Appendix B

Toward a Typology of Homeless Families: Conceptual and Methodological Issues

Appendix B.1: Toward a Typology of Homeless Families: Conceptual and Methodological Issues

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INTRODUCTION

Despite the general conviction that homelessness is a unitary phenomenon, there is ample evidence that persons without permanent living arrangements differ significantly among themselves (Culhane and Metraux, 1999). Recognition of this heterogeneity has led to attempts to classify subgroups of homeless persons (herein referred to as subtypes) according to a variety of characteristics and dimensions, such as (chronicity, substance abuse, psychopathology, and childhood vulnerability factors). An important consideration in the search for subtypes of homeless persons is the specification of essential environmental, situational, and personal characteristics that have a direct role in the development, patterning, and course of homelessness.

The goal of this chapter is to review conceptual issues and methodological strategies for developing a typology of homeless families with children. In particular, the chapter examines the feasibility of using a multidimensional conceptual and analytic strategy to determine how best to identify distinct subgroups of families with specific constellations of risk factors and service needs. The ultimate goal of this chapter is to inform both clinical practice and public policy, including the need for effective interventions and prevention programs.

Background Issues

The chapter begins with a review of the relevant scientific and clinical issues guided by the following questions: What is the purpose of typological classification? How can current knowledge about the epidemiology of homeless families contribute to the development of a typology? What are the existing typologies and risk factors relevant to typological classification, as well as methodological approaches used to derive typologies? What is the experience from other fields such as psychiatry, criminology, alcoholism?

What is the purpose of the typological classification?

Several possible functions suggest themselves: theoretical, clinical, and practical. Theoretical functions are those that deal with fundamental questions about the mechanisms through which individuals and families become homeless and continue in this condition. The condition of living in stable housing within a stable community that is supported by local and national government bodies is considered a

fundamental right of a civil society. Why some members of society are excluded from this fundamental right is critical to the development of effective methods of remediation and prevention.

A second function of typological formulations is to facilitate client-service matching. Here the concern is with efficient use of scarce resources, including cost-effectiveness. The idea of treatment matching has been popular in psychiatric research, guided by the assumption that treatment outcomes can be improved by matching patients with the most appropriate level, modality, and intensity of care. Service matching is a broader perspective that includes not only clinical interventions but other kinds of services, such as housing, income supplements, and case management, among others.

How can current knowledge about the epidemiology of homeless families contribute to the development of a typology?

Research over the past 25 years has yielded an extensive body of knowledge on the prevalence and determinants of persons who are homeless and, of particular relevance to the present project, families that are homeless. Some key epidemiological findings are summarized as follows:

- The population is heterogeneous with regard to homelessness history. Population-based longitudinal studies in New York and Philadelphia show that 80 percent of persons using shelters are newly homeless with a short duration of homelessness; 10 percent are recurrently homeless; and 10 percent are long-term homeless (more than a year) (Culhane and Metraux, 1999). Homeless families show a similar distribution. In New York City, homeless families were grouped in three categories; 52 percent were transitional (average of 1.2 episodes of homelessness, of average duration of 59 days); 43 percent were intermediate (average of 1.2 episodes of homelessness of average duration of 211 days); and 5 percent were episodic (average of 3.3. episodes of homelessness, of average duration of 345 days (Culhane, 2004)

- The homeless population is very large. Earlier studies underestimated the extent of homelessness in part because of designs that selected the long-term homeless, and in part because of the hidden nature of a good part of the population, especially those that are doubled up with families or friends. Later studies correcting for some of these factors, especially retrospective telephone surveys of the general population (Link et al., 1994), showed a much larger prevalence of

homelessness at some point in life. Homeless families with children have been the fastest growing segment of the homeless population during much of the past 2 decades.

- The one feature that homeless people, including homeless families, have in common is poverty (IOM, 1988; Jahiel, 1992a). Many poor people are not homeless, but nearly all homeless people are very poor. Because of this they contribute to an excess demand for low-cost housing, and those with features that might provide an additional barrier to housing are at a competitive disadvantage.

- Certain types of homeless families are much more prevalent than others (Bassuk et al., 1996; Weitzman, Knuckman, and Shinn, 1990; McChesney, 1995; Culhane, 2004): single mother families; families where the parent was a foster child or never had a real home; families where the parent has had a long history of abuse; families fleeing imminent or continuing abuse; and African American and Hispanic ethnic minorities.

- A small proportion of homeless individuals and homeless families are more salient and consume shelter and other services disproportionate to their numbers (Kuhn and Culhane, 1998). They include people or families that are chronically homeless, and families in which one or more members have mental disorders, substance abuse, illiteracy, and not infrequently physical or mild mental disabilities; often, there is significant overlap of these problems in the same individual. Given the hardships of homeless life, the word "multiproblem" is an understatement for these families.

- The number of homeless children has been estimated at 1.3 million in 2000 by the Urban Institute and 1.2 million in 2001 by the National Coalition for the Homeless. Despite better controlled studies of homeless children (Buckner, 2005), there still is relatively little in the way of systematic research on children whose families are homeless. Severe hunger is more frequent among homeless children than housed low-income controls (Weinreb et al., 2002). In addition, multiple barriers to education have been reported, including lack of schooling, multiple transfers, transportation problems, and lack of needed educational services such as special education (Rafferty and Rollins, 1989; Rafferty and Shinn, 1991; Whitman et al., 1992; Vostanis and Cumella; 1999; Masten et al., 1997). These children also have an increased rate of being in foster care or welfare service if parents are or have been homeless (Zlotnick et al., 1998; Culhane

et al., 2003). Education reform through the McKinney Act has improved the situation somewhat but much remains to be done.

- Pregnancy has an elevated prevalence in homeless women. Pregnancy is relevant to a potential typology in several ways: it is a risk factor for homelessness (Shinn et al., 1998), it is associated with increased perinatal morbidity, and is sometimes followed by disorders in bonding (Whitman et al., 1992).

In summary, epidemiology provides valuable information about prevalence, incidence and determinants of homelessness. The epidemiology of homelessness and of homeless families provides important insights into the potential usefulness of an empirical typology. First, homeless people and homeless families are homogeneous with regard to poverty, but heterogeneous in terms of their personal characteristics and service needs. Second, there seems to be a simple dichotomy separating complicated, multiproblem homeless families from relatively uncomplicated homeless families, who are more likely to be temporarily homeless and require fewer services. Third, epidemiology suggests that the prevalence of homelessness changes with a variety of economic and social conditions, as does incidence. Political considerations and public policy, particularly policies affecting the public "safety net" and resource allocations for social welfare programs, can have dramatic effects on the number of homeless persons and their personal and demographic characteristics. Without putting homelessness into a proper historical and socioeconomic perspective, any typology of homeless families may turn out to be a historical artifact.

What are the existing typologies and risk factors relevant to typological classification, as well as methodological approaches used to derive typologies?

From common knowledge in the field, one would expect three main groups to emerge in general discussions of a useful typology: (1) families that are homeless for economic reasons (e.g., cannot pay rent, loss of employment, low paying jobs that cannot cover the rent, loss of welfare support); (2) families that have left one family member's home because of abuse or fear thereof, usually a single female headed family; and (3) families that can be indexed as having a serious health or social problem (substance abuse, mental health, chronic illness or disability, criminal record, etc). There are also two smaller groups: (4) families that have lost their home in a disaster (earthquake, war, etc); and (5) migrant families (families that have a home elsewhere but have moved to another area (in the same or different country) where they do not have a home).

Typologies Based on Features of Homeless Persons

The first approaches to typologies of homeless persons were based on differing features of certain groups of homeless people, developed in part to describe the population and in part to ascribe a causal relation of these features to homelessness. Such studies, published from 1912 to the 1980s, have been reviewed by Louisa Stark (1992). Nearly all of these studies were derived from surveys of single homeless persons and were based on homeless shelter-based populations. Despite the fact that homeless people were typecast in different ways at different times, several major types were described: First, people were classified as unemployed workers, alcoholics, mentally ill, and chronically physically ill or disabled. Elderly people and "bums" constituted two additional, albeit much smaller, groups. Recognizing the heterogeneity of homeless people, Bahr and Caplow (1973) attempted to reduce this diversity to a single operational feature. They postulated a Durkheim-like concept of disaffiliation, a detachment from social roles and institutions, as a common pathway to homelessness. They distinguished three major categories of disaffiliation resulting from external changes that leave the individual with few affiliations: (1) society withdrawing from the individual in periods of economic depression, war, persecution, etc; (2) from individual choice (opting out of societal roles); and (3) handicap or lifetime "unsocialization" resulting from mental illness or other chronic disorders (Bahr and Caplow, 1973). This theory lost ground in the next 2 decades as studies showed that homeless people had a network of social roles and institutional or personal affiliations, albeit usually not with rich people.

This typological approach continued even after the growth of homelessness and changes in the homeless population that included younger homeless single people and families in the 1980s. For instance, Fischer and Breakey (1985) grouped mission users into the chronically mentally ill, the chronic alcoholic, street people, and the "situationally distressed." Other typologies of some of these groups were subsequently published, some of which were highly disaggregated. For instance, Shepherd (2000), who used cluster analysis with a population of homeless adults, distinguished 11 profiles (malingerers, depression with alcoholism, symptom minimizers, psychotic avoiders, service avoiders, newly homeless, local ethnic minority, women with children, healthy family, other-Caucasian, and nondrug users).

The 1980s saw homelessness emerge as a major social problem, and several streams of research on the homeless population were initiated (see Institute of Medicine [1988] and Jahiel [1992a] for reviews). The only common factor in this very heterogeneous homeless population was extreme poverty, associated with a decrease in low income housing in the late 1970s and 1980s (e.g., Calsyn and Roades,

1994). The concept of homelessness as a manifestation of extreme poverty began to replace that of homelessness as social disaffiliation. Homelessness was seen as an aggregate rather than an individual problem due to the disequilibrium between the number of poor people and the number of low-income housing units: a certain number of people had to become homeless at a given time unless the housing supply was increased, and environmental, situational, and personal characteristics determined who was most vulnerable to become part of that population (McChesney, 1992a).

Some years ago, Jahiel (1987) described a dichotomy between two types of homelessness: benign homelessness and malignant homelessness. Benign homelessness means that the state of homelessness causes relatively little hardship, lasts for a short time and does not recur soon. For these people, it is relatively easy to gain back a home and a stable tenure on that home. Malignant homelessness means that the state of homelessness is associated with considerable hardship or even permanent damage to the person who is homeless. It lasts for a relatively long time or recurs at short intervals; extraordinary efforts must be expended to gain back a home with a stable tenure, and these efforts are often unsuccessful.

Typologies Based on Trajectories of Homelessness

In the 1980s a series of national and local studies were undertaken to enumerate homeless people. Although these studies had considerable methodological difficulties, they revealed the great variety of sites used by homeless people. Some classifications of homeless persons were proposed according to where homeless people spend their nights. For instance, based on field studies of samples throughout Ohio, Roth et al., (1985) classified homeless people as street people, shelter people, and resource people (the latter including people who doubled up with family or friends). Doubled-up people, the largest category by far, had not been studied before the 1980s. Further studies showed that they were a large source of "literal homelessness" (Weitzman, Knickman, and Shinn, 1990) and that there was considerable back and forth movement among these three groups.

The same cohort of 1980s studies also provided valuable information about the way people became homeless, yielding two main groups: the majority became homeless because they could not pay for their housing; a lesser number became homeless because they fled abusive environments (battered spouses, runaway youth) or were thrown away from their home by parents or partners. Finally, the same studies showed that many people were recurrently homeless and pointed to three groups of homeless

persons: new (homeless for the first time), episodic (recurrent homelessness) and chronically homeless (continuously for more than a year [see, for instance, Ropers, 1988]).

A more recent contribution (Mackenzie and Chamberlain, 2003) introduces the concept of homelessness careers. It identifies homelessness as a career process for a series of transitional stages in the development of any form of biographical identity, (i.e., people passing through various phases before they acquire the identity of homeless persons). They distinguish three pathways: (1) the housing crisis career, with poverty, accumulating debt, unstable housing, and eviction preceding homelessness; (2) the family breakdown career, with abuse or violence associated frequently with return to an abusive home and recurrence of that process until a final break occurs; and (3) the youth homelessness career continuing into adulthood for people who have been homeless since their teens.

By focusing on people in homeless shelters in two cities and developing a city-wide information retrieval of administrative data from shelters, Dennis Culhane opened the way for very large and relatively accurate data collection projects. Kuhn and Culhane (1998) applied cluster analysis together with an information retrieval system to trace homeless persons through the shelters in Philadelphia and New York to produce three groups of homeless persons—transitionally, episodically, and chronically homeless—by number of shelter days and number of shelter episodes. Transitional, episodically, and chronically homeless constituted, respectively 80 percent, 10 percent and 10 percent of shelter users. However, the latter group consumed over 50 percent of shelter beds. These data were cited in congressional hearings that led to Federal appropriation of funds for initiatives to end chronic homelessness (U.S. Department of HUD, 2002 and 2004).

Kuhn and Culhane reported differences in racial origin, age, and physical and mental conditions among the three groups. However, they dealt with a selected population (shelter only and two cities). In studies of the users of a Toronto shelter, Goering and colleagues (2002) found little difference between transitional and episodic groups. In studies of chronically, episodic, and housed adults attending a detoxification program who were followed for 2 years, chronic homelessness was associated with poorer scores over time on a mental health instrument but not on a health-related quality of life instrument (Kertesz et al., 2005).

Typologies of the Homeless Environment

The European Homelessness organization FEANTSA (The European Federation of National Organizations Working with the Homeless) recently presented a European Typology of Homelessness and Housing Exclusion (ETHOS) with four main conceptual categories (Roofless, Houseless, Insecure Housing, and Inadequate Housing) and a large number of operational subcategories (FEANTSA, March 2005). This is a new perspective on typology: a typology of the environments associated with becoming and being homeless.

Typologies of Homeless Families

While homeless families have been a topic of concern prior to 1980, studies of homeless families started only in the 1980s. Early studies of homeless families are reviewed by McChesney (1995). More recent studies of homeless families have revealed several risk factors and protective factors (Bassuk et al., 1997; Rog et al., 1995). Wong et al., (1997), using Culhane's methodology, have investigated predictors of exit and re-entry among family shelter users in New York City. Families with housing vouchers had fewer re-admissions to shelters, and those with more children, minority status, pregnancy, and public assistance had more re-admissions. Bassuk et al., (2001) compared multiply homeless women with first-time homeless. A history of childhood abuse and adult partner violence were predictors of recurrence of homelessness. Qualitative studies have yielded more evidence on which to build typologies of homeless families. Based on ethnographic studies in Los Angeles, McChesney (1992b) described four types of homeless families: unemployed couples; mothers leaving relationships; mothers receiving Aid to Families with Dependent Children (AFDC), and mothers who had been homeless teens (the latter includes a subtype of mothers who have never had a home in their entire life).

Summary

Based on the literature on subtyping of homeless individuals and families, there is some evidence to suggest that most of the attempts to classify this population, either according to a priori domains or according to multivariate statistical techniques, have identified two broad types of homelessness that can be arranged on a single continuum ranging from relatively simple, benign, time-limited, uncomplicated cases (e.g., situationally distressed, resource people, new homeless, transitional) to more complicated, "malignant" chronic, multiproblem cases (e.g., chronically mental ill, chronic alcoholic, street people

(Fischer and Breakey, 1985), shelter people (Roth et al., 1985), episodic, chronic (Ropers, 1988; Kuhn and Culhane, 1998), multiply homeless (Bassuk et al., 2001). As discussed later, this simple dichotomy may be a good place to begin in the development of a useful typology of homeless families.

What is the experience from other fields such as psychiatry, criminology, and alcoholism?

There is along tradition of typological research in psychiatry, alcoholism, and criminology that may be useful in the development of typological approaches to the description and management of homeless families. For example, the fourth edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (APA, 1994), which is used primarily for clinical and reporting purposes, describes subtypes for schizophrenia, schizoaffective disorder, anxiety disorders, affective disorder, delusional disorder, and substance induced psychotic disorder. These subtyping schemes are derived primarily from clinical experience rather than from empirical research, and each one relies on a different organizing principle. The subtypes of schizophrenia (paranoid, catatonic, disorganized, undifferentiated, and residual), for example, are organized on the basis of "the clinical picture," which presumably refers to presenting symptoms. The subtypes of schizoaffective disorder (bipolar type, depressive type) are organized according to affect disturbance. The subtypes of delusional disorder (erotomanic, grandiose, jealous, persecutory, somatic, mixed) are organized according to the predominant delusion. What these psychiatric subtyping schemes have in common is their attempt to classify psychiatric patients who share the same general condition into more meaningful or clinically useful subgroups.

In the field of alcoholism, the tradition of clinical subtyping according to single domains extends back to the 19th century (Babor, 1998; Babor and Dolinsky, 1988) and includes the domain of childhood vulnerability factors, family history of alcoholism, onset age, dependence, severity, and co-morbid psychopathology. Over the past century there has been an evolution of typological theory from these single domain subtypes, such as familial and nonfamilial alcoholism, to multidimensional typologies, based on a variety of defining characteristics, such as etiological elements, personality characteristics, drinking patterns, and course of illness (Babor, 1998). This evolution in typological thinking has been in part influenced by the development of multivariate statistical techniques as well as reliable and valid measurement procedures that make it possible to search for homogeneous subgroups within a population of alcoholics. Similar to the simple dichotomy suggested above in the review of the homeless typology

literature, the alcoholism typology literature has identified a low severity, low vulnerability subgroup (Type A) and a high vulnerability, high severity subgroup (Type B) (Babor et al., 1992).

CONCEPTUAL ISSUES

Definition of Terms and Important Concepts

A number of important terms and concepts have been introduced in the introductory sections of this chapter that should now be more formally defined.

What is a typology? A typology is a classification system and a set of decision rules used to differentiate relatively homogeneous groups called subtypes. A subtype is an abstract category organized according to some conceptual, theoretical, and clinical principle. According to one student of clinical subtyping (Millon, 1991), subtypes of complex clinical phenomena are "splendid fictions" because nature was not made to suit the conceptual need for a well-ordered universe. As noted above with typologies of alcoholism, different concepts and categories can be formulated and labeled in a variety of ways, but bear in mind that these labels are not necessarily "realities." This realization should not discourage one from attempting to make sense of complex clinical phenomena and heterogeneous groups if the primary purpose is kept in mind to benefit people in need and make the most efficient use of resources.

What is a "homeless family"? Although this term appears to be self-evident, it is important to note that "homeless" should include both literal homelessness and families who are doubling up with others by necessity, and "family" should include couples without children, couples with children, and the large category of single parent with children.

Treatment and Service Matching

The concept of treatment or service matching refers to decision rules designed to facilitate matching to optimal treatment modality, service intensity, and ancillary services. An important consideration in the development of a typology of homeless families is the kinds of services that the typology might relate to in terms of treatment, prevention, and other needs. Obviously, the typology should be relevant to the types of services that are appropriate, feasible, and available to homeless families. These services include the following:

- Shelter facilities to deal with immediate and short-term housing needs
- Child care, preschool, and school placement to deal with children's needs
- Housing subsidies to deal with economic barriers to housing
- Supported housing and other housing programs to deal with long-term housing needs
- Services to keep families intact and to improve family dynamics
- Employment counseling
- Welfare programs to provide for basic needs
- Medical care, including sexually transmitted diseases and pregnancy care
- Clinical preventive services, including family planning, HIV prevention, and childhood immunizations
- Mental health counseling, especially for PTSD, depression, and domestic violence
- Treatment for substance abuse
- Case management to integrate and coordinate individual services

Services to help with stable housing or to rectify personal problems have to face unusually high obstacles. No matter how much help is given to finding housing, low income housing is often so limited (McChesney, 1992a) that only a small number can be rehoused unless the supply is increased.

Services to help with stable housing or to rectify problems have to be appropriately gauged to avoid a mix of insufficient and wasteful services. There is now ample evidence that the majority of homeless families can achieve stable housing based only on housing subsidies (Shinn et al., 1998; Stretch and Krueger, 1992; Wong et al., 1997). In other studies when subsidies and a variable set of support services or case management were given, the strongest predictor of housing stability was subsidized housing regardless of the intensity of services (Weitzman and Berry, 1994; Rog, Gilbert-Mongelli and Lundy, 1998). Thus in the majority of instances, housing subsidies should be sufficient to achieve stable housing, and there is no need to provide additional case management for those families. However, a small proportion of families return to homelessness during a 5-year follow-up period (Stojanovic, Weitzman Shinn et al., 1999). Thus an important role of a typology of homeless families would be to help in the identification of those families that need supportive services in addition to housing subsidies, and what kind of services are needed (e.g., case management, intensive case management, specialized services).

Possible Functions of a Typology

Given the nature of typological formulations and their history in clinical decision-making, an important conceptual issue is the possible functions of a typology for the management of homeless families. The major uses of clinical typologies that have been proposed in these various literatures are the following:

- Summarize important diagnostic, prognostic and descriptive information in a simple, understandable classification scheme.
- Provide an empirical basis for client-service matching, such as programs to help with stable housing**,** psychological problems, medical care, social services, child care, or substance abuse.
- Minimize or remediate effects on children.
- Improve specificity of prediction of short-term as well as long-term outcomes in relation to services received.
- Help to prevent family homelessness.

Optimal Taxonomic Standards of a Good Typology

Based on the experience of typological research in psychiatry and substance abuse (Babor and Dolinsky, 1988), a set of taxonomic standards can be suggested as the characteristics of a good typology. Optimally, a typology of homeless families should:

- Be simple in its structure;
- Have practical utility (e.g., mediate judgments about clinical evidence);
- Allow matching to clinical and preventive services;
- Be easy to derive from available data;
- Permit inferences to underlying causes;
- Predict future behavior;
- Facilitate communication;
- Demonstrate empirical validity and reliability; and
- Identify subtypes that are homogeneous within categories, remain stable over time, and are comprehensive in their coverage of the homeless population.

A typology of homeless families with children is relevant to at least three public health issues: (1) how to help such families gain stable housing; (2) how to help them with personal problems, including but not limited to those affecting housing; and (3) how to protect homeless children in situations that may interfere with their healthy development. The same typology may not be optimal for these three challenges. Therefore, it is possible that more than one typology of homeless families may be indicated.

CLASSIFICATION ISSUES

If there is general agreement that typological formulations are appropriate to consider for the description and management of homeless families, the following questions need to be addressed before beginning the search for subtypes:

- Should the approach be theory driven or directed by blind empiricism? [Does it have to be an either-or?]
- Should the typology work within a single domain of variables or should it be multi-dimensional?
- Should the working material for the typology include individual and group strengths as well as risk factors?
- Should the working material include cross sectional or longitudinal variables, family variables or individual characteristics? What are the relative merits of disaggregating families from individuals?
- Is one typology going to be sufficient, or should there be several?
- Is it better to focus on the causes or the consequences of homelessness?

Question One: Theory Driven or Blind Empiricism?

Regarding the first question (whether the typology should be theory driven or directed by blind empiricism), it is first necessary to evaluate the quality of theory. There are essentially five theories: (1) Homeless people belong to an underclass with a culture of its own that lacks the necessary personal structuring needed to develop a home life, employment etc, (Schiff, 1990). There is little, if any, evidence for this view. (2) Homeless people have "lost out in the battle for acceptance" and have gone through aversive learning experiences and as a result, they value their retirement from any institutional constraint (Levinson, 1963). This theory is compatible only with a very small fraction of homeless people, chiefly

single men. (3) Homeless people have a faulty relationship with society, a "social disaffiliation" that may be brought about in various ways, for example, by mental illness, drug use, or other causes (Bahr and Caplow, 1970). This theory, which was popular for a while, fails to take into account the extensive social networks that recent empirical research has demonstrated for homeless people. (4) Homelessness as an extreme form of poverty resulting from the gap between income and available low-income housing. There is no single theoretical paper about this theory, but a lot of empirical evidence suggests an association between homelessness and severe poverty and unavailability of low income housing. (5) Societal disinvestment theory (Jahiel, 1992) accepts the premises of hypothesis but looks beyond it to decisions made by society to disinvest in certain geographic areas, types of work, or types of welfare support. It also fits the empirical evidence.

Based on this brief review, there seems to be little consensus around an explanatory theory, and virtually no theories specific to homeless families. Nevertheless, it would seem like theory may offer some guidance on the selection of candidate variables for further empirical exploration. For example, there is good support for theory 4 at the aggregate level (to account for the size of the homeless population). At the individual level, some vulnerability factors (ethnicity, pregnancy, substance abuse, past homeless history, various disabilities, physical abuse by spouse, and others as well as being in the wrong place at the wrong time) account for who is selected by society (societal disinvestment) or by self (societal disaffiliation) to become homeless.

Question Two: Single Domain or Multidimensional Typology?

Regarding the second question (single domain or multidimensional typology), if a single domain is chosen, the only one that is general enough is the low-income housing/poverty relationship. In this instance, the typology should include exogenous variables (availability, accessibility of housing), personal variables (need for mere housing subsidies or subsidies plus support services) and situational variables (acceptability, appropriateness of the housing that is provided). That domain would be best adapted to a majority of homeless families, judging from the literature reviewed above. In addition, that domain could be used with a preventive approach to homelessness (including such additional variables as eviction preventive programs, and low-income housing guidance). A multidimensional approach would be better adapted to a (multidisciplinary) client-service matching strategy with two possible purposes: (1) ending homelessness (here the housing /income disciplines would be predominant); (2) alleviating or perhaps

diminishing the adverse effects of homelessness (here the effects on homeless children would have top priority, with mental, physical and re-adaptive services as a second priority for specific families).

Approaches to Understanding Homelessness

Another issue is whether homelessness should be approached in a cross-sectional way or situated in the larger context of developmental experience. Some types of homelessness may be developmentally cumulative, becoming progressively worse over time, whereas others may be developmentally limited (e.g., only during periods of economic depression and only when children are in care of parents). The successful negotiation of major life events such as completing an education, assuming adult roles, choosing a profession, marriage, and having children, may have important implications for the determination of which homeless families become economically self-sufficient and which ones deteriorate and remain chronically homeless. A cross-sectional approach may be the simplest one for a client-service matching, but it may not be without limitations, and it tends to select chronically homeless people unless statistical corrections are made for the effect of homelessness duration on the chance of being selected in the study. Homelessness, even of short duration, is often preceded by a period of considerable financial or emotional stress and poor quality of life. Thus, the variables included in the typology should not be limited to the period of homelessness, but also to preceding stressful periods and following periods of re-adaptation to having a home. Several studies have shown that the risk of homelessness is markedly increased by several distant developmental antecedents, such as physical and sexual abuse during childhood (Bassuk, Perloff, and Dawson, 2001); foster care or institutional placement during childhood, housing instability during childhood (McChesney, 1992b) or homelessness as a youth (Mackenzie and Chamberlain, 2003).

Family Variables vs. Individual Characteristics

Regarding the issue of family variables vs. individual characteristics, it would seem logical and necessary to consider both in any typology of homeless families. There are typologies of homeless youth, (i.e., youth who are homeless by themselves), with categories of runaway; throw away and "system" (e.g. foster care) youth (Farrow, Deisher, Brown, Kilg, Kipner, 1992). Very little has been done, to our knowledge, regarding a typology of children whose family is homeless. Daniesco and Holden (1998) proposed a typology of homeless families in which one type was associated with higher rates of parenting stressors, major life concerns**,** and children with cognitive, academic, and adaptive behavior problems.

METHODOLOGICAL ISSUES

Having described the conceptual issues that justify the development of typological formulations, particularly in relation to homelessness and homeless families, this section considers the benefits and disadvantages of various methodological approaches for typology development, as well as criteria for selecting variables, measurement procedures and statistical methods for the identification of homogeneous subgroups. Among the methodological approaches that have been employed in typological research on psychiatric populations are clinical description, statistical discrimination, and response to treatment.

Clinical description is based on observation of clinical cases that come to the attention of service providers. A major limitation of early attempts at clinical description is the failure or inability to use objective measurement techniques to provide a basis for testing assumptions about differences between subtypes.

With the advent of structured interview schedules, psychiatric diagnostic criteria, personality inventories, and administrative data bases used to collect descriptive information, quantitative procedures have been used to identify homogeneous groups. For example, subtype discrimination and identification can be brought to a higher level by using statistical clustering techniques that identify homogeneous subgroups based on correlations among individuals sharing similar characteristics.

From the experience gained in other areas of clinical research, it is clear that classification theory and clinical practice should both be grounded in objective clinical assessment and sound research methodology. It is, therefore, important to focus on the selection of classification variables and their measurement as the most fruitful empirical approach to the development of a typology.

Selection of Classification Variables and Data Sets

Several criteria may be helpful to guide the selection of variables. These are simplicity, ease of measurement, theoretical relevance, minimal measurement overlap, coverage of major domains of interest, and practical usefulness in service matching.

From the perspectives of efficiency and economy, the availability of current instruments is certainly an important practical consideration. Progress would be much faster if one could use existing instruments and data sets than if one had to devise new instruments. However, one should not be guided in the choice of a variable by availability of instruments for that variable. The choice of variables should be determined by its theoretical and practical value. However, one should also consider developing a new instrument for key constructs to the extent they are considered important.

A variety of measurement techniques and standardized assessment procedures have been developed to measure many of the variables relevant to typological formulations. Techniques include self-report questionnaires, personal interview schedules, and administrative data, including demographic characteristics. Assessment procedures include measures of psychopathology, substance use disorders, personal resources, and multiple problem inventories, such as the Addiction Severity Index (McLellan et al., 1992), which covers employment, psychiatric severity, substance abuse, family functioning, and criminal activity. Additional considerations important in the selection of measurement instruments are response burden, administrative load, and the availability of data sets to develop typologies.

A decision point in considering variables is whether to focus on endogenous variables (i.e., characteristics of the homeless families), exogenous variables (i.e., characteristics of the environment of such families), situational variables (i.e., characteristics of the interaction with the environment or of situation in the family's homelessness history), or all the above.

There has been very little use of available data on the environment of homeless families. Yet such data are of critical importance since homelessness is the result of interactions between persons and their environment (Jahiel, 1992b). There are several readily available sources of data with environment as a unit of analysis that could be used: (1) as a typology of homeless environments, or (2) in a typology of homeless situations (matching homeless persons' needs and environmental capacity to meet these needs). Environmental data fall into several categories: (1) housing-related; (2) welfare-related
(3) employment-related, (4) health-related, (5) mental health and substance abuse related.
A partial listing of available secondary data resources that are relevant to critical environmental factors is given in Appendix B.3.

Another decision point is whether to start with "epidemiological type variables" (i.e., variables shared with other environmental problems), or empirically derived variables (variables elicited in

qualitative or quantitative empirical studies in the field of homelessness, that are often more complex than the first type, and that have sometimes been used in developing typologies of homeless persons).

To the extent that the goal is to develop a typology that can be justified quantitatively and be useful in quantitative studies, the selection of variables is very important, particularly with regard to the state of disaggregation (to avoid noise), the locus of the variable (the one that best explains), and the specificity or the relevance of the variables for homelessness as it may be revealed by previous qualitative studies or published typologies. Appendix B.4 provides some examples to guide a starting point for an empirically derived typology.

A related consideration in the selection of variables is the availability of data sets that include various measures of homeless families. There are four existing longitudinal data sets on homeless families: the New York City Homeless Family Study (NYC HF, Shinn et al., 1998), the Worcester Family Research Project (WFPR, Bassuk, Buckner, Perloff and Bassuk, 1998)), the Robert Wood Johnson /U.S. Department of Housing and Urban Development data set (RWJ/HUD HF, Rog and Gutman, 1997), and the Substance Abuse and Mental Health Services Administration Homeless Families Program (SAMHSA.HF, SAMHSA, 2004)) and one cross-sectional study (the NSHAPC, Burt et al., 1999). Together the four longitudinal studies have 3,878 subjects. Each of these studies has a set of demographic data (age, race, marital status, work, education, currently pregnant) and certain service needs (health, mental health, substance abuse, trauma, legal history). Three of them have measures of income and foster care history. There are differences in the instruments used to measure these variables but there is enough similarity among them to make it possible to do replication studies, with appropriate correcting factors. There are marked differences in the selection of the study populations. Two of them (NYC-HF and WFPR) have populations of families on welfare and families in shelters. One (the RWJ/HUD HF) has families with multiple needs entering enriched housing. Another (the SAMHSA.HF) has families with mental illness, substance abuse, or both. Thus there are marked selection differences among families in the four studies, including differences in service needs and differences in the stage during the trajectory of homelessness when these families are studied. Furthermore, all studies underselect families that are doubled up (as opposed to literally homeless) and families that are in shelter for battered women, as well as families that have little or no contact with services. Thus, the four studies cannot be considered representative of the homeless family population at large. Further, families with multiple or severe service needs are selected in at least the two largest studies. Nevertheless, the advantage of the large sample sizes of the four combined longitudinal studies cannot be overlooked. They might yield typologies

that are robust in the presence of differences in types of populations selected, for instance, typologies reflecting the intensity of service needs.

The only study able to provide good data on families identified before they are homeless and followed longitudinally, including those that remain stably housed and those that do not and have episodes of homelessness, is the National Survey of America's Families (NSAF) (Abi Habib et al, 2005). NSAF has data from a representative sample of the civilian population with an oversampling of people with low income, with a large sample (n=> 40,000) surveyed in a cross-sectional design every 2 to 3 years. It is the best available source of information on doubling up, since it has a specific question asking whether the family had to move in with another family because of inability to pay mortgage, rent, or utilities. This data set would be very useful in investigating possible typologies of pre-literal homeless trajectories, as well as typologies related to history of doubling up. Further, it has demographic and service need data that might be used in conjunction with the five studies of homeless families.

Eventually studies designed to collect primary data will be necessary to achieve a nationally representative sample of homeless families or families at risk of homelessness and to have sufficient numbers to allow adequate statistical analysis. Ideally, such primary data studies should include longitudinal followup (e.g., 5 years).

Statistical Methods

A number of statistical procedures are available to identify homogeneous subtypes for the development of empirical typologies. Important considerations in the selection of a statistical procedure are the size of the data set, the value of classifying all cases, the relative importance of working with smaller rather than larger numbers of subtypes, and the need to confirm or reject subtypes reported in the literature.

Cluster analysis typically focuses on patterns of individual symptom clustering (e.g., syndrome manifestation). Most investigators apply cluster analysis to cases, rather than attributes. One advantage of empirical clustering techniques like the k-means clustering procedure is that all cases can be classified, and the method tends to favor the identification of a small (e.g., 2-5) rather than a larger number of groups.

In addition to cluster analysis, a variety of alternative procedures are available for representing structure. DelBoca (1994) has argued that nonmetric multidimensional scaling (MDS) can be useful to identify major dimensions along which members of a particular heterogeneous group can be ranked. This approach is particularly suited for finding a relatively small number of important dimensions that underlie the similarities or differences among cases or attributes ("objects"). Based on the degree of similarity or dissimilarity between each pair of objects, the procedure produces an array of objects in n-dimensional space. The reference axes in the resulting MDS spatial configuration are arbitrary but multiple regression can be used to fit substantive dimensions in the space.

Latent class analysis (LCA) is a multivariate statistical technique used to explore the structure and number of unobserved subgroups. LCA assumes that there are qualitatively meaningful groups (or classes) that exist in a population and that symptom frequency can be explained by the existence of a small number of mutually exclusive classes, with each class having a distinct profile of item endorsement probabilities. Another important assumption is that the variables are statistically independent and conditional on class membership.

Each approach has its strengths and limitations. With many different variables, possibly in different categories (exogenous, endogenous, etc), multidimensional scaling might be the method of choice for more complicated modeling.

Validation Procedures

The validity of a classification or typology can be established in a variety of ways. The approach most frequently emphasized in clinical research is predictive validity, which refers to the ability of a classification scheme to suggest the most likely course and treatment response for a given member of a class. Another approach is construct validity, which refers to the "goodness of fit" between a theoretical construct (e.g., an ideal type of homeless family) and a set of statistical relationships observed empirically. Discriminative validity means that the subgroups classified by a typological theory can be clearly discriminated from one another in terms of major defining characteristics and correlates of homelessness, such as demographic factors, situational variables, service utilization or exogenous factors.

The following is an example of a validation procedure that can be applied to subtypes derived from empirical clustering procedures. Once a satisfactory solution has been achieved: (1) compare the

clusters using variables excluded from the original analysis as evidence of discriminant validity; (2) compare clusters on measures of clinical course following a service intervention (predictive validity); (3) examine subtypes in terms of their fit with theoretical constructs of homelessness (construct validity); (4) determine whether there are differential outcomes for subtypes matched to optimal services. Other criteria for evaluating a typology are homogeneity within subgroups, comprehensiveness, simplicity, and practical utility.

CONCLUSIONS

A typology of homeless families should build on the existing knowledge. Most homeless families are experiencing severe poverty and that subsidized housing is enough in the majority of instances to help them gain a stable home. There are smaller groups for whom this does not seem to work, presumably because other environmental, personal, or situational factors. There may be environmental barriers to housing subsidies and other services.

Aside from their extreme poverty, homeless families belong to a heterogeneous population. They fall into three groups: newly and recently homeless, recurrently homeless, and chronically homeless. The first group is the largest and the third is much smaller. Personal factors associated with family homelessness are loss of employment, welfare support, spouse or partner; eviction from current living quarters; recent violence; physical or sexual abuse in childhood and/or foster care or lack of stable housing during developmental phases; belonging to African American or Hispanic minorities; pregnancy; hospitalization; and substance abuse, medical problems as well as mental disabilities. At the individual or family level, these findings are consistent with a theory that homelessness is associated with severe poverty, lack of access to housing, and exposure to traumatic events, some of which go back to childhood. At the population level, the theory that homelessness is associated with a gap between the number of low-income families and the availability of low-income housing units (the homelessness equation) is well suited to the facts.

There is evidence that, while children can be quite resilient, homelessness provides them with serious hazards shared, at least in part, with children experiencing severe poverty in their home (Buckner, 2005). Such hazards include hunger, poor physical health, poor access to health care, disrupted education, barriers to home work; exposure to bias associated with stigma; insults to self-image and to parental image; exposure to violence, psychological abuse; drug abuse; separation from family members;

separation from parents and foster care placement; and lack of a stable, secure home during development. Research on children who are homeless with their families is far less advanced than research on homeless youth.

Research on homelessness, in general, and on homeless family typologies in particular, should be guided by the context in which research policies are developed. In the historical context of the 1980s, the problem was focused on single homeless persons and on mental disorder ("the homeless mentally ill") and abuse of various substances. Thus, at the Federal level, the problem was "owned" by mental health and substance abuse agencies, and those agencies funded the waves of research in the 1980s and 1990s, and the characteristics of homeless persons were targeted. The rapid increase in the number of adults and children that are homeless as a family group led to additional research funded by private foundations and local government, as well as demonstration projects to address such homelessness. The results refocused the problem on housing and, therefore, housing subsidies, and on the developmental damage done by unstable housing situations, poverty, and sexual or physical abuse. The simplistic view that treating mental disorder or substance abuse would solve the homelessness problem is no longer tenable. Rather, the solution has to be systemic, a point that is reflected in the organization of the Federal U.S. Interagency Council on Homelessness. In the Department of Health and Human Services (HHS), the problem now requires planning and evaluation of the role of HHS's various social and health divisions, as well as a concerted collaborative effort involving the Department of Housing and Urban Development (HUD).

In this new context, typologies of homeless families must include exogenous (housing environment, housing and health/human services access), endogenous (characteristics and history of homeless families and their members), and situational (fit between homeless families' needs and accessible environmental resources) components. A systematic approach to developing a typology should take into account their practical value for: (1) preventing homelessness; (2) securing a home for homeless families; (3) preventing recurrence of homelessness; (4) providing human and health services to meet the needs of homeless families and their members; and (5) offsetting the harmful developmental effects of homelessness on children.

The typologies could be used to assign homeless families or children to groups that would be relatively homogeneous with regard to policy development at Federal and local governmental levels, and service provision at the provider level. At the governmental levels, the prevalence estimates and distribution of the population of homeless families among the various groups would guide the

development of programs among and between agencies. At the provider level, the classification of the client families among the classification categories would guide various providers in the selection of interventions at various stages in the process of experiencing and responding to homelessness: imminent eviction by landlord or flight from abusive home, presentation to initial service agency, assignment to initial shelter, interaction with welfare, employment and other agencies, provision of needed personal services to adults and children, temporary housing, with or without support, and finally, permanent housing.

A simple heuristic device that could be used to guide further work in typology development is shown below in terms of a four-celled model:

		Environment with Facilitators	Barriers
Service needs of families	minor		
	major		

Differing typologies within this general format might be applied to housing, health and human services, and education of children. Detailed typologies might be developed within each dimension (i.e., service needs based on endogenous variables, environmental context based on exogenous). Ultimately, the interaction between endogenous and exogenous factors needs to be investigated, to the extent that the distribution and prevalence of service need subtypes is likely to vary with the environmental context, with environments having a high density of barriers (e.g., high unemployment, lack of services, poor housing stock) more likely to include families with minor or moderate service needs, whereas facilitating environments (e.g., ample services, low unemployment, adequate low income housing) more likely to include families with major service needs.

Homeless individuals or families are often classified as being newly homeless, on the one hand, or recurrently or chronically homeless, on the other hand. Sometimes a third group of recurrent (but not chronic) cases is included. The smaller, chronic group utilizes a disproportionate amount of shelter and other services. It has been proposed (and introduced as policy to end homelessness) that efforts be targeted to this small chronic group. This has been countered by advocates of homeless families who point to the significant needs of the much larger group of new and recurrent homeless families.

RECOMMENDATIONS

Here are recommendations for two types of typological research: (1) new data collection efforts targeted at developing and validating one or more typologies; (2) studies using existing data sets.

Recommendations for New Studies to Develop Typologies Relevant to Homeless Families

New cohort studies should be conducted with children in homeless families, with follow up until adulthood, including data on the variables listed in Appendix B.4. This is given the highest priority because damage to children, whether associated with severe poverty or homelessness, may have long-term repercussions on their emotional, social, intellectual, and physical development. Most studies of homeless children have had relatively short follow up. The findings in homeless and housed children should be disaggregated to identify subtypes associated with more severe social or developmental outcomes. Duration/frequency of homelessness, context of homelessness (shelter, street, doubling up), prehomeless history of the family, social isolation of the family, continuity of family life during homelessness, personal family conflicts and conflicts of the family or children with the law, nature of public and private services received, and community support, indifference, or stigmatization are examples of categories that might be significant in building a typology. The objects of the typology would be to identify groups of children at risk of developing long-standing ill effects of childhood homelessness and protective factors thereof, as well as grouping children by service needs.

In addition, new cross-sectional and longitudinal (cohort) studies should be conducted to group homeless families based upon the environmental housing variables in the locality, and the housing, employment and financial needs of the families. Different typologies might be needed for the differing objectives of preventing eviction; securing housing for homeless families; and preventing recurrence of homelessness. This is needed to develop effective and efficient housing policies and services and perhaps could be accomplished by research on social indicators and other population statistics within states, metropolitan statistical areas, and other geographic or governmental subdivisions.

Finally, new cross-sectional and longitudinal (cohort) studies should be conducted to group homeless families according to needs for services and environmental access to needed services. This is needed to provide the services needed by this high risk population for adverse health and social effects and to help to offset some of the human damage caused by the homeless situation.

Recommendations for Studies with Existing Data

Readily available data sources on homeless families include four longitudinal studies (Shinn et al., 1998; Bassuk et al., 1998; Rog and Guttman, 1997; SAMHSA, 2004), two in a single city (New York and Washington, DC, respectively) and two in several sites. There is also one cross-sectional study (Burt et al., 1999). The two studies in a single city select single female headed families on welfare. The two longitudinal studies in several sites select families with serious problems, requiring health, substance abuse, and mental health services. The cross sectional study is based on a shelter population. There is considerable heterogeneity in the design and instruments used in these studies. A retrospective meta-analysis would require considerable statistical sophistication. One of the longitudinal studies of low-income housed families is likely to include families that experienced homelessness during the followup period. As a prospective study with good national sampling and little evidence of selection of families, it is a good candidate to study the development of family homelessness, provided there are enough instances of homelessness in the study population.

Clearly the currently available data do not include all types of homeless families with children and, at least in some studies, there has been a tendency to oversample those with mental disorder, substance abuse, and frequent service use. There is an exception in the instance of NSAF. Because its cohort begins as housed families, it is unlikely to select particular pathways or subgroups of homeless families. Thus, a secondary data-based approach to a typology might first find whether there are enough families in NSAF and enough variables relevant to homelessness in that study to warrant using it in clustering studies. Another approach would be to use the five homelessness studies very cautiously, with analysis of resulting clusters for dependence upon the excess categories described above. Along these lines, the following secondary analysis projects are suggested:

1. The longitudinal study of low-income housed families should be examined to determine whether it will yield a sufficient number of homeless families to warrant attempts to develop a typology. If so, the careful selection of available severity indicators could be recommended, within the context of the four-celled approach described above.

2. Preliminary typological analysis of the five homeless family studies should be performed to assess the extent to which the design and instruments are compatible with pooling their data to develop a typology; and find how much effort would be needed to index the subjects in these

studies with environmental data as described in Appendix B.3 and Appendix B.4. If the studies pass both tests, they might be worth further analyses both as pilot projects for the new studies and as a provisional source of data to guide policy and service delivery.

Available data in the five homeless family studies include the approximate dates when the findings were obtained and the localities where the homeless families were situated. Therefore, it should be possible to link demographic and endogenous measures from these studies with data on housing and other environmental variables listed in Appendix B.3 using date and locality information from Federal and local agencies and advocacy sources. Thus, it might be feasible derive a rough four-celled typology model from those linked data.

From a very practical point of view, perhaps it would be best to start with an attempt to create a relatively simple typology using readily available endogenous (e.g., psychopathology/psychiatric severity; substance abuse) and personal history variables (e.g., chronicity of homelessness, minority status) that are particularly relevant to women with children, and to test their interactions with environmental factors as suggested above. This approach could be applied to existing data sets (both longitudinal and cross-sectional) and might lead to a relatively easy way to provide a simple classification into the uncomplicated and complicated subtypes suggested in the literature. If replicated subtypes could be identified, they could provide a basis for some relatively straightforward decisions matching families to the most appropriate levels and types of intervention, including housing, social services, medical services and psychiatric care, with the more severe, chronic subtype perhaps being the subject of additional subtyping analyses to develop a more refined classification into service need categories. New research on primary data sources should also proceed in concert.

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B.2: European Typology of Homelessness and Housing Exclusion (ETHOS)

Conceptual category	Operational category	Sub-Category	Description
Roofless	1. Living in a public space (no abode) 2. Stay in a night shelter and/or forced to spend several hours a day in a public space	1.1 1.2 2.1 2.2 2.3	Sleeping Rough Contacted by outreach services Low-threshold / direct access shelter Arranged (e.g. low budget hotel) Short-stay hostel
Houseless	3. Homeless hostel / temporary accommodation	3.1 3.2 3.3 3.4	Short-stay homeless hostel Temporary housing (no defined time) Temporary housing (transitional defined) Temporary housing (longer stay)
	4. Women's shelter / refuge	4.1 4.2	Shelter accommodation Supported accommodation
	5. Accommodation for asylum seekers and immigrants	5.1 5.2 5.3	Reception centers (asylum) Repatriate accommodation Migrant workers hostels
	6. Institutional Release	6.1 6.2	Penal institutions (period defined nationally) Institutions (care and hospital)
	7. Specialist Supported Accommodation (for homeless people)	7.1 7.2 7.3 7.4	Supported accommodation (group) Supported accommodation (individual) Foyers Teenage parent accommodation
Insecure housing	8. No tenancy 9. Eviction Order 10. Violence	8.1 8.2 9.1 9.2 10.1	Living temporarily with family or friends (not through choice) (Housing /Social Service records) Living in dwelling without a standard legal (sub) tenancy (excludes squatting) Legal orders enforced (rented housing) Re-possession orders (owned housing) Living under threat of violence from partner or family (police recorded incidents)
Inadequate housing	11. Temporary structure 12. Unfit Housing 13. Extreme Overcrowding	11.1 11.2 11.3 12.1 13.1	Mobile home / caravan (which is not holiday accommodation) Illegal occupation of a site (e.g. Roma / Traveller / Gypsy) Illegal occupation of a building (squatting) Dwellings unfit for habitation under national legislation (occupied) Highest national norm of overcrowding

B.3: Sources of Data on Environmental Factors

1) **Data on housing and shelters**
    a) *Low income housing data.* The National Low Income Housing Coalition provides a report initiated by Dolbeare Cushing and updated every year or few years on the cost of rental housing at a very disaggregated level (town or county), and relates it to wages and other income. These data are essential to the understanding differences in rates of homelessness or of recovery from homelessness.
    b) *Data from HUD.* HUD has a wealth of data on low income housing resources disaggregated to town and county levels. There are several relevant programs, and only the most salient ones are included below.
        i. Section 8 certificates (local numbers and utilization rate);
        ii. Section 202 buildings;
        iii. HOME investment partnership program *(this would be significant for people already having a job who are coming out of homelessness, to help them with mortgage)*;
        iv. Section 232 providing mortgage insurance for assisted living facilities and board and care homes; and
        v. Public and Indian Housing Resident Opportunities and Self-sufficiency (ROSS) program.
    c) Data from the Department of Agriculture on Rural Housing Services Rent Assisted programs.
    d) Data from the periodic surveys (e.g., ‘‘the continuing growth of homelessness and poverty in American cities’’ conducted by the United States Conference of Mayors).
    e) Local area data (town or state level).
        i. Anti-eviction programs;
        ii. Housing subsidies for homeless families;
        iii. Mortgage assistance programs
        iv. Local data on items discussed in *a)* and *b)*.

2) **Data on income related programs**
    a) HHS data on federal supplemental security income (SSI) and state supplements to the federal SSI payments.
    b) Local town or state welfare programs (eligibility, amount of support).
    c) Data from local transportation departments on cost of transportation and availability of transportation vouchers.
    d) Data from local government social service and from Department of Labor on availability of jobs and rates of pay and unemployment rates in different localities.

3) **Data on health related services**
    a) Location of community health centers.
    b) Location of mental health services.
    c) Location of substance abuse preventive and detoxification service.
    d) Location of McKinney homeless programs.
    e) Local availability/accessibility of other kinds of health related services.

B.4: List of Exogenous, Endogenous, and Situational Variables

Exogenous Variables

1) Area housing resource indicators:
    a) State or local eviction prevention policies
    b) Title 8 vouchers
    c) Waiting time for 202 or other public housing
    d) Local area occupancy ratio of rental housing
    e) Local ratio of low income housing rent to minimum wage
    f) Local availability of SRO housing
    g) Local availability of housing subsidies: hotel rooms
    h) Local availability of housing subsidies: apartments, rental house
    i) Local availability of down-payment assistance programs
    j) Local mortgage assistance
2) Area shelter resources
    a) Homeless shelter-occupancy ratio
    b) Homeless shelters with extended stay-occupancy ratios
    c) Family shelters with both parents-occupancy ratio
    d) Family shelters with only one parent-occupancy ratio
3) Income sources in area
    a) Welfare policy indicators
    b) Area welfare income rate per family size
    c) Area hourly, weekly or monthly minimum wage
    d) Availability of jobs paying less than minimum wage
    e) Area unemployment rate
    f) Average number of applicants per low paying job
4) Environmental safety indicators in the area
    a) Nutritional: availability and quality of soup kitchen and other free foods
    b) Temperature extremes for season
    c) Drug dealing activity indicators
    d) Crimes (assault, robbery, rape) rates
    e) Infectious diseases (rates of respiratory, STD, skin, GI, etc)
    f) Building safety re: collapse, arson, etc.
5) Social environment in the area regarding people who are homeless
    a) Hostile: NIMBY
    b) Live and let live
    c) Supportive
6) Local service resources
    a) Educational
    b) Physical health
    c) Mental health
    d) HIV/AIDS
    e) Drug abuse
    f) Job training
    g) Legal/administrative assistance
    h) Sheltered workshops
    i) Homeless clients work programs

Endogenous Variables

1) Demographics
    a) Single or two-parent family
    b) Number of children
    c) Age of children (infants, pre-school, school, adolescents)
    d) Pregnancy
    e) Age of parents
2) Social capital
    a) Education of parents
    b) Parenting ability of parents
    c) Work skills and habits
    d) Helpful informal network
    e) Prison/jail record
    f) Illegal alien
    g) History of institutionalization (hospital, training school, etc)
3) Financial capital
    a) Income
    b) Savings
    c) Credit status
    d) Valuable possessions
4) Health status of family members
    a) Chronic illness
    b) Physical disability
    c) Mental disorder
    d) Intellectual disability
    e) Substance use and abuse
    f) HIV/AIDS
5) Past traumatic history and PTSD (parents)
    a) Physical abuse in childhood (parents)
    b) Sexual abuse in childhood (parents)
    c) Physical abuse as adults (parents)
    d) Sexual abuse as adults (parents)
6) Linguistic and cultural resources
    a) Mainstream culture: English
    b) Marginal culture: good English
    c) Marginal culture: poor English
    d) Ethnicity: nationality

Situational Variables

1) Precipitating factor
    a) Natural disaster or condemned housing
    b) Eviction by landlord or by foreclosure for lack of payment
    c) Immediate post-hospitalization loss of housing
    d) Immediate post-release from jail inability to find housing
    e) Loss of job
    f) Gradually increasing financial distress
    g) In and out of homelessness with short turnaround (less than a month)
    h) Moving to another town (state, country) and cannot find housing
    i) Evicted by parent or mate
    j) Physical or emotional battering by parent or mate
    k) "I cannot stand that home environment"
    l) Evicted for using drugs or being drunk
    m) Other

2) Current homeless situation
    a) Doubled-up with friend or family
    b) Supported or transitional housing
    c) Referred domicile (e.g. paid hotel room)
    d) Family shelter
    e) Individual shelter
    f) Own car
    g) Squatting
    h) The street or equivalent (e.g. airport, etc)

3) Time limits of domicile
    a) Number of days, weeks or months allowed
    b) Number of hours per day allowed

4) Relations with domiciliary setting
    a) Supportive
    b) Neutral
    c) Tense, conflicted
    d) About to be evicted

5) Reaction to homelessness
    a) Early crisis reaction
    b) Early adaptation reaction
    c) Short term efforts to regain a home
    d) Long term efforts to regain a home
    e) Resigned to homelessness, not trying, but not adapted
    f) Adapted to long term homelessness

6) Parents' general stress and coping with obligations of daily living
    a) Low stress, high coping
    b) Low stress, low coping.
    c) High stress, high coping
    d) High stress, low coping

7) Parenting stress and coping
    a) Same categorization as in *5)*

8) Work situation of parent or older youth during current homelessness
    a) Work full time (satisfied with work or not)
    b) Work part-time
    c) Occasional work
    d) Looking for work
    e) Has given up looking for work

9) Work situation of parent or older youth before current homelessness
    a) Employed or otherwise worked
    b) Failed welfare to work transition
    c) Had never worked

10) Non-work income situation of parent or older youth during current homelessness
    a) General welfare
    b) SSI
    c) SS (retired or disabled worker)
    d) Other (e.g., private pension, VA, etc)
    e) Underground economy
    f) No source of income

11) Informal social support (family, friends, other homeless)
    a) Quality of support: supportive, neutral or negative
    b) Reliability of support: steady, intermittent, unreliable
    c) Perception of support: perceived as meeting or not meeting needs

Additional Questions for Children

1) Housing history of the child
    a) Duration of current episode of homelessness for the child
    b) New or recurrent homelessness for the child
    c) Housing instability of the child prior to homelessness
    d) With parent(s) in shelters or separated from parent(s)
    e) History of foster care
    f) Child's appraisal of homeless situation

2) Traumatic history of the child
    a) Physical abuse or neglect
    b) Sexual abuse
    c) Psychological abuse or neglect
    d) Welfare involvement
    e) Accidents

3) Situation of school-aged child in family
    a) Expected to earn money (work, panhandle, etc.)
    b) Expected to care for siblings or parent
    c) Significant sibling rivalries
    d) Significant home behavioral problem
    e) Source of strength for family

4) Educational situation of school-age children without special needs
    a) In school with continuity of schooling
    b) In school: more than 2 schools during time homeless
    c) Not in school, were in school before
    d) Never in school

5) Educational situation of school-age children with special needs
    a) Evaluated, in special needs program with continuity
    b) Evaluated, in special needs program, without continuity
    c) Evaluated, in general schooling
    d) Evaluated, not in school
    e) Not evaluated, in school
    f) Not evaluated, not in school

6) Home or community factors related to education
    a) Ability to study at home (light, space, noise, other duties, etc.)
    b) Sleeping conditions, number hours sleep at night
    c) Transportation to school
    d) Negative/positive attitude of parents toward schooling
    e) Negative/positive attitude of school mates toward homeless child
    f) Negative/positive attitude of teachers toward homeless child
    g) Language, cultural, or disability barrier to communication and understanding
    h) Integrated in regular school or in school for homeless children

7) Pre-school children: daily life activities
    a) In Headstart or other program
    b) Adequate maternal bonding and conversation
    c) Regular schedule of feeding, sleep, activities
    d) Interactions with other than parents

8) Health: General
    a) Hunger
    b) Nutritional status
    c) Growth rate, stunting
    d) Blood count (anemia, etc)
    e) Immunization status
    f) Exposure to lead or other environmental toxins
    g) Chronic illnesses, allergies
    h) Frequent acute illnesses

9) Health: Disability
    a) Vision
    b) Hearing
    c) Motor
    d) Intellectual
    e) Attention deficit/hyperactive
    f) Emotional (mental disorder), substance abuse
    g) Social (passivity, shyness, aggressiveness, etc.)

10) Health: Services
    a) Has regular primary care
    b) Specialist care
    c) Emergency services visits
    d) History of hospitalization
    e) Medications
    f) Regular dental care
    g) Self or alternative health care

11) Health care coverage
    a) Medicaid
    b) McKinney program
    c) Other
    d) No coverage

12) Attitudes of the child
    a) Sense of self (identity) and self-worth
    b) Sense of locus of control
    c) Attitude toward a home and toward parents
    d) Antonovsky's sense of coherence
    e) Detachment
    f) Feelings of isolation or of belonging
    g) Feelings of humiliation, feelings of dignity
    h) Rage to serenity score
    i) Bonding to other youths, gangs
    j) Role models