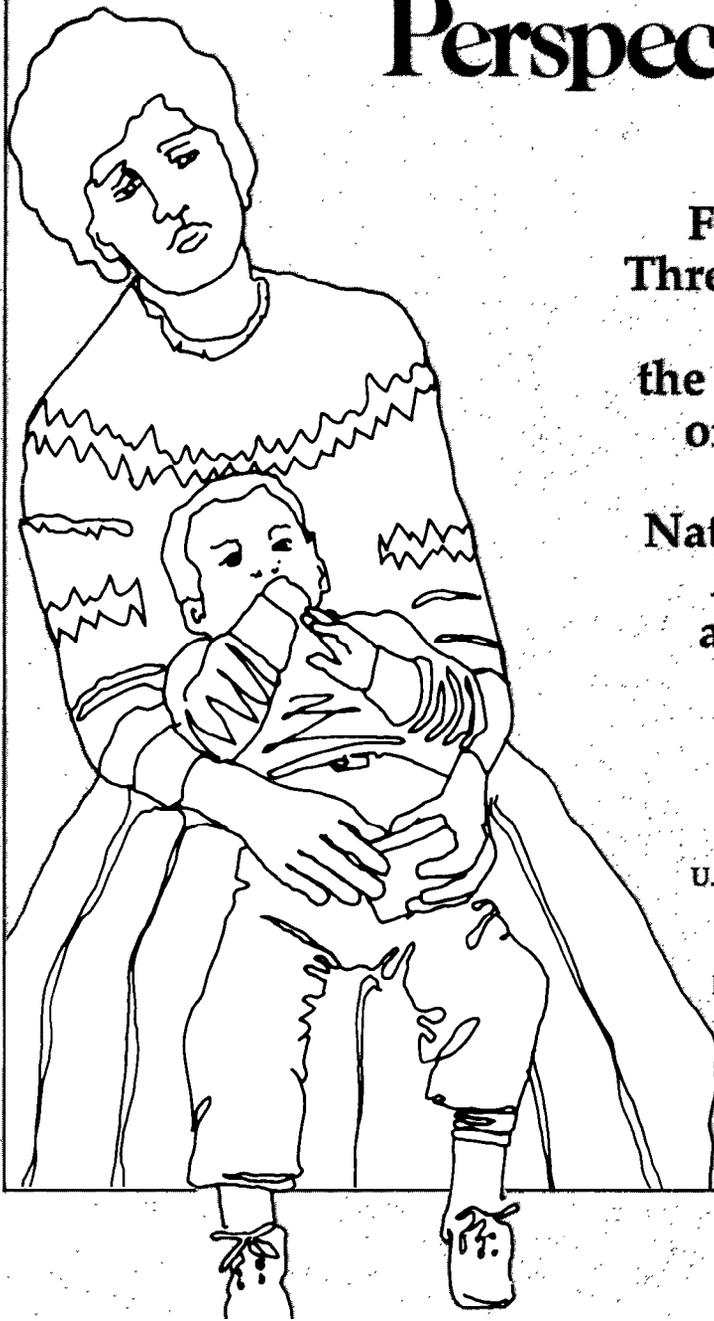


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National Institute on Alcohol Abuse and Alcoholism
National Institute of Mental Health

Homeless Families with Children: Research Perspectives



Final Report of a
Three-Day Conference
Sponsored by
the National Institute
of Mental Health
and the
National Institute on
Alcohol Abuse
and Alcoholism



U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and
Mental Health Administration

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Homeless Families with Children: Research Perspectives

**Final Report of a Three-Day Conference Sponsored by
the National Institute of Mental Health and the
National Institute on Alcohol Abuse and Alcoholism**

January 31 - February 2, 1991

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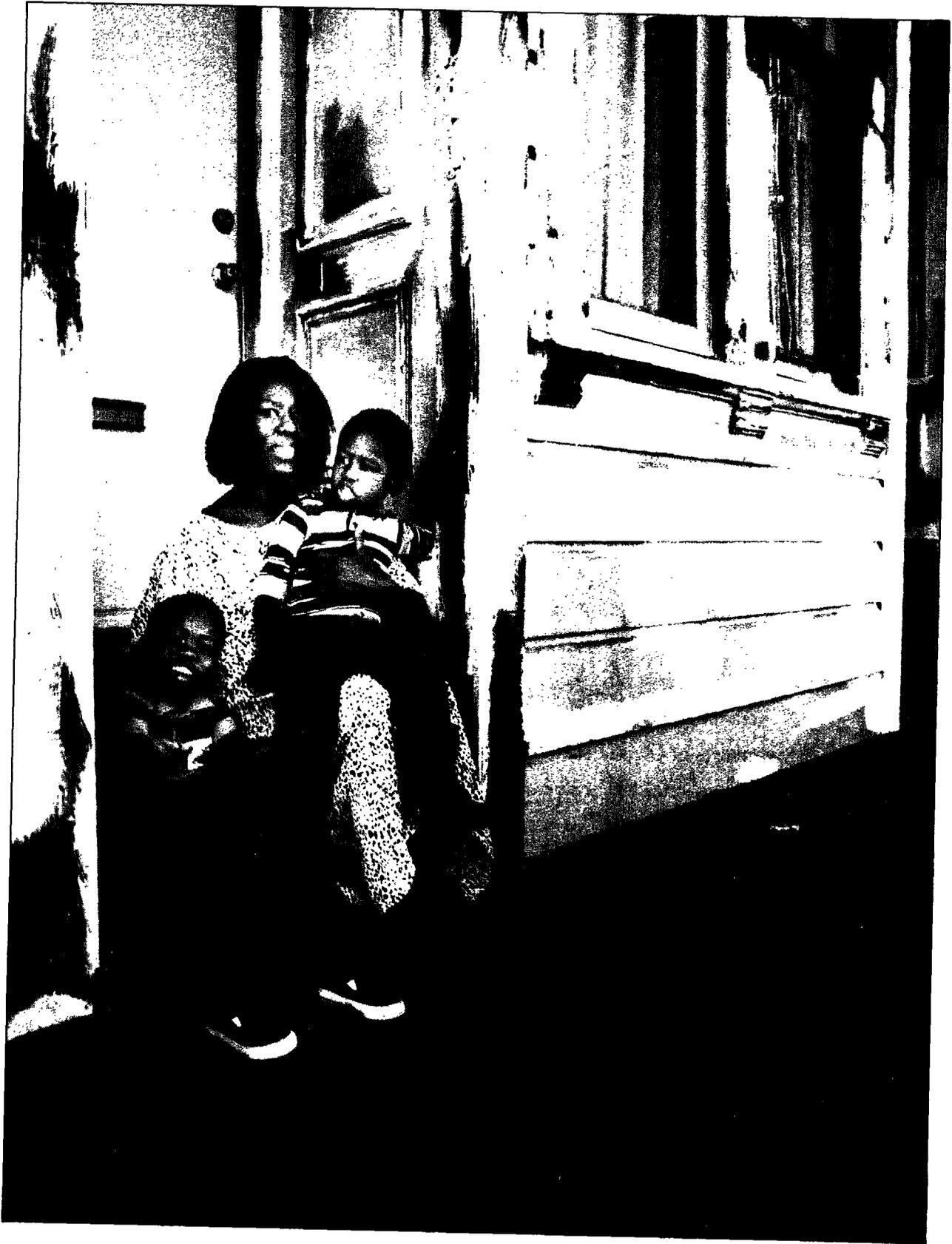
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TABLE OF CONTENTS

Preface	
Acknowledgments	
Executive Summary	
I. Crosscutting Assumptions, Perspectives, and Ideologies	1
A. Conceptions of Home and of Homelessness	.2
B. Views on Causality	3
1. The Importance of Macro-Level Factors: The Contexts of Homelessness	.
2. The Interplay Among Macro- and Micro-Level Factors	.5
3. Micro-Level Variables: Cause or Consequence of Homelessness	.5
4. The Importance of Historical Factors	6
C. Methodological Perspectives	7
1. Identifying Subgroups of Homeless Families	7
2. Using Multiple Comparison Groups	7
3. Developing Appropriate Instrumentation	8
4. Determining Outcomes of Homelessness	9
II. Crosscutting Methodological and Measurement Issues	11
A. Methodological Issues	11
1. Overview	11
2. Study Design	11
B. Measurement Issues	14
III. Summaries of Commissioned Papers	15
A. Introduction	15
B. Housing and Poverty <i>M. Stegman & L. Keyes</i>	15
C. Pathways Into Homelessness: Role of Supports <i>S. Gore</i>	20
D. Homeless Children <i>J. Molnar & D. Rubin</i>	25
E. Parenting <i>C. Hammen</i>	30
F. Family Violence <i>A. Browne</i>	37
G. Substance Abuse <i>E. Smith & C. North</i>	43
H. Mental Health <i>Conference Participants</i>	51
I. Programs and Evaluation <i>L. Weinreb & P. Rossi</i>	.53
IV. Research Recommendations	59
A. Descriptive Research	61
B. Analytic Research	65
C. Instrument Development	67
D. Program Development and Evaluation	.68
Appendix A: Conference Agenda	
Appendix B: Conference Participants	



PREFACE

The number of women with children who are living in homeless shelters, on the streets, or in other precarious housing arrangements has become increasingly apparent to those who are concerned with homelessness and poverty in this country. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Mental Health (NIMH) have supported research on homelessness for a number of years, spanning from studies of skid row alcoholics in the early 1970's, through current studies whose purpose is to obtain a better understanding of the relationship among homelessness, mental illness, and alcohol and other drug problems. As the demographics of the homeless population have changed, the Institutes increasingly have funded research and research demonstration studies that focus on specific homeless sub-populations, including homeless families with children. NIAAA and NIMH currently sponsor research and research demonstration projects which are testing the effectiveness of new treatment methodologies specifically targeted to homeless women, as well as studying risk factors and consequences of homelessness for families with children.

As the problem of homelessness among families with children intensifies, the Institutes have become distinctly aware of the gaps that exist in current knowledge about homeless families, especially in the areas of alcohol, drug, and mental health problems, and how these problems interact with life on the streets and in shelters. A number of important questions should be addressed in order to guide the development of policies and programs targeted to the special needs of this population. These include, for example, such issues as whether alcohol, drug, and mental health disorders are a cause of family homelessness or a consequence of it; and how the lack of a fixed, stable residence affects the emotional, psychological, and physical development of children.

For these reasons, NIAAA and NIMH joined together with Dr. Ellen Bassuk of Harvard Medical School and The Better Homes Foundation in organizing the research conference represented in these proceedings. The two main goals of the conference were to identify the gaps in knowledge regarding family homelessness and to develop recommendations for future research in this area. Recognizing that family

homelessness is a complex issue that needs to be viewed in the context of multiple causes with the need for multiple solutions, experts from a number of fields, including alcohol and other drug research, mental health research, pediatrics and child development, family violence, housing, and program evaluation, were brought together in Boston to explore these causes and potential solutions.

It is hoped that the conference and these proceedings will help stimulate new study and new understanding of families trapped in homelessness. A systematic approach to understanding the problems of family homelessness is essential to solving this national tragedy.

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Working closely with Dr. Bassuk were Barbara Lubran and Peggy Murray of NIAAA and Irene Shifren Levine, Fred Osher and John **Buckner** of NIMH. Joan Doolittle, Howard Garsh and Jayne Rollins of the Better Homes Foundation assisted in organizing the conference.

Special appreciation goes to the individuals and conference participants who authored and prepared papers for the report and committed themselves to the entire project. Without the efforts of these individuals any attempt to synthesize three days of expansive, provocative, and varied discussions would have been virtually impossible to accomplish.



EXECUTIVE SUMMARY

More women and children are homeless today than ever before. According to a 1989 U.S. Conference of Mayors survey in 27 cities, homeless families are the fastest growing subgroup and now constitute approximately one-third of the overall homeless population.¹ In fact, in cities such as New York; Portland, Oregon and Boston, families now comprise the majority of homeless persons. On any given night, at least 100,000 children are living in emergency shelters, welfare hotels, abandoned buildings, cars, or on the streets.²

The face of homelessness has changed. In the 1970's the stereotypical "homeless" person was an unattached single man, suffering from alcoholism and residing on Skid Row.³ In the 1980's growing numbers of women and children transformed the homeless population. Many women were alone on the streets, but others had two to three, mostly pre-school aged children in tow. Although both western and southwestern regions of the country describe more two-parent homeless families, the majority of homeless families are headed by women -- a striking reflection of the "feminization of poverty."²

Early research on homeless families primarily described the characteristics of these women and children.⁴⁻⁸ Despite the groundbreaking nature of some of the early studies, they were generally atheoretical and methodologically limited. Definitions of homelessness were inconsistent; studies tended to be cross-sectional and were most often conducted at single urban sites; choice of comparison groups varied widely, and available measures were limited for use in an ethnically diverse population of extremely poor women and children.² In addition, until very recently, evaluation of programs serving homeless families was in its infancy. Data about which services work for which families are still lacking. Thus, we have only rudimentary knowledge of the causes, courses, and consequences of family homelessness, and of program effectiveness.

In an effort to develop and expand the research agenda on homeless families and children, the National Institute of Mental Health (NIMH) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) held a small invitational conference in

Boston from January 31 to February 2, 1991. We structured the conference to reflect the complex multi-dimensional nature of the etiology, course, and outcomes of family homelessness. By emphasizing how economic, social, and cultural contexts affect the lives of extremely poor and homeless families, we hoped to capture the complexity of their experiences so that we might pose appropriate research questions. Therefore, we commissioned a set of papers that together described the multiple pathways into homelessness, the heterogeneous needs of homeless family members, and the diverse effects of homelessness on both parents and children. Each paper author was asked to discuss current knowledge, research gaps, and methodological and measurement issues, and to recommend future research directions. The paper topics and authors include:

*Housing, Poverty, and Homelessness. A Literature Review and Research Agenda --
Michael A. Stegman, Langley C. Keyes

*The Study of Homelessness In A Prevention Research Agenda --
Susan Gore

*The Impact of Homelessness on Children --
Janice Molnar, David H. Rubin

*What Does It Mean For A Child To Be Without A Home? --
James Garbarino, Kathleen Kostleny

*Mother-Child Interactions in High Risk Families --
Constance Hammen

*Family Violence and Homelessness --
Angela Browne

*Impact of Substance Abuse on Homeless Families --
Elizabeth M. Smith, Carol S. North

*Homeless Families: Public Policies, Program Responses and
Evaluation Strategies -- Linda Weinreb, Peter H. Rossi

In addition to the paper presenters, a small multi-disciplinary group of experts also participated in the conference. (See list of conference participants in Appendix B). These included researchers who had studied poverty issues, or issues related to families and children, as well as various federal officials responsible for research, planning, and policy related to poverty, homelessness or families and children.

The meeting was organized around the commissioned papers. (See conference agenda in Appendix A). After the author(s) summarized his/her paper, all the conference participants discussed the paper and then divided into three small break-out groups to discuss the issues in greater detail. In each group, a facilitator directed the meeting, while a recorder took notes on the proceedings. Although the basic structure of the break-out groups remained the same throughout the conference, the topic and membership changed each time. After the break-out groups met, the conference participants reconvened for a general discussion, during which the three reporters summarized the debates in their groups.

Overall, the final report synthesizes the conference discussions, summarizes the papers, and proposes a research agenda on family homelessness. In Part I, we discuss the central issues raised at the conference, focusing especially on the **perspectives** represented, and on latent assumptions and ideologies. In this section, the key question of causality and its methodological ramifications are considered. Since views on causality greatly influence the choice of methodologies and measurements, we focus in Part II on specific issues related to study design and to measurement. Readers interested in the content of the commissioned papers will find summaries of each of the papers in Part III with the exception of Garbarino's and Kostleny's, which is presented in Section I.A. In addition, a summary of the conference discussion on mental health is also included in this section. Finally, we conclude in Part IV by presenting a research agenda on homeless families with children.

In addition to the authors of the commissioned papers, research conference participants provided many general and specific research recommendations over the course of the conference. The final section of the report coalesces and integrates

these various recommendations into a broad-based agenda for future research. These recommendations, first of all, indicate that further descriptive research is necessary to understand the nature, course, and prevalence of family homelessness; the characteristics of homeless families; and the housing and service needs of this homeless sub-group. Analytic research is also necessary to understand macro-level factors which influence the incidence and duration of family homelessness and micro-level variables which heighten a family's vulnerability to experience homelessness. Such descriptive and analytic research will require careful consideration of assessment procedures as well as the use of age, gender, and culturally-appropriate instrumentation in research with homeless families. Recommendations in this area of measurement were also made and are listed. Finally, solutions to the problem of family homelessness will require that a variety of public and private entities develop housing and social service interventions -- some of which are preventive and some of which are ameliorative in nature. Recommendations relevant to the implementation and evaluation of such interventions are listed.

An unstated, but nevertheless clear, public policy goal among the conference participants was the eventual elimination of family homelessness in America. This goal entails both the rehousing of those presently homeless and the prevention of its occurrence among families. Conference participants were optimistic that carefully thought out and conducted research could make an important contribution to better understanding and combating this social problem; particularly at a time where increasingly scarce financial resources call for informed decision making and allocation. It was the hope of all conference participants that the products of this conference would play a useful role in guiding researchers to develop appropriate hypotheses and generate critical knowledge necessary to end this national tragedy.

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**I
Crosscutting
Assumptions,
Perspectives, and
Ideologies**

I. CROSSCUTTING ASSUMPTIONS, PERSPECTIVES, AND IDEOLOGIES

Before we can develop a research agenda on family homelessness, we must **scrutinize** the theoretical foundations -- and the values, ideologies, and biases -- upon which our research questions are based. During the conference, participants compared the synergies and conflicts among their diverse perspectives. Seldom, however, did they explicitly state the assumptions which inevitably informed these perspectives and which critically influenced how they generated specific questions and hypotheses. These assumptions constituted the **subtext** of the conference discussions.

Assumptions permeate all aspects of the research process, from the formulation of questions, to the methodologies employed, to the consideration of outcomes. Researchers use the richness of their experiences, their perspectives, and even their biases to define problems and to bolster areas where data are limited. Even when considerable empirical data are available, some questions remain value-laden. During early phases in the research of new topics, specific hypotheses are more likely to reflect a researcher's philosophical and ideological orientation despite attempts to be "objective." Because empirical data about the complex dimensions of family homelessness are currently limited, value-laden assumptions may play a **large** role in determining research priorities in this area.

In the following section, we present three major crosscutting themes which emerged from conference papers and discussions. Despite the multi-disciplinary backgrounds of the participants and their diverse professional experiences, the themes discussed below were raised repeatedly. Although participants frequently framed questions in the same way, their answers varied widely. By discussing differing viewpoints raised during the conference, we attempt to elucidate both the tacit and overt assumptions underpinning each theme. Finally, we discuss how these assumptions spark different research questions, affect research findings -- and ultimately influence public policy.

The conference themes can be divided into three major categories:

- A. Conceptions of Home and of Homelessness
- B. Views on Causality
- C. Methodological Perspectives

Conference discussions encompassed abstract themes, such as the meaning of homelessness, as well as more concrete issues of methodology and measurement. This section begins with the most broad and theoretical views of homelessness and then moves to more specific concerns. After discussing conceptions of home, we focus on causality -- the issue which, for many researchers, is the central question in the field. The final subsection on methodological perspectives explores how researchers' conceptions of homelessness and its etiology may fundamentally influence **design and measurement**.

A. Conceptions of Home and of Homelessness

What is the meaning of a "home"? The answer to this question may markedly influence the research agenda. In one of the commissioned papers, Garbarino and Kostleny discuss the meanings attributed to "home" and describe how children's notions of "home" are vital determinants of their experience of homelessness.¹ For example, the significance of "home" varies among age groups; younger children (ages six and less) apparently have fewer ties to their houses than do older children. For very young children, the concept of home is closely allied with the concept of family. According to Garbarino and Kostleny, "researchers have shown that young children can cope well with the stress of social disasters, such as war, if they retain strong positive attachments to their families, and if parents can continue to project a sense of stability and competence to their children."¹(p.6) Garbarino and Kostleny conclude that the problems of very young homeless children may stem from the functional problems of their parents rather than from the lack of shelter itself.

According to Garbarino and Kostleny, the term "home" encompasses far more than housing. For example, even if families are technically "housed," those who move frequently or who live in overcrowded or doubled-up situations do not feel a sense of security, safety, or permanence -- key ingredients in Garbarino's and Kostleny's definition of "home." Furthermore, they suggest that some of the negative developmental and behavioral consequences currently identified as the results of childhood homelessness may in fact have deeper and more complex roots. Indeed, some studies have shown that poor "housed" children living in precarious situations may

manifest as many emotional symptoms as children who are technically homeless (e.g., residing in shelters).’ Thus, poverty and its associated ills, not “houselessness”, may be primarily responsible for the problems of homeless children.

Conference participants questioned the relationship of homelessness to poverty. Who are the “homeless”? Does the homeless population only include people who are living in emergency shelters or on the streets? Or are the large numbers of doubled-up and transient families also “homeless”? Can homelessness be distinguished from extreme poverty, or are they merely different phases in the cycle of poverty? To date, most research has conceptualized homelessness as a static event. However, participants generally agreed that homelessness is an extreme point in the continuum of poverty, fundamentally inextricable from poverty itself. They concluded that the unit of analysis could, in some studies, be shifted from homelessness to poverty. Accordingly, homelessness could be conceptualized as a process rather than a dichotomous variable requiring different methodological strategies for study. Further, participants suggested that homelessness could be redefined as residential instability. This redefinition may more accurately reflect the experiences of homeless and poor families – and may therefore more readily lead to effective interventions.

B. Views on Causality

Causality is the central question for researchers in the field. Views on causality have far-reaching implications for every dimension of research on homelessness. For instance, as we shall see in Section II, assumptions about causality determine methodological choices. Yet only infrequently do researchers focus specifically on the assumptions that determine their views of causality; consequently, as was true at the conference, these assumptions sometimes become the subtext of discussions about homelessness.

The sections below attempt to make explicit many of the participants’ assumptions about causality. Participants discussed the role and interplay of macro- and micro- level causal factors. They questioned whether micro-level factors were causes or consequences of homelessness. Finally, they considered whether historical factors, such as childhood experiences, might increase an adult’s risk of homelessness.

1. The Importance of Macro-Level Factors: The Contexts of **Homelessness**

Macro-level factors -- defined as systemic, structural, and economic variables -- determine the contexts of homelessness. Poverty, racism, and sexism form the overarching context **for** family homelessness. Yet the causes and remedies for homelessness, as well as the actual experiences of homeless families, vary widely according to disparate economic, social, cultural, and community variables.

Conference participants agreed that until researchers incorporate both broad societal and specific local contextual variables into their research designs, we will not fully understand homelessness. Contextual variables profoundly affect research findings. Participants focused on how the nature of shelters, neighborhoods, and local and state policies, the availability of vouchers, variations in housing markets, and the nature and coordination of the service network may all influence homelessness.

Participants also agreed that by contextualizing the problem of homelessness in research designs, we can view poverty (see above), racism, and sexism as crucial mediating variables which could then be rigorously studied. For instance, Garbarino and Kostleny claim that in order to understand family homelessness we must explore sexism.' Structural inequalities along lines of gender in large measure determine women's experiences; racism further compounds the difficulties faced by women of color. Most homeless women suffer disproportionately -- and very severely -- from the problems which stymie the majority of women in this country. Many homeless women have low earning power, little education, and are burdened by child-care responsibilities. Furthermore, as recent studies have shown (see section III, Family Violence), a significant number of homeless women are survivors of childhood physical and sexual abuse, and a large number have been victimized as adults. Not until we **recognize that homeless women's** experiences derive from their experiences as women, will we fully comprehend the context of family homelessness.

2. The Interplay Among Macro- and Micro- Level Factors

Researchers investigating the factors associated with a high risk of family homelessness have not yet created models that account for the linkage among systemic (see 1. above), and interpersonal and individual factors. Participants generally agreed that a model which isolates single causal factors is misleading. Instead, they proposed that researchers should work to create models which explain and adequately link a wide range of macro- and micro-level factors.

However, participants disagreed about the relative balance among macro- and micro-level factors. These differences are reflected in the aims of specific research projects. For example, if we equate homelessness simply with a lack of shelter, then research will emphasize economic and housing factors, and our solutions will largely center around developing adequate housing and income options. However, if homelessness is defined as a rupture in ties with community, family, and friends -- as well as a lack of shelter -- then the research agenda will encompass economic, interpersonal, and individual factors. In this way, we may address the social and emotional well-being of homeless and extremely poor families.

Nevertheless, few participants disagreed about the necessity of modeling a more complex multidimensional approach for understanding the origins of homelessness. Case-study research can easily interrelate macro- and micro-level variables, but researchers must also employ hypotheses-testing designs.

3. Micro-Level Variables: Cause or Consequence of Homelessness?

Researchers have not yet succeeded in untangling the micro-level causes of homelessness from its effects. Is mental “illness” one of the factors contributing to the onset of homelessness? Is it in fact a reactive response to homelessness -- a “crazy” situation? Or is mental illness exacerbated by homelessness and then does it operate as an obstacle to maintaining permanent housing? Similarly, is substance abuse a cause or an effect of homelessness?

Conference participants generally agreed that we must describe the interplay among these factors or the debate over causality will remain inappropriately polarized.

4. The Importance of Historical Factors

How important are background, or historical factors, in the etiology of homelessness? How much do early childhood experiences such as physical and sexual abuse influence patterns and behaviors in later life? What is the relationship of historical factors to contextual variables? Should homelessness simply be viewed as an acute stress or should it be conceptualized as an acute series of stressful events superimposed on a background of high risk or even special needs?

Participants discussed two models. The first, an acute stress model, focuses primarily on variables such as housing instability, unemployment, and interpersonal conflict which are immediately proximal to homelessness. The second, a high-risk model, considers proximal events as well as early childhood experiences. Participants who advocated this latter model believe that support networks may mediate homelessness. In addition to focusing on macro-level variables, they claim that historical factors greatly influence people's capacities to form and maintain the supportive relationships which will help them to buffer economic and personal crises. Accordingly, they include retrospective questions about homeless mothers' backgrounds in their research designs.

As is evident, the debate over historical factors is a debate about causality and the interplay between micro- and macro-level factors. This debate may ultimately have considerable impact on public policy. If homelessness is simply an acute stress, then it can be remedied by increasing the stock of decent affordable housing. If, however, homelessness is an acute stress superimposed on a background of high risk, then policies must address these high-risk factors in addition to housing concerns.

C. Methodological Perspectives

Researchers' notions about causality largely determine their methodological perspectives. Methodologies are specific applications of conceptual paradigms. Consequently, debates about causality reverberate through discussions of methodological issues. In the section which follows, four methodological considerations are presented. Section II. below discusses more specific methodological and measurement issues.

1. Identifying Subgroups of Homeless Families.

Researchers should clearly define the subgroups they are studying. However, classifications should be viewed as exploratory. When our empirical data base broadens, we may find that a classification does not accurately reflect individual experience or lead to effective interventions.

Although homeless families have similar basic requirements (such as shelter, clothing, healthcare and support), they may have different demographic characteristics and diverse needs. For example, a woman who has custody of her children will require different supports from one who does not. Similarly, a woman with a substance abuse problem has different needs than someone with chronic mental illness. These problems require ongoing and specialized treatment which most homeless families do not currently receive. If we divided homeless families into subgroups according to similar clinical needs, we could prevent generalizations about all homeless families while also acknowledging the problems of some. With these data, we could develop interventions that responded specifically to the needs of the particular subgroup.

2. Using Multiple Comparison Groups

Comparison groups are selected so that inferences can be drawn regarding factors of interest; in the case of homeless families the factor of interest is usually "homelessness." Thus, to test hypotheses concerning the causes and consequences of homelessness, researchers generally select comparison groups that are as

similar as possible to the homeless population except for the fact of homelessness. However, such narrowly construed comparison groups may not be the best option for studies that attempt to document various characteristics of homeless families compared to housed families. For example, a root cause of homelessness is often extreme poverty. However, by selecting comparison groups of only families in poverty, this factor cannot be adequately studied.

The research questions ultimately determine the choice of comparison groups. For example, homeless families have heterogeneous ethnic and socio-economic characteristics and diverse health and educational needs. In order to study the effects of these different factors, or the consequences of homelessness for these various outcomes, multiple comparison groups may be needed. Researchers must select different comparison groups to answer specific questions related to these heterogeneous characteristics and needs. (Also see section II.A.2).

3. Developing Appropriate Instrumentation

Very few standardized instruments currently exist to assess the strengths of homeless families and individuals. (For an additional discussion of specific instrumentation see section II.B. below). Instead, in an effort to mobilize essential services, many researchers have focused on problems such as substance abuse and mental illness, ignoring macro-level factors (see I.A. and I.B.) and individual strengths. Although labeling a problem can have positive ramifications and may lead to effective treatments or interventions, labeling may also inadvertently cause victim-blaming, thereby stigmatizing an already disadvantaged population. For instance, some critics have seized on the literature on the homeless mentally ill to argue that homeless people should be institutionalized -- not housed and supported.

Homeless people are three-dimensional; until we explore their strengths as well as their weaknesses, we cannot hope to meet their needs. The child development literature offers a case in point. Conference participants agreed that homelessness impairs the well-being of children, exacerbates existing

difficulties, and contributes to the development of new problems. Nonetheless, research has demonstrated that despite extreme and prolonged stress, some children continue to do well. For example, a child may seem remarkably competent and resilient even though she lives in an overcrowded, vermin-infested welfare hotel with a crack-addicted mother. Few studies have described how children adapt, or why some children are resilient and more able to cope in desperate circumstances than are others.

Researchers have begun to consider “stress-resilient” children. By asking “what is right with these **children?**”²(p.97) and not merely focusing on deficits, they hope to help other children become less vulnerable in the face of life’s adversities. Before we can study resilience and competence, however, we must develop appropriate instruments which will broaden the range of our inquiries to include protective factors. Participants agreed that the findings of “resilience” studies will aid in reducing the risk of homelessness, in increasing the likelihood of satisfactory development, and in guiding future interventions.

4. Determining Outcomes of Homelessness.

What is an acceptable outcome of homelessness? As conference participants recognized, outcome variables are integrally related to their own beliefs about the causes of homelessness. Few participants disagreed that families must be stabilized in permanent housing. However, some advocated a lengthier agenda focusing on psychological, physical, and economic well-being as well as on quality of life issues. By investigating why some formerly homeless families succeed in permanent housing while others do not, we may discover a range of significant outcome variables that focus on housing and economics as well as on social and emotional well-being.

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II
Crosscutting
Methodological
and Measurement
Issues

II. CROSSCUTTING METHODOLOGICAL AND MEASUREMENT ISSUES

A. Methodological Issues

1. Overview

The previous sections discussed theoretical foundations for conceptualizing research and for designing studies. In this section, we focus on the specific technical dimensions -- the workaday aspects -- of these methodological and measurement questions..

Research about family homelessness is in its infancy. Most studies have been atheoretical and cross-sectional. As Molnar and Rubin describe (see section III.D.), many researchers have treated homelessness as a monolithic entity and have not recognized the similarities between homeless and extremely poor housed families. Furthermore, they argue that the varying methodologies of these studies (e.g., definition of homelessness, use of instruments, choice of comparison group and outcome variables) make it difficult to draw generalizable conclusions.

Participants agreed on the need for additional descriptive studies and model-building research. They also supported longitudinal designs which followed families in and out of homelessness. Participants felt that in order to refine the conceptual framework and to define variables of interest, quantitative research should be supplemented by qualitative and case study research. Issues related to ethnicity and race, as well as to extreme poverty, must be explicitly addressed when developing this research agenda.

2. Study Design

a. Definitions

In existing studies, family homelessness has generally been defined as a parent, accompanied by one or more children, living in a shelter or hotel.

Participants agreed on the importance of defining criteria for including subjects in the study. Among the factors they suggested are the composition of the family (women who have their children with them and those who do not), number of moves, eligibility criteria for admission to shelters or welfare hotels, and length and frequency of exposure to homelessness.

The research question should determine the choice of criteria. For example, since short-term exposure to homelessness may not affect a child's development, researchers interested in the effects of homelessness on children might operationalize and compare the effects of short- and long-term exposure to homeless conditions. On the other hand, if we are interested in identifying the causes of homelessness, we could include people who have recently become homeless. Interviewing chronically homeless persons may confound the sample because we may not be able to distinguish between the causes and effects of homelessness.

b. Sampling Issues

“Who should we study?” The answers to this question depend on the research hypotheses as well as on the study type. However, participants agreed that we should use samples of sufficient size to test hypotheses and to ensure that we have accounted for projected attrition rates. Further, they concurred that we must address problems which might bias our sample, including eligibility criteria for admission to shelters (e.g., exclusion of substance abusers); over-representation of long-term shelter residents in cross-sectional studies; and under-representation of adolescent boys who may be excluded from shelters.

c. Choice of Comparison Groups

To date, homelessness researchers have alternately used the general U.S. population, clinic populations, and non-homeless poor persons as comparison groups. Although the choice of a suitable comparison group depends on the research question, we can make a few generalizations. First, some participants argued that since AFDC eligibility varies widely by states, income levels -- rather than simply AFDC

payments -- may be better criteria for selecting a comparison group. Second, participants generally agreed that because homeless families have heterogeneous characteristics and needs, researchers might include multiple comparison groups. Depending on the group to be studied, participants suggested ECA comparison groups, poor and non-poor families, housed and non-housed chronically mentally ill persons. Third, if homelessness is conceptualized as a process, the need for a comparison group might be minimized. (See section I.C.2. above for additional discussion).

d. Need for Multiple Informants

For various reasons, informants' answers may be biased. Potential sources of bias include: the interview format, retrospective data, the stress of homelessness, and the perceived stakes of the interview (for instance, parents may either downplay or exaggerate their **childrens'** problems depending upon what they believe to be the results of their answers). Conference participants suggested that researchers can minimize distortions in their studies by employing multiple informants. For example, parental reports about their children can be supplemented by interviewer's, observer's, and teacher's reports. However, researchers must identify each group's potential biases.

e. Minimizing Attrition

In longitudinal studies, researchers most effectively minimized attrition when they formed respectful and supportive relationships with subjects. Other methods included: obtaining names of friends or family members, making regular phone calls even when not collecting data, providing monetary and other incentives (babysitting), and offering bonuses for first contact and for completion of the study.

f. Human Subjects Concerns

Participants considered the ethics of using monetary incentives and expressed concern that the practice of paying subjects might be coercive. They agreed

that it was respectful to offer an ‘honorarium’ to subjects in return for their participation. To minimize the possibility of coercion, they suggested that researchers should pay subjects at the beginning of the interview and should inform them that they are not obligated to answer every question and can end the interview whenever they choose. While we must be sensitive to ethical concerns, the reality of research in this area requires that subjects be paid for participation.

B. Measurement Issues

Many standardized instruments available for the evaluation of adult health, mental health status, substance abuse, family violence, and social supports may not be appropriate for use with homeless people. They have not been used extensively with homeless persons, nor have they been normed on poor or minority populations, including women. Likewise, most instruments available for the evaluation of child health, developmental and socio-emotional status, and social supports have not been administered to homeless children or normed on poor or minority populations. Furthermore, most instruments cannot distinguish variations within extreme circumstances.

Conference participants generally agreed that the criteria for selection of an instrument should include 1) use with homeless, high risk or poor populations; 2) use in large-scale community studies or other national data bases in which diverse socioeconomic subgroups have been sampled; 3) feasibility and ease of administration in a shelter environment and with stressed individuals; 4) proven validity in collecting retrospective data; and 5) good reliability and validity.

Participants also emphasized the need to supplement existing instruments with 1) qualitative, open-ended measures; and 2) measures that focused on individual’s and family’s strengths.

III
Summaries of
Commissioned
Papers

III. SUMMARIES OF COMMISSIONED PAPERS

A. Introduction

In sections I and II, we extracted the major conceptual questions and the significant methodological and measurement issues from the commissioned papers and from the conference **discussions**. Section III includes summaries of the commissioned papers (with the exception of Garbarino's and Kostleny's paper, included in section I.A.) as well as a brief summary of the conference discussion on mental health. For purposes of this report, the paper authors reviewed what is currently known about their topic areas, distilled their arguments, and briefly discussed methodological and measurement issues. Research recommendations from the papers are primarily included in Section IV.

B. Housing and Poverty

Michael Stegman, Ph.D. and Langley Keyes, Ph.D.

In their paper, "Housing, Poverty, and Homelessness: A Literature Review and Research Agenda", Stegman and Keyes analyze the connections between poverty, rising housing costs, and the recent growth in family homelessness. In an effort to disentangle bias from this controversial question, they explore advocates' perspectives in the light of available empirical research. Faulting advocates for their selective use of evidence and erroneous conclusions, Stegman and Keyes claim that significant conceptual and methodological issues have virtually been ignored and have led to ill-founded generalizations. In conclusion, they propose a research agenda designed to understand the housing-related needs of homeless and precariously housed families.

According to Stegman and Keyes, poverty is the key factor in the homelessness equation. However, neither the affordable housing problem nor poverty trends can be as simply diagnosed as advocates have claimed. Between 1974 and 1983, the numbers of poor persons increased by more than four percent, from 23.4 million to 33.7 million. However, between 1984 and 1988, the poverty rate, as well as the real numbers of poor persons, decreased by about 2.1 percent, or 1.8 million people.¹ Yet even as the poverty rate fell, the numbers of homeless families increased.

To explain this phenomenon, we must carefully examine a nexus of revealing statistics. The high rate of poverty for single-parent families, which includes 27% of all children in 1988, has not receded. Between 1979 and 1987, the numbers of poor families headed by women grew by 46% to more than 3.5 million.² Furthermore, during the 1970's and 1980's the poorest fifth of American families, many of whom were female-headed, suffered a six percent decline in average real incomes while all other families' incomes either increased or remained the same.³

Between 1974 and 1987, the numbers of poor renters increased substantially, and their plights worsened. Public assistance benefits were far outdistanced by inflation. According to Rossi, "AFDC payments in 1985 were worth only 63% of their 1968 value."⁴(p.40) In 1987, more than two-thirds of all poor families (8.1 million) either lived in substandard housing or spent more than half of their poverty-level incomes on housing.⁵ Unfortunately, only a small percentage of the families who qualify for affordable housing can actually find it, explaining why demand-side housing programs like Section 8 rental assistance do not currently meet the housing needs of the poor. In 1987, there were 3.2 million fewer units renting for less than \$300 than in 1974.⁶ Measured in 1989 dollars, the median rent for all poverty-level households living in unsubsidized housing increased by 41% between 1974 and 1987.

During the last decade, the federal government retreated from its commitment to low-income housing. Although total outlays during these years actually increased because of previous multi-year spending commitments made by Congress, new budget authority (multi-year spending) plunged 75 percent, from nearly \$41 billion to an estimated \$10 billion in real dollars.' By supporting rental assistance rather than new construction, the government has reduced the number of newly-assisted households; each year from 1989, 41,000 fewer families qualified for governmental assistance than in 1979.⁷

By questioning how advocates use data, Stegman and Keyes show that the determinants for homelessness are often ambiguous. Critics who claim that individual failings are largely responsible for homelessness do not take into account the scarcity of affordable housing and the decline in the number of low-income families receiving

housing **assistance**.⁸ On the other hand, many supply-side advocates for the homeless contend that these two factors fully explain homelessness. They do not consider individual vulnerabilities, nor do they explain why one poor family remains housed while another is forced to turn to emergency shelters or to the **streets**.^{4,9-11} Some supply-side proponents blame the increase in homelessness solely on variables such as restrictive housing codes, exclusionary zoning laws, or rent control.¹² Yet, as Stegman and Keyes point out, systematic research has not shown that local housing codes and land use controls affect local homelessness rates.

Stegman and Keyes argue that research on homelessness will not be generalizable, comprehensive, or conclusive until it addresses the following three key issues: the housing histories of homeless families, the coping mechanisms of poor families, and the accurate counting and sampling of the homeless population. They review four types of empirical studies on housing and homelessness, indicating areas of strength and weakness. First, although inner-city studies of the causes of homelessness aim to quantify the effects of both supply- and demand-side variables, they do not consider why some at-risk families become homeless while others do not.^{13,14} Second, case studies (includes homeless families in a single locale) comparing homeless and housed families reveal important information about this at-risk population, but are not usually generalizable because they have a limited range of data.^{15,16} Third, although ethnographic studies may provide in-depth information on housing-related problems, they too employ limited samples and are not generalizable.¹⁷ Furthermore, most housing studies have been cross-sectional. Finally, state-sponsored evaluations of homeless assistance and prevention programs have been severely limited by the fact that very few programs keep methodologically-sound, systematic data on clients.¹⁵

Stegman and Keyes propose a three-pronged research agenda. First, researchers should discover why some “at-risk households” become homeless, while others maintain housing. Second, programs should use various intensive case management models and evaluate their effectiveness. Third, programs should include an evaluation component that gathers client follow-up data. To fulfill Stegman and Keyes’ research agenda, agencies and providers must collect basic data on clients, and researchers must improve their counting methods and attempt to understand how social problems (e.g., drug abuse) in low income communities influence housing delivery.

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C. Pathways Into Homelessness: Role of Supports

Susan Gore, Ph.D.

In her paper, “The Study of Homelessness in a Prevention Research Agenda,” Gore argues that homelessness should be studied from the perspective of prevention research, which addresses social stress and its influence on the course of individual and group adaptation. By exploring a prevention research agenda, she demonstrates first, how it differs from clinical research, and second, how these differences offer new perspectives on homelessness. In the second half of the paper, she proposes two prevention paradigms that have implications for family homelessness. In conclusion, Gore suggests that researchers should conceptualize the study of homelessness within the broader framework of extreme poverty.

Prevention research has four important characteristics. First, it focuses on normal populations, as well as on those who are at high-risk. By examining the variations between these groups, prevention research aims to understand “upstream” processes, as well as “downstream” outcomes. Second, in contrast with clinically-oriented, case-control studies, prevention research focuses on the interplay between structural conditions and individual behaviors. Research on stress mediation has probed this linkage, analyzing how broader institutional forces (such as economy, family, gender, ethnicity) may relate to mental health and well-being.¹⁻⁴

Third, prevention research considers the complex relationships among social characteristics, individual characteristics, and health or disorder. For example, recent literature on the social support construct has demonstrated that not only are these networks critical buffers of stress, but that they are also impacted by hardships and psychological functioning. Social class may considerably affect the nature and quality of social relationships; the financial and social costs of maintaining affective ties in poor communities may ultimately strain or weaken these networks.⁵⁻⁸ Fourth, prevention research investigates both risk and resilience, and especially considers the protective factors and individual characteristics that may bolster coping resources. As opposed to clinical models that concentrate on psychopathologies, resilience literature considers the adaptive outcomes which result from exposure to risk. Interactive models, which resilience theorists currently favor over additive models, examine how social supports may mitigate stress.⁹

From the literature on prevention research Gore suggests two conceptual models for designing research about homeless families. The first model considers both risk factors and mediating variables to determine the pathways into homelessness. Gore divides risk factors into three types: variables pertaining to the family of origin or early childhood experiences; accomplishments and resources (school, employment, relationships, health) available during adolescence and young adulthood; and later life crises, including the events most proximal to homelessness. As Gore points out, researchers must recognize that this model may conceal the diversity of peoples' experiences. For instance, a family's housing status may vary widely, depending upon whether they are living in a doubled-up situation, in permanent housing, or in a welfare hotel. Also, early life experiences may be more significant for some individuals than for others. For example, studies have indicated that children who lose a parent may be more vulnerable to depression as adults^{9,10}

Gore's pathways model also demonstrates how individual or social coping resources and desirable life events may counteract or mitigate stressful experiences.

However, the data on the social networks of homeless women are contradictory. Although Bassuk and Rosenberg's study found that poor housed women had larger support networks than homeless women,¹¹ Goodman reported that the women's networks differed very little, with the exception that homeless women did not trust that their friends or family would provide help.^{9,12} Reliability, rather than size of support networks, may be more essential for offsetting stress. Epidemiological research has shown that traumatic life experiences or chronic psychiatric conditions may weaken social relationships. Similarly, studies have indicated that conflict in intimate relationships may lead to clinical depression.¹³

Gore's second proposed model seeks to explain the developmental adaptation of homeless children. Three factors have direct and mediating effects on child outcomes: maternal history, including early childhood experiences, mental¹⁴ and physical health, addiction history, history of family violence; family and community factors, including family disruptions, illness, quality of relationships, use of community resources, and housing status; and child characteristics and experiences. The child's resilience factors (social supports, resources, child's own traits), and vulnerability factor (homelessness)¹⁵ moderate the effects of the risk factors.

For instance, studies have demonstrated that for some children school achievement may offset traumatic events at home.¹⁶ Although Gore includes housing status as both a risk and a vulnerability factor, she explains that these categorizations vary depending on the duration and severity of the episode of homelessness; in other words, while homelessness may always be a vulnerability factor, it is not necessarily a risk factor for all children.

Finally, Gore argues that researchers concerned with homelessness should consider all low-income women. Because studies have documented that chronic stress is a more influential etiological factor than acute stress and also more destructive to social support systems,¹⁷⁻¹⁹ she suggests that researchers focus on the cumulative stresses experienced by these women.

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D. Homeless Children

Janice Molnar, Ph.D. and David **Rubin**, M.D.

Molnar and **Rubin** describe “The Impact of Homelessness on Children” by reviewing prior studies and discussing the implications for research and policy. The review begins with a discussion of background issues. In the past decade, the child poverty rate increased, the number of families headed by women grew, income supports such as Aid to Families with Dependent Children (AFDC) eroded, and the shortage of affordable housing persisted.¹⁻³ These factors precipitated the current crisis in family homelessness. According to the U.S. Conference of Mayors (1989), families headed by women are the fastest-growing segment of the homeless population.⁴

Although the plight of homeless children has received increasing attention from researchers in the last three or four years, the field is still young. Comparatively little is known about the impact of homelessness on the health, development, psychology, and cognition of children. Methodological difficulties limit most studies’ conclusions. As researchers acknowledge, their findings must be considered preliminary, and may not be generalizable.

Even so, this work demonstrates that there are distinct differences between the physical health of homeless and non-homeless poor children. Studies have shown that homeless children have low birthweights,⁵ poor health,⁶ and many common infectious illnesses such as upper respiratory tract infections.⁷⁻⁹ Homeless children are also likely to have restricted access both to routine healthcare and to preventive medicine;⁶ they are poorly nourished¹⁰ and sometimes iron deficient,¹¹ have elevated blood lead levels,¹² and often are not immunized on schedule.¹² They are admitted to hospitals more often and frequently rely on emergency rooms for general medical care.^{6,12}

The situation of homeless children in the classroom is similarly bleak. Research on homeless childrens’ academic performance has indicated that they do poorly in school, a finding that may largely be attributed to erratic school attendance. Homeless children miss school more frequently at every grade level, have higher overall dropout rates, and are frequently placed in special education

classes.^{10,13-16} Furthermore, homeless children are more often held back at least one grade than non-homeless children.^{10,16,17} Thus, it is not surprising that homeless children have poorer school performance compared to comparison groups of housed poor children.

Although hampered by methodological shortcomings such as sampling difficulties and inadequate instruments, researchers who study the developmental and psychological status of homeless children have found that they have greater rates of developmental and cognitive delays than non-homeless children. Using the Denver Developmental Screening Test (DDST), three studies documented that a significant percentage (54%¹⁷ 44%¹⁸ 15%¹⁰) of homeless preschoolers manifested at least one developmental delay, most frequently in the areas of language, gross motor, and personal/social skills. Other studies using different measures, including the Early Screening Inventory (ESI)¹⁹ and Peabody Picture Vocabulary Test-Revised (PPVT-R),²⁰ have not found significant differences between homeless and housed poor preschoolers. However, they found that both groups scored lower than the general population.

Studies on the behavioral and emotional problems of homeless children (such as sleep disorders, withdrawal, aggression, short attention span) indicate that homeless pre-schoolers and school-aged children had more difficulties than housed poor children;^{17,19-22} the differences were less marked among the school-aged children. Two studies which compared pre-school homeless and housed children found a significant difference between the proportions of homeless and comparison group children who scored above the clinical cut-off on the Child Behavior Checklist.^{19,20} Yet similarly gauged studies with school-aged children showed no statistical difference between the two groups' means, although there were more behavioral and emotional problems among the homeless children.^{17,20-22} Other studies using different measures, such as the Children's Depression Inventory^{17,18,22} and the Children's Manifest Anxiety Scale confirmed this latter pattern.^{16,17}

Although these data are suggestive, Molnar and Rubin argue that it is not conclusive. They are especially critical of atheoretical attribute studies, or research which studies a specified characteristic within a sample of homeless people.²³

According to Molnar and **Rubin**, these studies ignore the process by which homelessness affects children, as well as the impact of macrolevel factors (e.g., economic) on **children**.²⁴ Molnar and **Rubin** suggest that researchers have treated homelessness as a monolithic entity, and have therefore failed to recognize the similarities between the “homeless” and the poor “housed populations”.²⁵ Researchers have relied almost exclusively on cross-sectional studies, neglecting longitudinal **work**.²⁶ Yet, claim Molnar and **Rubin**, the varying methodologies of these studies (in such crucial areas as definition of homelessness, choice of comparison group and specific outcome variables) make it almost impossible to draw generalizable conclusions from their findings.

In order to remedy the methodological shortcomings and conceptual gaps that have hampered previous research, Molnar and **Rubin** make three recommendations. First, future research on homeless children must employ a systems approach, which takes into account the wide range of influences -- individual, family, community, and macro-level variables such as political and economic -- that affect development. Second, studies should employ a standardized approach (with both quantitative and qualitative elements) to enable the compilation of a national data base. Third, policymakers should support innovative research demonstration projects which have been developed from systematic research findings.

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E. Parenting

Constance **Hammen**, Ph.D.

Hammen's paper, "Mother-Child Interactions in High Risk Families: Implications for Homeless Parents" discusses how parenting is a mediator of children's risk.

Supportive, dexterous families may mitigate or even offset economic and social stressors. Yet parenting itself is a complex and interactive process, the result of many intertwined factors both past and present. Although little is known about parenting in homeless families, researchers can draw on other pertinent literatures to formulate research agendas. Especially relevant to the homeless parenting field are studies on the effects of stressful conditions on parenting, including poverty, social adversity and episodic stressors, and studies on child-rearing in depressed and mentally ill mothers. These 'high-risk' conditions coincide in some homeless families.

Successful parenting is often defined as a combination of demandingness, defined as the amount of control the parent attempts to exert over the child, and responsiveness, the degree to which the parent responds to the needs and actions of the child.^{1,2} According to researchers in the field, competent parents have reasonable expectations of their children and react effectively to meet their needs. The degree to which parents are likely to display appropriate levels of demandingness or expectation and responsiveness is determined by at least three elements: the mother's background and skills, the child's characteristics, and the current pressures and strains on the family.

First, childhood experiences in large part determine an adult's "social competence", including parental effectiveness.³⁻⁷ Interpersonal, problem-solving, and coping skills learned in childhood enable people to respond to disruptive challenges and to maintain supportive networks. Second, parenting is also affected by the child's attributes. Increasingly, researchers have recognized that a child's temperament and personality may be important ingredients in the parenting relationship.⁸⁻¹⁰ Finally, the context in which parenting occurs -- the particular economic, social, and cultural milieu -- is of vital importance.

Maladaptive child outcomes can often be traced to non-optimal parenting. In the past two decades, researchers have conducted an abundance of studies on children at high risk, many of which have concentrated on the effects of parental psychopathology.¹⁻¹⁹ Various studies on depressed mothers have observed that they are frequently either negative and critical towards their children, or unresponsive and withdrawn,²⁰⁻²⁹ according to Burge and **Hammen**, withdrawal is more common in women with current depressive symptomatology, while aggression is associated with chronic stress.³⁰ Many observational studies have documented that depressed mothers and their children communicate less than normal mothers and their children?¹⁻³³ Depressed women may react more truculently to children who cause them **trouble**.³⁴ Researchers have noted that even mildly depressed women are less engaged and sensitive to their infant's actions.^{23,25-29}

Research on schizophrenia and depression has demonstrated that children of diagnosed parents, especially those whose functioning is impaired, are at increased risk for developing psychiatric symptomatology, as well as for academic, behavioral, and developmental problems.¹¹⁻¹⁸ Children, and even infants, react to their mothers' depressions with behaviors which are frequently dysfunctional and incapacitating in the long-term.³⁵⁻³⁷ Studies have found higher rates of insecure attachment and anxiety in these children.^{36,38} They score lower on IQ tests, and have impaired social skills. Further, the traumatic events of their childhood may lay the foundation for maladaptive behaviors in adulthood. In this way, disorder and dysfunction may become family legacies.

A related literature highlights the interplay between stressful life events and depression. At increased risk for depression are poor women, women with little education, and women who are raising young children but are not employed outside the home.³⁹⁻⁴² Thus, many studies of parenting in depressed women are also studies of black, single, poor women who are highly stressed by economic and sociocultural disadvantage. Research in this area has not yet specifically assessed stressful circumstances or evaluated the separate effects of depression and stress on non-optimal parenting.^{5,12}

Homeless women are, as **Hammen** states, quintessentially stressed women. Many must deal with chronic stressors (poverty, difficult childrearing circumstances), as well as episodic stressors (eviction, domestic violence, shelter living). As a result they frequently feel depressed, angry or withdrawn. As studies have shown, these chronic stressors also negatively impact those poor, but housed, children who are subjected to them.⁴³⁻⁴⁵

Little is known about the features and parameters of parenting under homeless conditions; the methodological challenges are great. **Hammen** recommends that researchers initially collect preliminary ethnographic information such as data on how much time the mother and child spend together, and the extent of supervision and nature of their transactions. Microanalyses of the quality and content of verbal interactions would serve to supplement such broad descriptive information.

To study the complex factors affecting parenting, **Hammen** proposes a multivariate model of interacting variables that reflects the contextual and behavioral influences affecting children's development. The model views parenting behaviors (product of the mother's background and current symptoms) toward the child as an important determinant of the child's social competence, which will in turn affect the child's diagnostic outcomes.^{12,46} Such a model may provide a framework for understanding the adaptation of homeless children.

Hammen concludes by noting that the high-risk conditions which are likely to be associated with both dysfunctional parent-child relationships and ongoing maladaptation by the child may culminate in an adult history of marginal adjustment and social dysfunction. Can this cycle be broken? Some of the research on children of depressed and stressed mothers hints that impaired mother-child interactions in the first year of life may set the stage for insecure attachment and emotional difficulties which will further accumulate over time. This dismal picture is a significant challenge to researchers. Our findings can be used to develop practical solutions and preventive interventions.

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F. Family Violence

Angela Browne, Ph.D.

Family violence is prevalent in both the past histories and the present circumstances of many homeless families. Moreover, recent research suggests that the effects of childhood victimization may have significant repercussions in the later lives of homeless women. Browne argues that various “characteristics” which have been identified in many homeless women -- such as difficulty in forming and maintaining relationships, dearth of external supports, insufficient job and life skills, anxiety or panic disorders, substance-abuse problems -- may in fact result from childhood victimization and signal a post-traumatic stress disorder. Browne concludes that in order to design supportive interventions for both homeless women and women at risk for homelessness, researchers must further explore the association between family violence and homelessness.

Family violence, according to Browne, is a “national phenomenon”. Studies conducted between 1975 and 1986 have shown that intimates -- not strangers -- pose the greatest danger to women and **children**.^{1,2} National surveys estimate that each year at least 1.5 million children and 1.8 million women are severely assaulted physically by their parents and **mates**.²⁻⁶ Citing chronic underreporting and faulty sampling methods, researchers claim that the true prevalence may be twice as high as the estimated rate; according to their calculations, nearly eight million (combined total) women and children are seriously abused by intimates each year.

Many studies have documented the short- and long-term effects of victimization. Emotional reactions -- such as fear, anger, guilt, shame, and a sense of being contaminated -- are common in survivors of all types of **victimization**.⁷ Researchers have noted chronic anxiety, feelings of vulnerability, self-blame, and loss of control in victims of personal attacks, such as **rape**.⁸⁻¹³ These feelings are often particularly severe in victims of assaults by intimates. Studies indicate that since victims are likely to be reliant emotionally and financially on their aggressors, and that since aggression by intimates often occurs more frequently and over a longer period than assault by strangers, the effects of these victimizations are magnified.¹⁴ Further, because of this chronic abuse, survivors may behave in contradictory and confusing ways; for instance, they may be wary and untrusting of help-givers, but seemingly passive towards abusers.¹⁵

Browne points out the correlates of childhood sexual molestation parallel the characteristics commonly attributed to homeless mothers. Both homeless mothers and molestation victims often have disrupted relationships and problems developing, maintaining, and accessing other supports, such as with service providers.¹⁶⁻¹⁹ Both groups often perform poorly in school, and consequently have reduced earning power. Both suffer emotional manifestations of earlier trauma, such as chronic depression or panic disorders.²⁰⁻²³ Both are reluctant to trust service providers, and some are hostile to ‘help sources’.

The empirical research on victimization and homeless women has begun to substantiate this link. D’Ercole’s and Struening’s study of 141 women residents of a Manhattan shelter found that 21% reported that they had been raped at least once, 43% reported that they had been raped and otherwise physically abused, 23% reported childhood sexual molestation, and nearly two-thirds -- 62% -- reported physical abuse not accompanied by rape. Further, this study showed high correlations between histories of victimization and depressive symptoms.²⁴ Two studies showed that homeless mothers had been abused physically or sexually more frequently than the comparison group of poor housed women. Bassuk and Rosenberg discovered that 42% of the women who responded to this question had been abused in childhood, compared with 5% of the housed mothers;¹⁸ Knickman and Weitzman found that 11% of their sample reported childhood sexual abuse, compared with 7% of the housed.¹⁹

Although prevalence rates of family violence between homeless and housed women are inconsistent, both groups have very high rates. Goodman’s 1990 study of 50 homeless and 50 poor housed mothers discovered that 60% of the homeless and 54% of the housed had been physically abused as children, and 42% of the homeless and 50% of the housed had been sexually abused as children.²⁵

Finally, given these high percentages of family violence, we may suppose that children in homeless families are themselves at risk. Bassuk and Rosenberg found that 27% of the homeless mothers were neglecting or abusing their children, compared to 15% of the housed mothers.¹⁸ Without additional data, we cannot draw any conclusions from these statistics, but certainly the exigencies of life on the street and in shelters may make attentive parenting nearly impossible and sometimes stress parents to their limits. Apart from parental abuse, qualitative research

indicates that many homeless children have been exposed to violence or threats of violence in precarious doubled-up living situations, on the streets, or in shelters.

Researchers suggest that seeing or hearing marital violence may be as injurious to a child's psychological welfare as actually being physically abused themselves.²⁶ Studies have shown that witnessing abuse may impair a child's future interpersonal relationships.^{27,28} In addition, children who have been abused are more likely as adults to abuse their own children.

Browne addresses various issues specific to research on family violence. Researchers have consistently found that many victims are willing to disclose this information to skilled interviewers in what they perceive as safe environments.^{1,6,24} Over the past decade, several instruments have been developed to obtain information about the physical and sexual abuse of children and physical and sexual assault by adult relational partners.³⁰⁻³² These instruments share several common features: (1) terms such as "abuse", "violence", "rape", and "assault" are typically avoided, (2) questions consist of discrete behavioral descriptors of a perpetrator's actions (e.g., "kicked, bit, or hit you with a fist"; "exposed his/her genitals to you"), and (3) questions are constructed so that respondents need only answer yes or no; behavioral descriptors are read by the interviewers, relieving the respondent of volunteering the information or saying discomforting words.

Studies based on such designs have obtained far higher prevalence rates than those using questions that require respondents to judge whether particular behaviors were "abuse" or "violence". Criteria for abuse are determined as a part of the study design and applied systematically to all cases. Such a procedure relieves respondents of attaching difficult labels to individuals for whom they have loyalty or love, and also avoids cultural biases and stereotypes about the appropriateness of behaviors in parent-child or couple relationships (e.g., a determination by the respondent on whether forced sex in marriage is "rape", or being slapped by a parent is child abuse or an appropriate form of discipline).

In order for the data to be meaningful, inquiries about histories of family violence should include information on the following dimensions:

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- * Types of abuse experienced--child physical, child sexual, adult physical, and adult sexual;
 - * Types of perpetrators--family (usually including non-related parental figures) or non-family, and relationship of perpetrator(s) to the victim;
 - * Time frame and duration of abuse--estimates of onset and cessation by victim's age;
 - * Outcomes of abuse--e.g., lists of potential injuries sustained, resulting social welfare or legal action, changes in residence, etc.

Because of the sensitive nature of the research, interviewers must be specially trained (using role plays) and must also participate in frequent support groups. Interviewers must consider their own emotional reactions to respondents.¹⁹ Furthermore, Browne cautions that interviewers must ask questions systematically, inform subjects of their right not to answer questions, and provide subjects with information about locally-available resources for victims of violence.

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G. Substance Abuse

Elizabeth Smith, Ph.D., and Carol S. North M.D.

According to Smith and North in their paper entitled 'Impact of Substance Abuse on Homeless Families' little is known about this topic. Existing studies are methodologically limited by small samples, a focus on men, lack of uniform measures, inconsistent definitions, single sources of information, and lack of comparison groups. Without longitudinal studies specifically designed to measure the prevalence rates and impact of substance abuse on homeless families, our knowledge in this field remains general and preliminary. However, the large body of literature on both substance-abusing women and the children of alcoholics can help researchers to sketch what is known of the general terrain.

Estimates of the lifetime prevalence rates of alcohol disorders among homeless women have ranged from 10% to 37%, with the most recent research indicating a 30% lifetime prevalence rate.¹⁻⁴ When compared with the lifetime prevalence rate of 5% for women in the general population, homeless women are at greatly increased risk for developing alcohol disorders.⁵ Furthermore, although alcohol problems are more common among homeless men than among homeless women, the gender difference is far less than in the housed population.¹⁻⁴ However, the medical complications of alcoholism, such as neurologic deficits, are more severe in women.^{2,6,7} Additionally, patterns of heavy drinking among women remain constant throughout childbearing years.⁸

In contrast to homeless individual women, homeless mothers may be much less likely to suffer from alcohol disorders (40% v. 23%),⁹ or to be told that they have a drinking problem (31% v. 5%)¹⁰ than homeless women without children. Three studies have documented an approximate 8% to 10% lifetime prevalence rate of alcohol abuse in homeless mothers, but the numbers may have been underestimated.¹⁻¹³

Reports of lifetime prevalence of drug abuse problems among homeless women have varied from 9% to 32% as compared to the lifetime rate of 5% in the general female population.^{5,9,14-17} In contrast, homeless mothers have an estimated lifetime prevalence rate of drug abuse of 9% to 12%.^{12,13} Anecdotal reports from service

providers suggest that growing numbers of homeless mothers are abusing alcohol and crack, an increase which studies do not yet reflect.¹⁸⁻²⁰ Studies of the general U.S. population demonstrate that women are as likely as men to become addicted to drugs; this finding is also borne out among the homeless population.

Substance abuse often occurs concomitantly with other psychiatric disorders. Findings from the Epidemiologic Catchment Area project indicate that almost half of those with a diagnosis of alcoholism meet criteria for a second diagnosis.²¹ Similarly, drug abuse and dependence are associated with considerable co-morbidity. In the general population, for instance, alcoholism is frequently associated with schizophrenia and antisocial personality. Female alcoholics suffer from other psychiatric disorders more often than do male alcoholics, a finding partly accounted for by the higher rates of depression and phobias in women.²²⁻²³ Concurrent disorders appear to be common in the homeless population. Wright's 1990 study found that two-thirds of a sample of homeless clinic attendees had either an alcohol, drug, or mental problem; one-quarter of this sample had a combination of these problems.²⁴ Similarly, Breakey et al. discovered that the lifetime prevalence of DSM-III Axis 1 disorders in homeless women was 80%, that 32% of the women were alcoholics, and that 17% abused drugs.²⁵

In general, adverse pregnancy outcomes are more likely in substance abusing homeless women, since they are frequently poorly nourished and have limited access to prenatal healthcare and treatment for their alcohol or drug problem. Chavkin reported that 39% of pregnant homeless women received no prenatal care, compared to only 14% of low income housing project women and 9% of the general population.²⁶⁻²⁸

According to Smith and North, substance abuse problems are pervasive in homeless individual women, and presumably also in homeless mothers and pregnant women. The implications of this abuse are far reaching, affecting both the mother and her child at every stage. The most immediate effects of maternal substance abuse are those that occur prenatally.

Children born to pregnant women who abuse alcohol and drugs are at increased risk for medical and developmental problems. Fetal Alcohol Syndrome (FAS), for example, is characterized by birth defects, growth deficiencies, and increased risk for infant mortality.²⁹⁻³⁵ One study documented that 46% of children with FAS were mentally retarded, 74% were hyperactive, and 80% had difficulties with speech and language.³⁶ Children of alcoholic parents may also be genetically predisposed to developing alcoholism,³⁷⁻⁴⁵ whether or not they actually become alcoholics is determined in large measure by the degree of family dysfunction, individual characteristics, and social and economic opportunities.^{39,41,46-53}

Drug abuse during pregnancy has been studied less than alcohol abuse. However, according to recent surveys, approximately 10% to 16% of all pregnant women have used illegal drugs.^{20,54} The effects (especially long-term) of maternal drug abuse on children are not yet fully known. The negative effects of prenatal cocaine exposure -- by all accounts the most common perinatal addiction -- include high rates of stillbirths, high rates of pregnancy complication, genitourinary tract malformations, and low birthweight and length.^{26,55-60} In addition, researchers have shown that women who use cocaine frequently also use other psychoactive drugs which can impair fetal growth and development.^{58,61}

Although preschool and school-aged homeless children manifest various medical, developmental, socioemotional and learning difficulties,^{17,62-66} the portion of these problems attributable to substance abuse in a family member remains unknown. Additional research is needed to document the extent and nature of alcohol or drug abuse in homeless families and children.

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H. Mental Health

Conference Participants

We did not commission a separate paper on mental health issues in homeless families and children since various authors discussed this topic in their papers. (See papers on Homeless Children, Parenting, Family Violence and Substance Abuse.) On the third day of the meeting we formed a group to discuss mental health. This section summarizes the discussion.

Studies describing the prevalence rates and nature of mental disorders among homeless family members are sparse and methodologically limited due to small samples, inconsistent instrumentation, and lack of comparison groups. Furthermore, because many shelters exclude clients with histories of current or past mental illness, a significant sampling bias may have been introduced in some studies. Based on existing research, however, we can conclude that homeless mothers have lower rates of chronic mental illness than homeless women (in shelters without children), but higher rates than in the general population. In addition, studies have shown that unlike adult individual homeless women, very few mothers had histories of state hospitalizations. Although homeless mothers' disorders did not cluster into a single category, DSM-III Axis I psychiatric diagnoses are generally overrepresented.

Preliminary data from a Massachusetts study of homeless mothers found that many suffered from so-called personality disorders, which are Axis II diagnoses. However, these "disorders" can be regarded as responses to serious deprivation and "problems in living". Participants also noted that these labels are not sensitive to contextual issues, such as poverty, racism and gender.

The group discussed strategies for contextualizing mental disorders, particularly Axis II problems. By distinguishing between reactive and chronic disorders, and by recognizing the interface between chronic stress and some disorders, researchers can integrate contextual factors into their research design. For instance, researchers should attempt to identify early trauma such as physical and sexual abuse, and to account for the effects of stress. Some participants cautioned researchers about

confusing personality disorders with post-traumatic stress disorders, particularly since many homeless women have also been victims of personal violence. (See summary of Angela Browne's paper on Family Violence).

Participants expressed concern about the problems of labeling an already stigmatized population. Some researchers questioned whether psychiatric diagnoses were necessary, pointing out that the Axis II and some of the childhood diagnoses were less reliable and valid than Axis I diagnoses. However, others argued that labeling a mental disorder may enable the person affected to receive an entitlement or specific treatment. Since the purpose of labeling is to develop effective treatment interventions, participants suggested that researchers should try to provide a context for current problems and symptoms by determining the degree of functional disability and by gathering historical information about the person's background.

Most participants agreed on the importance of developing technical assistance programs which will help providers to understand the meaning of diagnoses within the context of homelessness, and to develop pragmatic treatment strategies. In addition, conference participants agreed about the importance of public education about mental illness.

I. Programs and Evaluation

Linda Weinreb, M.D. and Peter Rossi, Ph.D.

Weinreb and Rossi describe the policy and program responses to family homelessness and discuss evaluation strategies. They conclude that these responses have been, for the most part, stop-gap measures designed to ease immediate suffering. Working on the assumption that homelessness was chiefly a temporary economic crisis, state and local governments, and non-profit and charitable organizations supported the construction of a massive emergency shelter network. However, despite their efforts, the crisis of homelessness has persisted, and, in some areas, worsened.

Recent research has indicated that the causes of homelessness are complex and variable, in many cases the result of intersecting individual, interpersonal, and economic factors. The problem of family homelessness is not as simple as was originally assumed, nor are the solutions to the problem as straightforward. To understand how to prevent family homelessness and to serve better homeless families, researchers and policymakers must critically examine the assumptions undergirding current policies, as well as the effectiveness of present programs.

Although estimates of total numbers vary widely, researchers concur that families constitute approximately 25% to 36% of the homeless population.¹⁻⁴ Factors contributing to the increase in family homelessness over the past decade include: growth in poverty, drastic shortage of affordable housing, decrease in the value of social welfare benefits, and increasing numbers of female-headed families. Researchers paint a grim portrait of these families' circumstances. Compared to poor housed mothers, homeless mothers have more medical problems, higher incidence of past or current family violence, higher rates of substance abuse, more severe mental health problems and fragile or non-existent support networks.^{2,5-10} Their children often suffer from medical difficulties, do poorly in school, manifest developmental or cognitive delays, and display behavioral or emotional problems.^{2,6,11-13}

Clearly, meeting the manifold, complex needs of this population is an extremely challenging and sometimes arduous task for service providers. Yet very few shelters

or transitional facilities are properly funded, staffed, or trained to help homeless families with their full range of needs. Many were established with the idea that food, shelter, and a dollop of counseling would remedy the problem of family homelessness. The federal government, which largely disregarded the problem of homelessness until the passage of the **McKinney** Homeless Assistance Act in 1987, has encouraged this emphasis on emergency responses.¹⁴ Rather than establishing coordinated, preventive, and long-term programs and policies to eliminate homelessness, the federal government chose to turn responsibility for homelessness over to the states and nonprofit sector.¹⁵ Although some states have responded effectively to the crisis, others have not -- with the result that local governments, charities, and foundations have been charged with a duty they are manifestly unable to fulfill.^{14,16}

Programs for homeless families must be understood within this context. Emergency shelters are the heart of the United States' response to homelessness. Developed locally, these programs have widely varying lengths of stays and range of services. Some programs allow clients only a few days, while others provide housing for up to six or eight months. In response to the serious needs of homeless families, some programs offer additional services, such as substance abuse programs, enriched day care, or job training. Others, because of financial insolvency or a belief that such programs are unnecessary, do not provide these services.

Transitional facilities, designed for longer stays (six months to two years) and enhanced support services, are more structured and supervised than emergency shelters. These programs may be ideal for extremely dysfunctional families, offering them continuous support while they gain the skills necessary to maintain homes in their communities. However, for other families, transitional facilities are an unnecessarily expensive and restrictive substitute for independent housing. Some families currently served by transitional facilities could manage successfully in permanent housing if they also had access to long-term support services.^{6,17}

Despite the variations in programs, some generalizations are possible. The vast majority of programs are financially unstable, and have enormous difficulties obtaining ample and sustained funding. As a result, many programs are either

chronically understaffed, or staffed by personnel who are inadequately trained to respond to the complex needs of homeless families.¹⁸ Staff burnout and attrition rates are high, and consequently programs frequently face the problems of staff turnover.^{16,19} Without qualified professional staff, few programs can effectively respond to the special developmental, educational, and psychological needs of homeless infants and young children. Similarly, only a limited number of programs address substance abuse issues. Finally, because of the high volume of potential clients, many programs can enforce “exclusionary criteria”, screening out male children or seriously dysfunctional families with histories of mental illness, domestic violence or substance abuse.^{9,17} As a result, some families who are desperately in need of help cannot obtain it.

Despite the rapid growth in programs for homeless families, few evaluation efforts have been undertaken. Rossi defines evaluation as the set of related research activities that answer questions about effectiveness and efficiency. In addition, evaluation also includes social research that is useful in the design and monitoring of social programs.²⁰⁻²² Of the evaluations that have been conducted in this area, the majority are on a small scale and descriptive. The critical first step in any evaluation effort is to review and collate existing reports. It is likely that this review will not provide a sufficient base for evaluating the effectiveness of current programs, but rather will raise additional questions for further study.

The second step in evaluating a prospective or ongoing program is to determine the program’s goals--those which it can be expected to achieve within a reasonable length of time. Understandably, these goals may change. The evaluator’s task is to make explicit those goals to which program managers are implicitly committed. The end result of an evaluation assessment is a consensus on the nature of the program’s goals, the major processes by which effects are to be achieved, and the course of the evaluation process.

Formative evaluations should provide management with information about how a program is functioning; this information assists managers in making a program more efficient and responsive to client’s needs. The simplest type of research activity in a formative evaluation is the design and operation of management information systems

(MIS), which provide systematic and continuous data on a program's operations. A MIS can be a source of timely information about the clients served, the types of services delivered, and the amount of progress made.

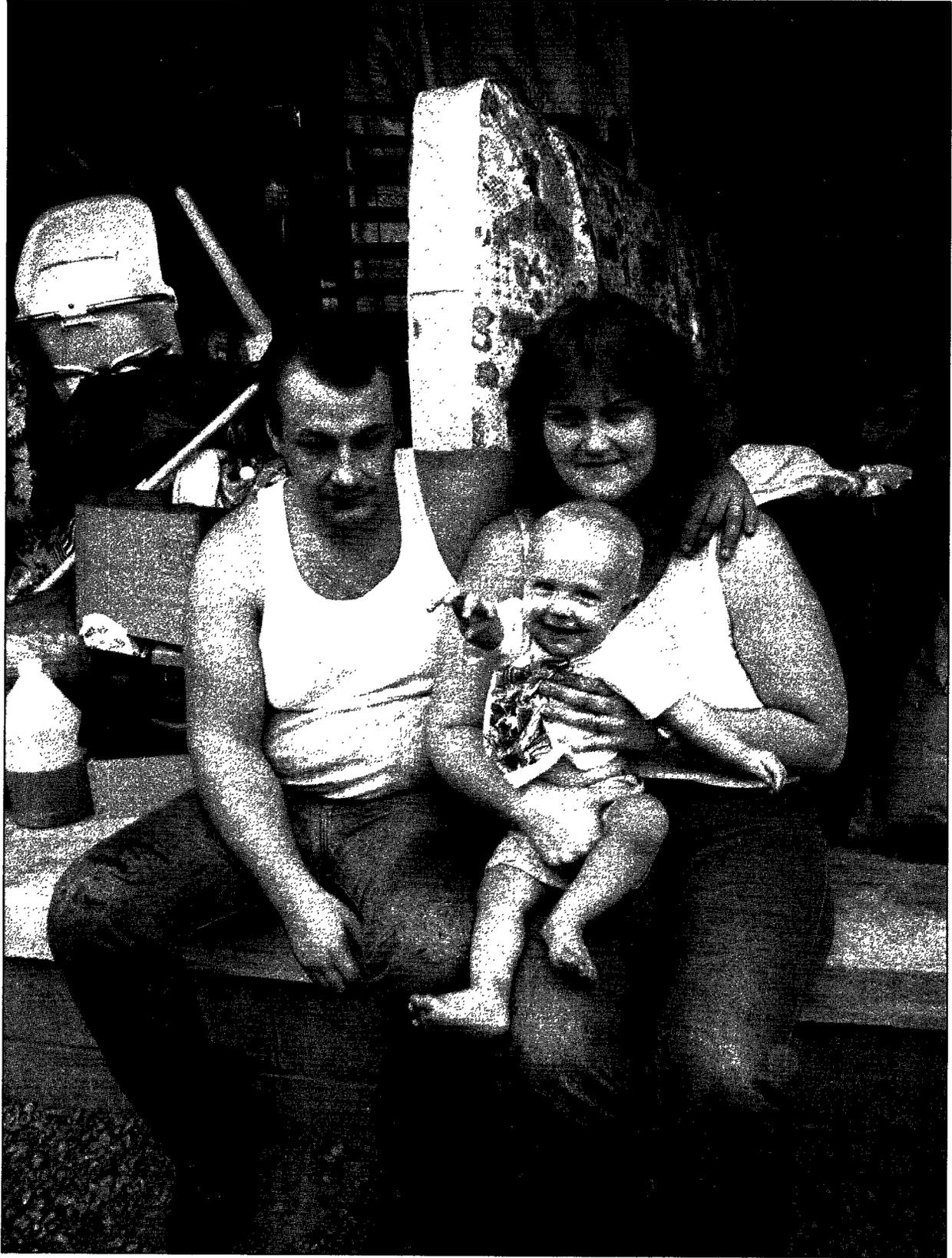
The ultimate evaluation question asks whether a program has achieved its stated goals. Do the clients of a program improve more than would be the case had they not come in contact with the program? A program is effective to the extent that it assists clients to improve more than comparably motivated non-clients of similar psychosocial composition would improve without the help of the program.

For human service programs there are a limited number of different ways to make such comparisons including: reflexive comparisons, comparable non-clients, and randomized experiments.²² Because of the superior credibility of effectiveness estimates derived from randomized experiments, it is difficult to understand why so few such studies are conducted. The main obstacles to the use of such randomized experiments are first, their cost and second, the widespread reluctance of human service providers to sanction random (read arbitrary) withholding of services to otherwise deserving and eligible clients.

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IV
Research
Recommendations

IV. RESEARCH RECOMMENDATIONS

Every conference session included some discussion of research and evaluation issues, but the participants did not as a group formulate an overarching research agenda or define research priorities. They did, however, suggest various essential components to a comprehensive research plan. The goal of this section is to coalesce and integrate these components into a broad-based agenda for future research.

An unstated, but nevertheless clear, public policy goal among the conference participants was to eliminate family homelessness in America. The goal entails both the rehousing of those presently homeless and the prevention of homelessness among families. As this report indicates, the problem of family homelessness is tremendously complex, involving significant interplay among macro-level and micro-level factors including economics, housing, family violence, substance abuse, mental disorders, parenting patterns, and support networks. Thoughtful research that addresses the interaction among these factors will vitally contribute to the development of interventions to combat homelessness.

Although homelessness is neither a “disease” nor a “disorder,” it can be useful to adopt a public health/epidemiologic framework for establishing research priorities and objectives. We must first understand the nature, extent, and severity of the problem of family homelessness. This requires descriptive research to determine the prevalence of family homelessness, and the characteristics and housing and service needs of those families. We must then tackle the complex issues of why family homelessness occurs, the domain of analytic research. This requires researchers to consider multiple levels of analysis: that is, to examine contextual and public policy (macro-level) variables in tandem with micro-level factors that increase vulnerability to homelessness among families. It also dictates the need for developing and using valid and reliable instruments to measure clinical, social, family, and ecological domains. Finally, once the multiple causes of family homelessness are more clearly understood, long-term, preventive solutions can be implemented and evaluated.

In this section, we present a comprehensive agenda for further descriptive, analytic, and experimental research. General recommendations applicable to the conduct of sound research as well as recommendations specific to the topic of family homelessness are included. The recommendations have been organized into four subsections: descriptive research, analytic research, instrument development, and program development and evaluation.

A. Descriptive Research

1. Recommendations Conducive to Sound Research

- * Use research designs that are representative of homeless families and are of sufficient size to allow for meaningful subgroup comparisons. Distinguish and compare relevant subgroups where appropriate.
- * Ensure that studies are of culturally relevant research participants. This requires understanding of variations in the cultural meaning of homelessness as well as the use of culturally sensitive assessment instruments.
- * Complement quantitatively-oriented descriptive studies with studies involving in-depth, ethnographic portrayals of homeless families. This **strategy** will facilitate a better understanding of the families' perspectives, their survival strategies and day-to-day experiences, and their social context. Qualitative research should both guide the interpretation of quantitative data and facilitate the generation of hypotheses.
- * Design multi-site studies to assess adequately variation across geographic locales, racial and ethnic groups, and other comparisons.

2. Recommendations Specific to Family Homelessness

- * Develop reliable estimates of the incidence and prevalence of family homelessness that examine variation across geographic locales, urban/rural sites, and racial or ethnic groups. Develop a system of monitoring that can assess changes in the prevalence of homelessness over time.

- * Distinguish between rates of incidence and prevalence across different geographic locales to understand how duration of homelessness episodes varies. Examine factors which account for differing lengths of homelessness episodes among geographic areas.
- * Describe the characteristics of homeless families (including, but not limited to, the prevalence of medical problems, and alcohol, drug abuse, and mental disorders).
- * Describe the longitudinal course of family homelessness and the extent to which it is chronic or recurrent. Studies need to follow currently homeless families to determine factors accounting for natural exits from homelessness as well as reasons for re-entry and to evaluate the extent to which homelessness is episodic.
- * Describe how the experience of family homelessness varies as a function of the pathway into homelessness (e.g., the experience of families who become homeless due to a natural disaster versus the experience of families who become homeless after a family dispute).
- * Document the “effects” of homelessness on both adults and children as well as the nuclear and extended family system. Future studies need to move beyond comparisons of group differences between homeless and housed families into isolating the Effects of homelessness per se. Future studies should isolate the independent effects of homelessness from the effects of family violence, parental alcohol or drug abuse, parental mental health problems, or non-optimal parenting. The experience of homelessness may, in turn, affect these parental variables, and this potential reciprocal process needs to be documented and understood. Such goals can best be achieved using longitudinal designs and multivariate statistical analyses.

- * Determine if and to what extent the effects of homelessness relate to its duration and/or reoccurrence.
- * Compare homeless families to other high risk groups, such as adolescents in foster care, runaway and homeless youth, battered women, and pregnant adolescents.
- * Describe the current service needs of homeless families (both adults and children), service utilization over time, and perceived and real barriers to service.
- * Describe housing provision and service delivery for high risk, formerly homeless, and homeless families.
- * Describe multiple points along a “continuum of residential stability” ranging from literal homelessness to residentially unstable to residentially stable. What are meaningful points on this continuum? What does a frequency distribution of this continuum look like across different locales? What can be used to group families into ‘homeless’ and ‘housed’ categories? What are the ramifications, in terms of rates of prevalence of ‘homelessness’, in shifting this cut-point? Examine to what extent there is congruence between a continuum of residential stability and a continuum of “financial well-being”.
- * Describe the attachment behavior, development, peer and social functioning, social supports, emotional status, and academic achievement of homeless children.

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- * Isolate those aspects (e.g., loss of “home”, disruption of normal family and parenting functioning, dislocation from neighborhood, shelter life, interruption of job or school, loss of self-esteem, etc.) of family homelessness that may be especially pernicious to adults, children, and the family system. Determine the processes by which stressors specific to the experience of homelessness impact on the mental health and well-being of parents and children.
 - * Describe strategies that allow families (adults and children) to cope adaptively with the experience of homelessness. Which strategies allow adults to parent effectively or to maintain a sense of personal efficacy while homeless? What characterizes children who remain resilient to the stressors of homelessness from children who experience difficulties?
 - * Describe children’s developmentally evolving conceptions of “homelessness” and “houselessness”. From a phenomenological perspective, is there an important distinction for children and adults between lacking a home and lacking a house (i.e. a place of permanent residence)? What are the important aspects of “home”? How is the experience of “home” disrupted by the experience of “homelessness/houselessness”?
 - * Consider the use of population registers and large scale ongoing population surveys (such as the Current Population Study and the Survey of Income and Program Participation [SIPP]) that could provide a cost-efficient means of conducting representative population surveys of low income families. Such ongoing surveys could be useful in understanding the broader population of extremely poor families from whom homeless families are drawn.

B. Analytic Research

1. Macro-Level

- * Develop a better appreciation for how macro-level variables such as the supply of affordable housing, employment and other economic conditions, income maintenance programs, availability of health care and other social services relate to the incidence and prevalence of family homelessness.
- * Develop a better understanding of how prevalence and incidence rates of homelessness vary as a function of the social ecology (e.g., degree of cohesion) of different neighborhoods and communities.

2. Micro-Level

- * Through multiple research designs (including “case-control”, “retrospective cohort”, “prospective cohort”) identify factors which place families at increased risk for homelessness.
- * Consider a broad range of micro-level variables which may heighten vulnerability to homelessness, including past and present episodes of family violence (examining types and severity of abuse); current and lifetime occurrences of alcohol, drug, or mental disorders; the structure of friendship and kinship networks; and the past use and present availability of various forms of social support (e.g., instrumental support, emotional support). Distinctions between more proximal (recent) and more distal (historical) risk factors are important. An examination of potential mediating processes as well as interaction among risk factors should be considered in the modeling of quantitative data. Consider macro-level variables and social context in interpreting findings from risk factor research investigating micro-level variables.

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- * Consider the use of multiple comparison groups (e.g., families living in shelters compared with housed but residentially unstable families and with stably housed families) in risk factor studies to allow for greater variation in hypothesized risk factors under investigation. Studies should avoid comparing homeless families with very similar groups (e.g., families on the verge of homelessness or with a past history of homelessness).
 - * In risk factor studies, distinguish between homeless families experiencing a first episode of homelessness from a **reoccurrence**. When developing a sample of homeless families for a risk factor study, consider the duration a family has been homeless in order to avoid oversampling families who have been homeless for an above average length of time.
 - * Control for confounding variables in risk factor studies. This can be achieved in the design through matching on potential confounding factors or after data collection through multivariate analyses. Researchers should consider the pros and cons of each of these methods of controlling for confounding.
 - * Risk factor studies should consider the absolute, relative, and attributable risk of variables which are found to be associated with the occurrence of family homelessness.
 - * Disentangle the “causes” from the “consequences” of family homelessness. This will require the use of longitudinal designs (e.g., retrospective and prospective cohort designs as well as the “nested case-control” design).
 - * Examine a broad range of micro-level variables which affect homeless families’ capacities to resecure housing and to remain housed.

C. Instrument Development

- * Assess the appropriateness of well-established assessment instruments for use with homeless persons, minority group members, women, and children. These instruments should show good internal consistency, test-retest stability, and evidence validity. Furthermore, sensitivity to age-appropriateness and gender-appropriateness should be considered. Finally, instruments may need to be translated for use with certain populations (e.g., hispanic).
- * Develop new instruments in cases where existing instruments are inappropriate or where no instrument exists. Particular emphasis should be placed on refining measures of social support, adapting indices of stressful life events to the experience of homelessness, and developing gender sensitive instruments that measure alcohol and other drug abuse. Additionally, the measurement of effective coping strategies and other indices of competence and resilience needs further attention.
- * Organize a small invitational conference to discuss appropriate domains for research with homeless families and children. Determine if a consensus can be reached on “best choice” instruments for the assessment of particular domains. Encourage investigators to use common instruments where appropriate; this will facilitate data comparison.
- * Identify appropriate and standardizable assessment procedures in qualitative, ethnographic research.

D. Program Development and Evaluation

- * Document and describe the existing service delivery system for homeless families and children in urban, suburban, and rural areas. This should include mental health services, alcohol and drug treatment services, job-training, day-care, and other relevant social services.
- * Describe how service providers assess family members' service needs and the extent to which services are tailored to address specific needs of families. To what extent is service provision culturally sensitive?
- * Encourage dialogue and interaction among service providers and evaluation researchers to examine the goals and assumptions of programs, develop logic models, and conduct implementation and outcome evaluation studies if an evaluability assessment has deemed this appropriate.
- * Conduct process evaluations of innovative service delivery programs to examine client characteristics of clients served, service components, frequency of service provision, the nature of interaction between service providers and clients, various models of care (e.g., intensive case management vs. "typical" case management"), the evolution and fidelity of an intervention over time, factors affecting the participation of clients in a service delivery program, and contextual factors affecting a service delivery program.
- * Examine the experience, training, support, and responsibilities of service providers. Explore methods for reducing staff burnout. Investigate methods for creating incentives for service providers to cooperate with and utilize evaluation research (both process and outcome).

- * Examine the process of development, cost of development, and effectiveness of various housing alternatives (including those funded by the Department of Housing and Urban Development) for homeless families.
- * Develop research demonstration projects which test innovative approaches to service delivery with homeless families. What works, for whom, under what conditions, and at what costs are integral questions to be addressed. Demonstration projects should involve the collaboration of service providers who can successfully implement the intervention and researchers who can evaluate the implementation and effectiveness of the intervention(s).
- * Interventions need to be described in sufficient detail to permit replication in other sites and to assess the generalizability of results.
- * Develop interventions guided by a sound conceptual framework, grounded in prior research and linking intervention components to well-specified, realistic, and measurable outcomes. Use rigorous research designs (e.g., experimental when feasible) with control or comparison group(s) that will enable possible treatment effects to be attributed to the intervention. Use samples of sufficient size to detect meaningful effects should they be created by the intervention. Assess the implementation of the intervention to insure that service provision was adequately conducted. Assess appropriate and meaningful short-term and long-term outcome effects of the intervention. Examine, when hypothesized, variables which may mediate the effect of an intervention on an hypothesized outcome. Evaluate the relationship between the degree of intervention and effect achieved. Examine, to the extent possible, whether an intervention has more pronounced effects for certain subgroups or under certain conditions. Examine, to the extent possible, the independent effects of specific components of an intervention “package”.

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- * Develop interventions which address the housing and service needs of clients. Examine what configurations of service provision and housing improve residential stability and other relevant outcomes. Encourage the development of multiple types of interventions to **faciliate** comparisons of effectiveness and to respond to the potentially diverse needs of subgroups of homeless families.
 - * Consider that interventions may need to continue once a family is rehoused and develop interventions that maintain a sufficient level of support to enhance long-term residential stability and other positive outcomes.
 - * Develop interventions to help children effectively cope with the experience of homelessness and, when indicated, provide case management, treatment, and supportive services.
 - * Develop interventions aimed at intervening at an organizational level (e.g., shelter, school, AFDC office). Create policies and procedures conducive to meeting the needs of homeless parents and homeless children.
 - * Where feasible, evaluate the effectiveness of “natural experiments” created by changes in social policy that influence the incidence of family homelessness or the rehousing of those families presently homeless.

Appendices

DAY1

AGENDA: NIMH/NIAAA CONFERENCE
JANUARY 311991

THURSDAY

The Context of Family Homelessness

10:15 - 11:00

- Welcome - Ellen Bassuk, M.D.
- Introductions
- Comments: NIMH - Fred Osher, M.D.
NIAAA - Barbara Lubran, M.P.H.
- Conference Format:
 1. Focus of breakout groups:
 - What are the research gaps?
 - What are the methodologic issues?
 - What measures should we use?
 2. Role of group leader and reporter
 3. Housekeeping details

11:00 - 12:15

- Paper Presentations and General Discussion
 1. Housing and Poverty: M. Stegman & L. Keyes
 2. Pathways Into Homelessness/Role of Supports:
S. Gore

12:15 - 1:30

Lunch

1:30 - 2:45

- Three breakout groups led by:
M. Stegman/N. Milburn
L. Keyes/D. Rog
S. Gore/M.B. Shinn

2:45 - 3:00

Coffee Break

3:00 - 4:30

- Report back to entire group
- General discussion

6:00 -

Dinner

DAY 2

AGENDA: NIMH/NIAAA CONFERENCE
FEBRUARY 1, 1991

FRIDAY

Homeless Children and Parents

8:30 - 10:00

- Paper Presentations and General Discussion
 1. Homeless Children: J. Molnar & D. Rubin
 2. Methodologic and Measurement Issues: J. Garbarino

10:00 - 10:15

Coffee Break

10:15 - 11:45

- Three breakout groups led by:
 - A. Masten/D. Rubin
 - J. Garbarino/B. Fagot
 - J. Molnar/D. Wertlieb

11:45 - 1:00

Lunch

1:00 - 2:00

- Report back to entire group
- General discussion

2:00 - 2:45

- Paper Presentation and General Discussion
Parenting Issues: C. Hammen

2:45 - 3:00

Coffee Break

3:00 - 4:00

- Three breakout groups led by:
 - C. Hammen/C. Garcia Coll
 - T. Jacob/A. Masten
 - B. Fagot/P. Fischer

4:00 - 4:30

Report back to entire group

DAY 3

AGENDA: NIMH/NIAAA CONFERENCE
FEBRUARY 2, 1991

SATURDAY

**Family Dysfunction: Family Violence, Substance
Abuse, and Mental Illness**

8:30 - 10:00

- Paper Presentations and General Discussion
 1. Family Violence: A. Browne
 2. Substance Abuse: E. Smith

10:00 - 10:15

Coffee Break

10:15 - 11:30

- Three breakout groups led by:
 - A. Browne/M.B. Shinn
 - E. Smith/D. McCarty
 - P. Fischer/M. **Gutman**

11:30 - 12:30

- Report back to entire group
- General discussion

12:30 - 1:45

Lunch

1:45 - 2:30

- Paper Presentations and General Discussion
Programs and Evaluation: P. Rossi & L. Weinreb

2:30 - 2:45

Coffee Break

2:45 - 4:30

- Large group discussion

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