of subsidies) and that there is no one standout risk factor that, if ameliorated, would substantially lower the incidence rate of family homelessness.

Thus, targeting families based on their needs, such as domestic violence, mental health, and substance abuse, is likely not to be fruitful given the equally high rates for low-income families generally. In addition, none of these factors predicted shelter entry in New York, when other factors, primarily demographic characteristics and housing histories, were taken into account (Shinn et al., 1998).

Based on the research to date, two groups of families that may be at highest risk are young families and those who have experienced shelter in the past. As noted earlier, studies have consistently shown that homeless families are younger than other low-income families (Shinn & Weitzman, 1996). One possibility of identifying families at risk is to assess the housing assistance needs of pregnant women and mothers of newborns using health clinics serving low-income families. Housing loans and assistance to pregnant and new mothers, such as through WIC (the Women, Infant, and Children Food and Nutrition Information Program) and subsidized child care might help reduce burdens that contribute to financial problems that can lead to homelessness.

In addition, there is a small subgroup of families who return to shelter, even after receiving subsidized housing. In New York, families who left subsidized housing to return to shelter did so primarily because of serious building problems or safety issues (rats, fire or other disaster, condemnation, or the building's failure to pass the Section 8 inspection) (Stajonovic et al., 1999). Thus, efforts to assure the quality of housing to which families go might lower shelter return rates. Finally, poor families with many competing financial pressures may benefit from subsidies paid directly to landlords, to aid in making housing the first priority.

Another approach to preventing homelessness is to select families on the basis of the neighborhoods in which they live. In Philadelphia and New York, between three-fifths and two-thirds of families entering shelter over an extended period came from identifiable clusters of census tracts (Culhane, Lee, & Wachter, 1996). Geographic-based prevention could include a range of environmental- and individual-focused efforts, including housing construction or rehabilitation, job development and training, child care that permits mothers to take jobs, substance abuse treatment, and so forth.

Community-Wide Prevention

To learn about effective prevention strategies, the U.S. Department of Housing and Urban Development funded a study to identify communities that have implemented communitywide prevention strategies with

documented effectiveness and to describe and review these strategies and the supporting data (Burt, Pearson, & Montgomery, 2005). Six communities were ultimately selected, three for their primary prevention strategies for families: Hennipen County, Minnesota; Montgomery County, Maryland; and five counties in the Kansas City metropolitan area. These three communities targeted families with short-term problems that could be resolved with the resources they had available. Communities offered cash assistance to prevent eviction and pay back rent, utilities, and mortgage, as well as other in-kind assistance and counseling. Other strategies used included mediation services, which help families resolve conflict with various parties; rapid exit strategies, which get families into housing first (or exiting shelters quickly); and programs that use data and research to target families at highest risk of entering shelter for special outreach and assistance (Burt, Pearson, & Montgomery, 2005). The authors also note that there is ample evidence for housing subsidies as a prevention strategy from other studies, though not in their six-community review.

Overall, the study concluded that the most effective prevention efforts were in communitywide systems having elements that affect their ability to target families well (e.g., systems for sharing data); reflect the community motivation and obligation to serve this population; maximize resources, such as agency collaboration; and demonstrate community leadership in setting future direction. Of the three communities studied, Hennepin County was found to have most of the elements and thus had the best potential to prevent homelessness and document its success.

Recommendations for Future Research

Research on Homeless Families

Broader geographic samples. The research base on homeless families has grown over the last decade, but there continue to be significant gaps in knowledge that, if addressed, could bolster our understanding of the needs of families and strategies for preventing and reducing homelessness. One of the limitations of the current research base is that most of the rigorous studies are in selected cities across the country and several are targeted to specific subgroups of families, often those with heightened needs. Thus, there is a need for information on homeless families from broader geographic areas, especially in the Midwest and South and in rural areas. There is also an absence of research on key population groups, including families at risk for homelessness; moderate-need families; families who fall back into homelessness after receiving interventions; families who are working but continue to be homeless; two-parent families; families headed by a single father; families living in extended family networks; and single homeless adults who are noncustodial parents.

Longitudinal designs. Most studies to date, with a few recent exceptions, have had cross-sectional designs. Longitudinal studies are needed to explore the course of residential instability and homelessness over several years, and the individual, contextual, and intervention factors that influence this course. Longitudinal research of at-risk families would also help to differentiate distal risk factors for homelessness from proximal, mediating variables, which serve as risk and protective factors for family homelessness.

Research on housing affordability strategies. The core importance of housing affordability in mitigating homelessness among families and children calls for research on broad-scale housing and income policy interventions. For example, among the interventions that could be studied for effects on

rates of homelessness are varying amounts of housing subsidies; tying income supplements to housing vouchers; and any other mechanisms for increasing incomes and reducing housing costs for young families.

Intervention research. Finally, there is still a large need for research on the match between housing approaches and the needs of families. In particular, there is a need for rigorous data on the role of services in ameliorating the range of health, mental health, child welfare, substance abuse, and other service needs that families may have, especially in the context of providing housing. How much service is needed and by whom? The evaluations to date provide evidence that most tested housing approaches result in increases in housing stability, but there are no studies to date that offer comparative information on different housing and service models. These data are critical to understanding which families need what level of intervention to acquire and keep housing as well as to make strides in other outcome areas (e.g., employment).

The findings from the CMHS/CSAT Homeless Families Project indicate the challenges of devising effective interventions to address the mental health, substance abuse, and housing stability issues of mothers who are homeless (Rog, Buckner, & the CMHS/CSAT Homeless Families Program Steering Committee, in press). Additional intervention development work is needed to learn effective strategies that benefit homeless families in these realms.

Research on Children Who Are Homeless

Understanding the specific homeless experience and its impact. Research conducted to date on children who are homeless has illuminated a fair amount of knowledge on current needs and the impact of homelessness. It would be desirable for future research to address aspects of the homelessness experience that are particularly detrimental to children (Buckner, 2004b). This could help refine the question from *whether* homelessness has an effect to what *aspects* of homelessness are prone to creating problems in what age groups and in what domains. Shelter conditions are probably an especially important factor in moderating the impact of homelessness for a child and research is needed in this area. No doubt, this would be a challenging task and most previous studies have likely not encountered sufficient variability in shelter conditions to examine such issues. Nonetheless, it stands to reason that there are important qualities of shelters that may worsen or buffer a child's experience while living there. These could include the amount of privacy accorded to families, the crowdedness of the facility, the extent to which rules are strictly enforced, the warmth and skill level of shelter staff, the size of the facility, its location, and whether families are asked to leave during the day or may remain on the premises.

In addition, it would be useful to clarify the relative impact that homelessness can have on children in relation to a wider range of negative life events and chronic strains that children living in poverty experience. This would be helpful in better targeting treatment resources and preventive efforts to those low-income children (homeless and housed) most in need.

Research on subgroups of children who are homeless. Likewise, further research on whether there are special subgroups of homeless children with needs would help to determine whether it makes sense to more narrowly target intervention and treatment resources to select children living in shelters. Most of the research to date on children who are homeless has taken a *variable-centered* approach to analyses, focusing on specific areas such as mental health, behavior, and academic performance. Little if any attention has been paid to whether there are subgroups of children with quite different patterns of

functioning *across* these areas of domains. One study that did employ a *person-centered* approach (Huntington, Buckner, & Bassuk, in press) used cluster analysis to determine whether preschool and school-age homeless children could be classified into subgroups based on measures of behavior problems, adaptive functioning, and achievement. Interestingly, two very distinct subgroups were found within each age category: children who were doing reasonably well across each of the three domains (behavior, adaptive functioning, and achievement), and children who were consistently evidencing worse problems or lower functioning in these realms. These results warrant replication in other settings but suggest that children who are homeless, when compared across indices of functioning, are not a homogenous group.

Intervention research. Very little progress has been made in determining effective interventions that specifically target children who are homeless. Evaluations of the impact on children of interventions that primarily focus on the mother as the recipient of services have yet to yield promising leads. If homeless children are to benefit, it is likely that more child-centric intervention strategies will need to be developed and tested.

Parent-child separation. Parent-child separation is an important area that needs further research. The factors that account for child separation from families prior to shelter entrance need to be better delineated. Also, the effects of such separation on children have yet to be investigated. Mostly due to logistical reasons, research on homeless children to date has focused entirely on children who remain with their parent(s) and have not included children who have been separated.

Resilience. It is also worthwhile to understand factors both internal and external to a child that lead to positive outcomes despite the adversities of poverty. Such findings lend themselves to more strengths-based interventions that attempt to promote positive factors as opposed to trying only to eliminate risk factors. Buckner, Mezzacappa, and Beardslee (2003) found two characteristics of homeless and low-income children in Worcester that distinguished those who were resilient from those who were not doing nearly as well on multiple indicators of mental health and adaptive functioning. One of these factors was parental monitoring. A child whose parent(s) engaged in active awareness of where and with whom their child was on a daily basis tended to exhibit more resilience. Another, even more important, variable distinguishing resilient from non-resilient children was an internal set of cognitive and emotional regulation skills that researchers refer to as "self-regulation" (Baumeister & Vohs, 2004). Self-regulation helps an individual accomplish both short and longer term goals and can be important in coping effectively with stress. In the WFRP, children high in self-regulation looked much better across measures of mental health, behavior, adaptive functioning, and academic achievement than children low in self-regulation (Buckner, Mezzacappa, & Beardslee, n.d.). Furthermore, those high in self-regulation appeared to be better able to cope with stressors in their lives. Variables such as parental monitoring and self-regulation offer promising leads for strengths-based interventions to promote resilience in homeless and other low-income children.

Conclusion

This paper provides a summary of the literature on the risk factors and characteristics of homeless families and children as well as a synopsis of what has been learned through tested interventions to reduce homelessness, ameliorate its conditions, or prevent its occurrence. The paper highlights the implications of what has been learned for future prevention, intervention, and research efforts.

Overall, research to date has guided us in understanding the factors that heighten a family's vulnerability to homelessness—largely resources and life stage—and the problems faced by families who experience homelessness. Although certain problems, such as family separations, are greater for homeless families, most of the struggles experienced by homeless families are also experienced by families who are equally poor but remained domiciled. Similarly for children, studies involving both homeless and low-income housed children have consistently uncovered evidence for a "poverty-related" impact on children, that is, finding that both groups have more problem measures compared to children from non-poverty backgrounds. As such, homelessness serves as an important marker of risk for children. Detecting an additional, homelessness-specific, impact in different realms of child functioning has been more difficult.

What we know about intervening is that subsidies have a strong role in reducing homelessness and helping to end it for families who receive them. There has been much less research on strategies for dealing with risk factors or the struggles families cope with on a day-to-day basis. We need to know more about the housing and services that are needed to match the "typology" of families that exist. It may be most advantageous to develop interventions from the "ground up," examining the needs that families have and understanding the possibilities and constraints in the context of implementing different interventions. This may involve developing a theory of intervention based on what we know about the problems families are experiencing and the realities of what is available or can be made available. Clearly, targeting those most in need of services may be the most efficient and worthwhile approach to addressing psychosocial and substance abuse issues. Data collected thus far suggest that most families may improve over time with limited intervention, but there may be a subset of families living in shelters that require much more intensive interventions than are readily accessible.

The low incidence of homelessness even among those who have limited financial means suggests that there is more efficiency in mounting secondary, versus primary, prevention efforts targeted to families at imminent risk of homelessness. Strategies underway that warrant further study include conflict mediation, financial assistance strategies, and other context-specific strategies. This is not to rule out other prevention efforts, as it is clear that many families are living on the edge and precariously housed, but to acknowledge that prevention of imminent homelessness is likely best focused on those who request shelter.

Finally, more research is needed on the course of homelessness and its effects on families, especially on children. These studies need to strive to focus on broader populations of families (i.e., not just those with specified needs) to provide a greater understanding of the needs of various segments of the population and how they may be best met.

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