2. LITERATURE REVIEW

2.1 Building on the Existing Knowledge Base

This chapter, describing the contributions of existing research, provides the first in a series of building blocks toward developing a typology of homeless families. Although the number of studies conducted on homeless families is small, the considerable overlap in the findings suggests that there may be a sufficient knowledge base upon which to begin to develop a typology. The literature review in this chapter focuses specifically on what has been learned about the characteristics, needs, and service-use patterns of homeless parents and children to guide the development of a typology. Also highlighted are the gaps in the current base of knowledge that should be filled to construct a useful typology based on existing research in typology development.

Studies in this review include published literature, government reports, and documents identified through contacts with programs and organizations involved in these issues. Both research and evaluation studies are included if they focus on the characteristics, needs, and/or service-use patterns of families or the individuals who comprise these families. Single site and multisite studies are included, as are studies that focus on specific subpopulations and those that attempt to be more epidemiologic in scope.

The review begins with a synthesis of the research on the demographic and background characteristics of homeless families, including basic demographics of the families, human and social capital, and residential patterns (Section 2.2). Section 2.3 describes what is known about the service needs, access, and utilization patterns of homeless mothers, followed by a similar section on the service needs, access, and utilization patterns of homeless children (Section 2.4). Key findings from prior efforts in developing typologies, how current knowledge on homeless families can begin to guide the conceptualization of a typology, and what still needs to be known to fully inform these efforts are described in Section 2.5. Finally, Section 2.6 summarizes the main points of the review and outlines implications for next steps.

2.2 Demographic and Background Characteristics of Homeless Families

2.2.1 Age, Marital Status, Family Composition, and Ethnicity

The typical profile of a homeless family is one headed by a single woman in her late 20s with approximately two children, one or both under 6 years of age (Bassuk et al., 1996; Burt et al., 1999; LaVesser, Smith, and Bradford, 1997; Lowin, Demirel, Estee, and Schreinder 2001; Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka, 1995b; SAMHSA Homeless Families Project, 2004; Shinn, Knickman, and Weitzman, 1991). Despite the fact that homeless families are predominately headed by women, adults in homeless families are more likely to be married than individual homeless adults (23% vs. 7% in the NSHAPC survey [Burt et al., 1999]) and also more likely than adults in other poor families to be married at the point of shelter entry (Shinn et al., 1998). In fact, Shinn and her colleagues found that being married or living with a partner increased the risk of requesting shelter. The relative proportion of homeless families who are married in a particular study depends greatly on whether the homeless families are recruited from shelters that exclude men. In 2003, shelters in 57 percent of the cities involved in the U.S. Conference of Mayors (2005) report indicated that families could not always be sheltered together primarily because many family shelters excluded men and adolescent boys.

Not only are homeless families overwhelmingly households headed by women, but they are disproportionately families with young (preschool) children. The risk for homelessness is highest—and higher than the general population rate—among children under the age of 6. Furthermore, the risk increases for younger children, with the highest rate of risk among children under the age of 1 (infants), of whom approximately 4.2 percent were homeless in 1995 (Culhane and Metraux, 1999).

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

Homeless families are more likely than poor families, and both are substantially more likely than the general population, to be members of minority groups, especially African Americans (Lowin et al., 2001; Rossi, Wright, Fischer, and Willis, 1987; Susser, Lin, and Conover, 1991; Whaley, 2002). This is also true of homeless single adults. For example, in the NSHAPC, 62 percent of families and 59 percent

of single adults, compared with 24 percent of the general population, were members of minority groups (Burt et al., 1999). However, the particular minority groups represented vary from city to city. Their race and ethnicity reflect the composition of the city in which they reside, with minority groups invariably disproportionately represented (Breakey, et al. 1989; d'Ercole and Struening, 1990; Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka, 1995b; Shinn et al., 1991; Lowin et al., 2001). The rates of risk are again highest among young children. For example, an annual rate of homelessness in New York City among poor African American children under the age of 5 was 15 percent in 1990 and 16 percent in 1995 (Culhane and Metraux, 1999).

2.2.2 Family Separations and Influence on Family Composition

One of the unfortunate experiences for a significant portion of homeless families is the separation of a child from the family, either temporarily or permanently (Cowal, Shinn, Weitzman, Stojanovic, and Labay, 2002; Hoffman and Rosenheck, 2001). The NSHAPC reported that 60 percent of all homeless women in 1996 had children below 18 years, but only 65 percent of those women lived with any of their children (and often not all of their children); similarly, 41 percent of all homeless men had minor children, yet only 7 percent lived with any of them (Burt et al., 1999). Other studies yield similar findings (Cowal et al., 2002; Maza and Hall, 1988; North and Smith, 1993; Rossi, 1989; Zima, Wells, Benjamin, and Duan, 1996). The likelihood of having one's children separated from the family is higher for homeless mothers with a mental illness (Buckner, Bassuk, and Zima, 1993; Hoffman and Rosenheck, 2001; Smith and North, 1994; Zima et al., 1996; Zlotnick, Robertson, and Wright, 1999) and for mothers suffering from alcoholism (33%). Approximately one- to two-thirds of the mothers who reported domestic violence also experienced family separations (Browne and Bassuk, 1997; Cowal et al., 2002).

Homelessness is a major factor influencing these separations, with or without other service needs. Five years after entering shelters in New York City, 44 percent of a representative sample of mothers had become separated from one or more of their children (compared to 8 percent of poor mothers in housed families) (Cowal et al., 2002). Three factors predicted separations: maternal drug dependence, domestic violence, and (controlling for drug dependence) any institutionalization, most often for substance abuse treatment. But at any level of risk, homeless families were far more likely to become separated from their children than housed families. That is, even if a housed mother was both drug-dependent and experiencing domestic violence, she was less likely to have her children separated from

her than a homeless mother who had neither of these factors (Cowal et al., 2002). Surprisingly, many of the separations occurred after families were rehoused.

There is also a link between homelessness and foster care. Although the majority of separated children in the studies reviewed were living with relatives, a substantial minority were in foster care or had Child Protective Service (CPS) involvement (26%, Cowal et al., 2002; 6%, DiBlasio and Belcher, 1992; 15%, Zlotnick, Robertson, and Wright, 1999). In a 5-year followup of a birth cohort of children in Philadelphia, being in a family that requested shelter was strongly related to CPS involvement and to foster care placement (Culhane et al., 2003). The risk for CPS involvement increased as the number of children in a family increased. Similarly, in another Philadelphia study, there was a greater risk for child welfare involvement for families with longer shelter stays, repeated homelessness, and fewer adults in the family (Park, Metraux, Brodbar, and Culhane, 2004a).

Family separations are not only disruptive to the family and the child during the separation, they can foster a multigenerational cycle of homelessness. Numerous studies have found that separation in childhood from one's family of origin is a predictor of homelessness in adults (Bassuk et al., 1996; Bassuk, Rubin, and Lauriat, 1986; Knickman and Weitzman, 1989; Susser et al., 1991; Susser, Conover, and Streuning, 1987). In turn, homeless adults who experienced family separation as a child were more likely to be separated from their own children (Homelessness: The Foster Care Connection Institute for Children and Poverty, 1992). In fact, one study found that a large proportion of the children in foster care in the county being studied were born to parents who had histories of homelessness (Zlotnick, Kronstadt, and Klee, 1998).

Among the factors that influence separations are shelter admission rules (as noted earlier), social service policies, shelter life stresses, and parental efforts to limit the child's exposure to shelter life (Barrow, 2004). Shelters often cannot accept larger families or children past a certain age (especially male children). The sheer stress and stigma of living in shelters can cause mothers to send their children to live with family or friends, especially among African American and Latino families (Shinn and Weitzman, 1996). Finally, homeless families and families involved in special service programs following shelter [after leaving a shelter] are subjected to high levels of professional scrutiny. Although several states have ruled out placement of children [in special programs] because of homelessness alone (Williams, 1991), at least one state training manual notes that the presence of risk factors such as homelessness, though not considered proof of abuse or neglect, "may point to a need for further investigation and future intervention" (New York State Society for the Prevention of Cruelty to Children, 1990).

Homelessness is not only a major factor in family separations; it also makes the reunification of separated families more difficult. This is particularly true if, after separation, parents lose access to income and housing supports that allow them to create a suitable environment for their children (Hoffman, Rosenheck, 2001). In particular, court-ordered separations may require that certain conditions be met before a family can be reunited, such as finding housing and employment and participating in specific treatment and parenting programs. Consequently, reunification occurs only for a subset of families (e.g., only 23% of the separated children in the New York City study were living with their mothers at the 5-year followup [Cowal et al., 2002]).

2.2.3 Human Capital: Education, Employment, and Income

Adults in both homeless and other poor families generally have low levels of educational attainment and minimal work histories. Compared to the national average of 75 percent of all mothers having a high school diploma or graduate equivalency diploma (GED), for example, high school graduation or GED rates for mothers in homeless families range from 35 percent to 61 percent across a number of studies (Bassuk et al., 1996; Burt et al., 1999; Lowin et al., 2001; Rog et al., 1995b; Shinn and Weitzman, 1996). In studies that compared homeless families to poor families, 46 percent of the poor mothers had at least attained high school graduation or a GED (Bassuk et al., 1996); Shinn et al. (1998) found a similar percentage of 42 percent. Overall, the educational rates for homeless families are lower than for homeless single adults (47% vs. 63% in the NSHAPC) (Burt et al., 1999) but similar to other poor families. Again, there are often regional differences reflected in education ranges, with West Coast rates of education typically higher than East Coast rates (Lowin et al., 2001; Rog et al., 1995b).

Not surprisingly, most homeless mothers are not currently working while in a shelter. In a sample of 411 homeless families being helped by shelters in Washington State (Lowin et al., 2001), only 15 percent of the respondents had worked 20 hours or more in the week prior to the interview, with 44 percent of their spouses or partners working during that period. Rog and colleagues (1995b) found that 14 percent of homeless women in the study were working upon entry into a shelter, whereas less than 1 percent were working in the Worcester Family Research Project (Bassuk et al., 1996).

The majority of homeless women in the study, however, have had work experience. Bassuk and colleagues found that 67 percent of the homeless mothers had held a job for more than 3 months. Rog

and colleagues found that nearly all (92%) of the women reported working at some point in the past; 62 percent had held a job for at least 1 year (Rog et al., 1995b). Similarly, in the more recent SAMHSA Homeless Families Project, involving homeless women screened for mental health and/or substance abuse problems in eight sites across the country, 96 percent of the women reported working sometime in the past, although only 14 percent were working at baseline (SAMHSA Homeless Families Program, 2004).

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

2.2.4 Social Capital: Social Support, Conflict, and Violence

Social support is an important buffer for stress and a major predictor of emotional and physical well-being (Cohen and Wills, 1985). Social networks can be an important housing resource for poor families, who frequently double-up with others when they cannot afford independent housing. Findings about social networks of homeless families, however, are mixed. Several studies have found that mothers in the midst of an episode of homelessness, compared to housed poor women, have less available instrumental and emotional support, less frequent contact with network members, and more conflicted relationships (Bassuk et al., 1986; Bassuk and Rosenberg, 1988; Bassuk et al., 1996; Culhane, Metraux, and Hadley, 2001; Passero et al., 1991). Two studies found that homeless mothers were more likely to name children as sources of support (Bassuk and Rosenberg, 1988; Wood et al., 1990), although this could reflect the circumstance of living in shelter with children.

An ethnographic study of 80 homeless families found that the lack of friends or relatives, or the withdrawal of support from these people, was an important factor in the families becoming homeless (McChesney, 1995). However, Goodman (1991b) found no differences in support between homeless and housed mothers. In the New York City study of homeless families and poor housed families, Shinn and

colleagues (1991) reported that newly homeless mothers had more recent contact with network members than did poor housed mothers, and over three-quarters had stayed with network members before turning to shelter. This suggests that families may exhaust social capital, rather than having less capital to begin with, than other poor families. Moreover, additional analysis (Toohey et al., 2004) 5 years later found that social networks of the (now) formerly homeless mothers in this sample were quite similar to those of their housed counterparts.

Social networks, unfortunately, can be the sources of conflict, trauma, and violence, as well as support. In the Worcester Family Research Project, homeless mothers had smaller social networks than housed women and reported more conflicted relationships in their networks. Therefore, large social networks emerged as a protective factor for homelessness, but having a network marked by interpersonal conflict was a risk factor for homelessness (Bassuk et al., 1997). For both homeless and housed mothers, conflict with family and friends was related to impaired mental health (Bassuk et al., 2002). Sibling conflict, in particular, was a stronger predictor of mental health symptoms than was parental conflict.

Homeless mothers, like poor women in general, have experienced high rates of both domestic and community violence (Bassuk et al., 2001). Many women report having been both victims and witnesses of violence over their lifetimes. In the Worcester Family Research Project, almost two-thirds of the homeless mothers had been severely physically assaulted by an intimate partner, and one-third had a current or recent abusive partner. More than one-fourth of the mothers reported having needed or received medical treatment because of these attacks (Bassuk et al., 1996). Supporting these findings, Rog and her colleagues (1995b) reported that almost two-thirds of their nine-city sample of homeless women described one or more severe acts of violence by a current or former intimate partner. Not surprisingly, many of these women reportedly lost or left their last homes because of domestic violence.

In addition to adult violent victimization, many homeless mothers experienced severe abuse and assault in childhood. The Worcester Family Research Project (Bassuk et al., 1996) documented that more than 40 percent of homeless mothers had been sexually molested by the age of 12. Women participating in the SAMHSA Homeless Families Project reported similar findings, with 44 percent reporting sexual molestation by a family member or someone they knew before the age of 18. Sixty-six percent of the women in the Worcester Family Research Project experienced severe physical abuse, mainly at the hand of an adult caretaker. Other studies have found similar results (Rog, et al., 1995b; SAMHSA, 2004).

2.2.5 Residential Stability

Family homelessness is perhaps most aptly described as a pattern of residential instability. Homeless episodes are typically part of a longer period of residential instability marked by frequent moves, short stays in one's own housing, and doubling-up with relatives and friends. For example, in the 18 months prior to entering a housing program for homeless families in nine cities (Atlanta, Baltimore, Denver, Houston, Nashville, Oakland, Portland, San Francisco, Seattle) families moved an average of five times, spending 7 months in their own place, 5 months literally homeless or in transitional housing, 5 months doubled up, and 1 month in other arrangements. Overall, one-half (53%) had been homeless in the past. It is important to note, however, that this was not a random sample of families, but one selected for a variety of service needs, with "chronic homelessness" (defined as repeated episodes of homelessness) being a marker for some of the families.

Other studies document the lack of stability that homeless families experience. In a more recent study of newly homeless families who were screened for having mental health and/or substance abuse problems in eight sites across the country, less than one-half of the prior 6 months was spent in one's own home (SAMHSA, 2004). Staying with relatives or friends was the most common living situation during that period for this sample (SAMHSA, 2004) and was also the most common living arrangement for families before entering shelter in Washington State (Lowin et al., 2001). Similarly, Shinn and colleagues found that a key predictor of first-time homelessness for families in New York was frequent mobility, as well as overcrowding (Shinn et al., 1998).

The length of time families stay homeless is a function, in part, of shelter limits on stay and the availability of subsidized housing. The availability and quality of subsidized housing also affects the number of families who return to homelessness. Research has indicated that the strongest predictor of exiting out of homelessness for families is the availability of subsidized housing (Shinn et al., 1998; Zlotnick, Robertson, and Lahiff, 1999). In a longitudinal study of first-time homeless families and a comparison random sample of families on public assistance, residential stability was predicted only by receipt of subsidized housing (Shinn et al., 1998). In followup interviews that occurred 5 years from initial shelter entry, 80 percent of the homeless families who received subsidized housing were stable (i.e., in their own apartment without a move for at least 12 months), compared to only 18 percent who did not receive subsidized housing. The 80 percent figure equaled the percentage for the comparison sample of families from the public assistance caseload. After leaving shelter, formerly homeless families were not

part of special case management programs but had access to services generally available to families on public assistance. The study provided strong evidence that subsidized housing was both necessary and sufficient for families to be residentially stable (Shinn et al., 1998).

An earlier followup study of formerly homeless families in St. Louis found similar evidence of the role of subsidies in fostering stability. Of the families who had received housing placements at termination from the shelter and who could be located during the followup period (201 families out of a possible 450 families), those who had received a Section 8 certificate at termination were much less likely to have had a subsequent homeless episode than families who had received some other type of placement (6% vs. 33%) (Stretch and Krueger, 1992).

Finally, studies using administrative records in both New York City and Philadelphia provide additional support for the role of subsidized housing in ending homelessness. In New York City, families discharged from shelters to subsidized housing were the least likely to return to shelter (7.6% over 2 years). Families who were discharged to "unknown arrangements" had the highest rate of shelter return (37%) (Wong, Culhane, and Kuhn, 1997). Similarly, after a policy of placing homeless families in subsidized housing was adopted in Philadelphia, the number of families with repeated shelter visits dropped from 50 percent in 1987 to less than 10 percent in 1990 (Culhane, 1992).

Part of the success of subsidies is that they not only allow homeless people to live affordably, but they generally also allow them to live in safer, more decent housing. In a study of single adults with severe mental illness, Newman and her associates found that Section 8 certificates are associated with improved housing affordability and improved physical dwelling conditions. The quality of the physical housing, in turn, is related to other outcomes, especially residential stability (Newman, Reschovsky, Kaneda, and Hendrick, 1994).

Similarly, in a nine-city study in which homeless families received both Section 8 certificates and case management services, 88 percent of the families accessed and remained in permanent housing for up to 18 months (based on 601 families in six sites where followup data were available) (Rog and Gutman, 1997). Although all families also received some amount of case management and access to other services, the level of service provision varied greatly across and within each of the nine sites and did not appear to differentially affect housing stability. This finding was replicated in an evaluation of families participating in the 31 sites across the country receiving FY 1993 funding under the Family Unification Program (FUP). The FUP, administered by collaborating housing agencies and child welfare

agencies, provides families with Section 8 rental assistance and child welfare services. The study found that 85 percent of the families were still housed after 12 months and the finding was almost universal across the 31 sites, despite different eligibility criteria and services, among other differences (Rog, Gilbert-Mongelli, and Lundy, 1998).

A smaller study in New York City in the early 1990s examined a similar intervention involving subsidized housing, coupled with short-term intensive case management, and yielded similar findings. A comparison group received subsidized housing but no special services. At the end of a 1-year followup period, the majority of families in both groups were housed, and less than 5 percent had returned to shelter. Whether or not families had received the intensive services did not affect the outcomes. Rather, the type of subsidized housing received was the strongest single predictor of who would return to shelter, with families in buildings operated by the public housing authority more stable than those in an alternative city program (Weitzman and Berry, 1994).

Although housing subsidies appear to reduce returns to shelter, some families do return after living in subsidized housing. In the New York City followup study, 15 percent of 114 families who obtained housing subsidies returned to shelters at some point during the 5-year followup period (Stojanovic, Weitzman, Shinn, Labay, and Williams, 1999). Reasons for leaving subsidized housing included serious building problems, safety issues, rats, fire or other disaster, condemnation, or the building's failure to pass the Section 8 inspection. Informal discussions with city officials suggested that families may return to shelter because of failure to renew Section 8 certificates. Similarly, Rog and colleagues (1995b) speculated that failure to complete paperwork might explain some of the dropout of families from the Section 8 voucher program at 30 months in three sites in the nine-city study.

2.3 Service Needs, Access, and Utilization Patterns of Homeless Mothers: Health, Mental Health, Trauma, and Substance Use

Homeless mothers and their families face a number of challenges and problems, some that may stem from being homeless and others that may have contributed to becoming homeless. Homeless mothers, for instance, have more acute and chronic health problems than the general population of females under 45 years of age. Bassuk and her colleagues (1996), for example, found that 22 percent of the homeless mothers in their study reported having chronic asthma (more than four times the general

population rate), 20 percent reported chronic anemia (10 times the general population rate), and 4 percent reported chronic ulcers (four times the general rate).

In the Robert Wood Johnson/Housing and Urban Development (RWJ/HUD) Homeless Families Program (Rog et al., 1995b), 26 percent of the mothers reported having two or more health problems in the past year and 31 percent characterized their health as poor or fair. Likewise, in the more recent SAMHSA Homeless Families study, 44 percent of the women in the study reported their health as being only fair, poor, or very poor when they entered the study, and 43 percent indicated that they had needed some sort of medical services in the prior 3-month period (SAMHSA Homeless Families Project, 2004). Despite the reported poor health, however, in both of these studies most women reported having had some access to health services while homeless: 75 percent in the RWJ Homeless Families Program, typically through Medicaid (Rog et al., 1995b), and 81 percent in the SAMHSA Homeless Families Project (SAMHSA Homeless Families Project, 2004).

A greater unmet health need among homeless families is dental services. The RWJ/HUD Homeless Families program found that 62 percent of the families needed dental services at baseline, while only 30 percent reported receiving services prior to entering the program (Rog and Gutman, 1997). Similarly, in the more recent SAMHSA Homeless Families project, 44 percent of the families reported needing dental services at baseline, and only 28 percent of these families reported receiving dental services in the 3 months before entering the program (SAMHSA Homeless Families Project, 2004).

Studies differ on overall prevalence of mental health and substance abuse problems among homeless mothers, largely because of how they are defined and measured (including both the actual measure and the time period being assessed) (Shinn and Bassuk, 2004). Regardless of the measurement employed, however, it is clear that the nature of the problems is far different than for single homeless adults. Depression is relatively common, as it is for poor women generally, while psychotic disorders are rare (Bassuk et al., 1998; Shinn and Bassuk, 2004). Given the high levels of stress and the pervasiveness of violence, it is not surprising that homeless mothers have high lifetime rates of posttraumatic stress disorder (PTSD) (three times more than the general female population), major depressive disorder (2.5 times more than the general female population), and substance use disorders (2.5 times more than the general female population) (Bassuk et al., 1998).

Bassuk and colleagues (1996) found, however, few differences between homeless and poor mothers. Thirty-six percent of homeless mothers had a lifetime prevalence of PTSD, with 18 percent

currently reporting PTSD, while 34 percent of poor housed women experienced lifetime prevalence of PTSD, with 16 percent of poor housed women reporting current PTSD.

Similar findings have been reported by a variety of other researchers (Fischer and Breakey, 1991; Smith, North and Spitznagel, 1993; Zima et al., 1996). The most common current co-occurring disorders were major depression, substance use disorders, anxiety disorder, and PTSD (Bassuk, et al., 1998; Shinn and Bassuk, 2004). In addition, between one-quarter and one-third of homeless mothers report attempting suicide at least once in their lifetime (Bassuk et al., 1996; Rog et al., 1995). In fact, Rog reported that a majority of the mental health hospitalizations reported by women were related to suicide attempts (Rog and Gutman, 1997).

Homeless families are more likely than other poor families, but less likely than homeless individuals, to report abusing substances (Bassuk et al., 1997; Burt et al., 1999). Rates of reported lifetime use of substances range from 41 percent (Bassuk et al., 1996) to 50 percent (Rog et al., 1995b), with much lower rates reported for current use (12 percent in Rog et al., [1995b] report illicit drug use in the past year; 5 percent in Bassuk et al., [1996] report use of drugs in the past month).

Smith and North (1994) found that single homeless women have more personal vulnerabilities than homeless mothers, such as higher rates of psychiatric (e.g., schizophrenia, bipolar disorder) and substance use disorders (i.e., alcoholism); in fact, some may have lost their children as a result. In contrast, they describe homeless mothers as more socially vulnerable because of their lack of employment and the stress of caring for dependent children. The findings among homeless mothers support Belle's (1982) argument that psychiatric disorders are more common among poorer women, largely because of the multiple stressors associated with poverty. Pervasive violence, in the context of poverty, may account for many of the emotional disorders in homeless mothers, particularly the high rates of PTSD.

Although poverty is associated with elevated risk of psychiatric and substance use disorders (Robertson and Winkleby, 1996), little empirical data exist on the prevalence, patterns, and correlates of mental health and substance abuse service use among homeless women with children. Studies that gathered data on both psychiatric status and mental health service use suggest a high proportion of homeless women have unmet treatment needs (e.g., Rog et al., 1995b; SAMHSA, 2004).

Finally, it is important to recognize that many homeless women face multiple problems and issues. Rog and her colleagues (Rog et al., 1995b), for example, noted that 80 percent of the homeless women enrolled in their study had current needs in at least two of three areas examined: human capital (poor education or lack of a job), health, and mental health (including substance abuse and trauma-related issues). One-quarter of the women had issues in all three areas.

2.4 Service Needs, Access, and Utilization Patterns of Homeless Children

Research indicates that homeless children have high rates of both acute and chronic health problems. They are more likely than their poor housed counterparts to be hospitalized, to have delayed immunizations, and to have elevated blood lead levels (Alperstein, Rappaport, and Flanigan, 1988; Parker et al., 1991; Rafferty and Shinn, 1991; Weinreb et al., 1998; the Better Homes Fund, 1999). They also have high rates of developmental delays (Bassuk and Rosenberg, 1990; Molnar and Rath, 1990) and emotional and behavioral difficulties (Bassuk and Rosenberg, 1990; Buckner and Bassuk, 1997; Molnar and Rath, 1990; Zima, Wells, and Freeman, 1994).

Masten and her colleagues found that homeless children experienced nearly twice as many stressors as a comparison group of children in poor families (Masten et al., 1993). Higher levels of stress, in turn, are associated with mental health and behavior problems. Twenty-one percent of homeless preschoolers and almost 32 percent of older homeless children (ages 9-17) in the Worcester Family Research Project, for example, had serious emotional problems with functional impairment. More specifically, the results from this study indicate that children who are homeless have more problems with internalizing behaviors (e.g., anxiety, depression, withdrawn behavior, or somatic complaints) than children in poor families (Buckner et al., 1999).

Interestingly, the relationship between length of time homeless and internalizing behaviors (as measured with the Child Behavior Checklist [CBCL]) in this study was curvilinear, which suggests that children might be adjusting to their surroundings (or scores could perhaps be a function of services being provided by shelters). It also should be noted that, while the overall CBCL scores of homeless children were higher than those in the housed group, these differences were generally minimal, and nearly equal numbers of children in both the homeless and poor but housed groups scored in the clinical range on this measure (Bassuk et al., 1997; Buckner et al., 1999).

In addition to being homeless, trauma and violence are endemic in the lives of both homeless and housed poor families, with the majority of children either witnessing violence or being directly victimized. The most powerful independent predictor of emotional and/or behavioral problems in both homeless and housed poor children in the Worcester Family Research Project was their mother's level of emotional distress, often due to trauma experienced (Buckner and Bassuk, 1997).

Homelessness appears to have negative effects on school performance. Rafferty and associates (Rafferty, Shinn, and Weitzman, 2004) used Board of Education records to trace children's performance on achievement tests before, during, and after homelessness. Prior to becoming homeless, children in families who would later become homeless had similar scores to other poor children who would remain housed. Homeless children's scores dropped significantly during homelessness and partially rebounded afterward. However, by this time, 50 percent of formerly homeless children had repeated a grade (compared to 40% of housed poor children and 25% of school children in New York City). Further, 22 percent of the homeless children had repeated two grades (compared to 8% of the housed poor children). Within the general population, grade retention is a strong predictor of failure to complete high school (e.g., Hess, 1987; Rumberger and Larson, 1998).

As noted earlier, large numbers of homeless children become separated from their families during homelessness. Research suggests that children who are separated from their families face a number of problems later in life. A study of individuals who were in the New York child welfare system as children, for example, found that children who experienced out-of-home placement were twice as likely to eventually enter the New York City homeless system as adults than those who received nonplacement preventive services (Park, Metraux, Brodbar, and Culhane, 2004b). Similarly, a study of dually-diagnosed homeless adults in three Philadelphia programs found that those who experienced out-of-home placement as children progressed worse than others in the program (Blankertz, Cnaan, and Freedman, 1993). Because most research on homeless children concerns only those who remain with their parents in shelter (e.g., SAMHSA, 2004), and because those who are separated are likely to be worse off than those who remain with families, the needs of homeless children are likely to be underestimated in the literature.

2.5 Developing a Typology of Homeless Families

The literature review provides a broad understanding of what is known about homeless families from the research conducted to date and offers a foundation for developing a typology of

homeless families. There are also, as noted next, a number of unanswered questions about the population that may be important to address in moving forward. However, the purposes of the typology must first be determined to know what is pertinent from the existing literature and which knowledge gaps are the most critical to close.

Typologies are generally intended to create subgroups of cases. They may be developed for more than one purpose, including classifying individuals into groups, describing and improving the understanding of a population, matching groups to different levels or modes of service or treatment, and improving the ability to predict behavior (Harris and Jones, 1999). For this particular typology, the initial purposes are to foster a better understanding of homeless families' characteristics, service needs, interaction with human services systems, and the dynamics of their use of shelter and other services assistance. This understanding, in turn, is intended to assist in more effectively targeting existing services, maximizing the potential of existing programs to meet the needs of specific subgroups, and identifying new efforts to prevent homelessness for specific groups and to more effectively intervene with others.

Given these initial goals for the typology, it is important to understand families as they differ on levels of risk of homelessness, patterns of homelessness, service needs, and responsiveness to different interventions. It is also important to go beyond describing and predicting patterns of homelessness to determine which families can manage on their own, which need housing subsidies, and which need more help (supportive housing or something else) to exit homelessness and remain stable. For example, large families may be harder to place and, hence, family size might predict length of shelter stay, but large families without other risks might do well with only a housing subsidy.

The goals of a typology guide the selection of the overall approach, the variables to include, and the ways in which the typology can be validated. In this next section, based on a review of efforts to develop typologies in other areas, the following steps are outlined: strategies identified for developing a typology (including the selection of variables), criteria for evaluating the usefulness of a typology, and strategies for determining that these criteria are met. In reviewing these strategies, the implications of the experiences in other areas for developing a typology for homeless families are delineated in each section.

2.5.1 Review of the Literature on Use of Typologies

Although there has been some limited attention to typologies for homeless families (e.g., Danesco and Holden, 1998) the literature that is most helpful involves efforts to develop typologies and classification systems for a range of populations, including individuals who abuse substances (e.g., Epstein et al., 2002; German and Sterk, 2002), individuals with chronic mental illness (Braucht and Kirby, 1986), individuals in the criminal justice system (e.g., Harris and Jones, 1999), homeless single adults (Kuhn and Culhane, 1998), homeless and runaway youth (Mallett, Rosenthal, Myers, Milburn, and Rotheram-Borus, 2004; Zide and Cherry, 1992), families involved in Head Start (Ramey, Ramey, and Lanzi, 1998), and children referred to mental health treatment (Hodges and Wotring, 2000).

There are numerous dimensions along which typologies vary, including whether the typology is based on a theoretical scheme or developed empirically; whether it is developed on one variable or dimension, or multiple dimensions and variables; the nature and measurement of the variables used; and whether the variables include only risk factors or strengths as well. In addition, some typologies are developed using qualitative data (e.g., German and Sterk, 2002), while others involve quantitative data, often using cluster analysis (e.g., Babor et al., 1992). The variations often relate to the purposes of the typology, as well as to the state of the knowledge in an area.

Although typologies based on theory are found in the literature, the majority of typologies are developed through various statistical approaches (e.g., Epstein et al., 2002). Braucht and Kirby (1986) demonstrated the value of a step-wise statistical approach to developing a typology of individuals with chronic mental illness. As a first step, the authors examined 49 variables and used cluster analysis to identify subsets of the variables that correlated along a similar dimension (Tryon and Bailey, 1966). Four dimensions resulted, involving 17 of the measures. The four dimensions, or homogeneous subsets of variables, resulted in little loss of information over the use of the 49 original individual variables and became the core building blocks for the typology. For step two, a score on each dimension was computed for each client in the sample. With these four scores on each client, another cluster analysis was conducted to identify subsets or clusters of clients. Twenty-one distinct subsets or types of clients resulted. As a third step, the authors followed an iterative process to systematically condense the 21 types into a smaller number of groups. Five groups resulted and the four average dimension scores were computed for each. For the fourth and final step, to determine whether the division into the five groups was meaningful, the authors examined additional clinical and psychosocial variables to see if they distinguished the groups from each other. The pattern of statistical differences across these variables for

the five groups verified that they were distinct and provided a much more complete characterization of the types.

This example illustrates the value of a multivariate approach to typology development. Although some typologies are developed using a single measure, especially those involved in classification systems that need to be used by practitioners, multidimensional typologies appear to hold the most promise for delineation of meaningful groups. Epstein and colleagues (2002) demonstrated the value of a multivariate approach to typology development of individuals with alcohol use disorders. The authors compared four prevailing typologies and examined the extent to which they overlapped using baseline data from five treatment outcome studies. Two of the typologies were multidimensional and two were single-variable, dichotomous typologies. The comparative approach the authors used was instructive in revealing the strengths and problems with each typology. The authors found that the dichotomous typologies (single variable, two groups) were not complex enough to be clinically useful and often described only a portion of the population.

As in these other areas, a multidimensional strategy appears most promising for the typology of homeless families. Past research, as reviewed earlier, has revealed that understanding the complexity of demographic, background, family composition, service need, human and social capital, and other variables is critical to fully understanding families and how their needs may best be met. In particular, understanding families at various stages of vulnerability for homelessness will be important to a more complete understanding of when and how to intervene.

Typology development, however, is sensitive to variable measurement (e.g., type of measure, cutoff points such as age cutoffs, and extent of missing data). In particular, multidimensional typologies can be sensitive to the existence of outliers and can be temporally less stable if current status variables are used in their development (Epstein et al., 2002). In the homeless families' area, it is important to understand the operationalization of the variables and how they vary across different data sets. Different measures of stability have been used across research studies, as have varying measures of mental health and other areas of service need. In addition, for any database or panel surveys that are candidates for use in this project, it will be important to understand the extent to which there are any artifacts to the data that will challenge its usefulness, such as missing data on particular variables or on subsets of the population.

Because of the many subjective decisions made in developing a typology, the strategy of developing more than one possible typology, as well as investigating multiple data sets and conducting concordance analyses, is also a useful idea for reconciling differences and developing the best, most parsimonious, and most feasible approach (Epstein et al., 2002). This strategy allows cross-validation and testing the universality of the typology.

Criteria for Evaluating a Typology. In evaluating the usefulness of a typology, several criteria can be used (Babor et al., 1992; Epstein et al., 2002; Harris and Jones, 1999). The typology can be examined to determine whether it satisfies the following conditions:

- Results in subgroups that have homogeneity within them;
- Results in subgroups that are nonoverlapping and have distinct nontypology characteristics (i.e., has discriminant validity);
- Is comprehensive in its coverage of the overall population;
- Demonstrates construct validity by having the theoretical constructs empirically supported; and
- Has predictive validity in that members of different subgroups show different patterns of homelessness and different responses to treatments (i.e., has clinical utility).

Developing distinct homogeneous subgroups is aided by techniques such as cluster analysis and the use of rich data systems that cover the complexities of the population. One of the challenges in the study of homeless families, however, is to identify data systems that provide for comprehensive coverage of the population. Each of the typology efforts reviewed concentrated on developing the typology in one data system.

Many of the existing homeless families' data systems involve a subset of the population, such as first-time homeless families or families with multiple problems. Others are limited geographically and would have questionable external validity given the context-dependent nature of homelessness. Still others, such as NSHAPC, provide greater external validity and a less selective population but lack the richness of inquiry needed to fully understand the complexity of the individual groups. Similarly, few data sets currently available provide the longitudinal perspective needed to examine the predictive validity of the typology. Given the status of the research, it may be useful to develop a limited number of typologies in the most comprehensive data set and test them in several other candidate data sets. This would provide a greater test of the generalizability of the typology.

2.5.2 Knowledge Gaps

Whatever the purpose of a typology, its development entails a series of decisions and choices that require comprehensive knowledge of the population, the research that produced the knowledge, and the tradeoffs with the available approaches to typology development. There are several gaps in the knowledge of the overall homeless family population that hinder the development of a typology that can provide the most coverage and be of maximum utility for practice and policy. One gap is the lack of research on homeless families across the country, especially studies involving midwestern or southern populations, as well as those in rural areas. Much of the current knowledge is based on research in specific cities, such as New York, Boston, Worcester, Massachusetts, and the cities involved in the multisite initiatives. This is a particularly important gap to fill given the role that context plays in affecting who becomes homeless, the course of homelessness, and the service response.

In addition to lacking geographic diversity, population coverage of most of the studies that have been conducted is limited. For example, few studies focus specifically on families at risk for homelessness or families before they become homeless. Most of the research attempts to collect data retrospectively on families before they became homeless and provides only a limited understanding of the possible factors that buffer other similar low-income families from experiencing homelessness.

Little is known about the families who fall back into homelessness after receiving interventions. Although subsidized housing is shown to assist 80 to 90 percent of families out of homelessness, 10 to 20 percent of the families continue to be residentially unstable in spite of the assistance. Understanding the extent to which the difficulties are contextually-based or involve other factors is critical to understanding this key subgroup, which may end up being one of the major purposes for a homeless family typology. Also, very little is known about the subset of families who are working but remain homeless. Understanding their needs and experiences while homeless and the factors that impede their residential stability would be useful in aptly characterizing these families.

When one talks about homeless families, one almost always refers to homeless mothers and their children. Most studies have omitted two-parent families and few have collected data on the men who once were, or who remain, part of these families. Similarly, some of these families are part of extended family networks that may be critical to both prevention and intervention efforts. In addition, although studies have noted that many single homeless adults are parents, few studies have examined their familial roles.

Because many studies of homelessness have been funded by agencies charged with understanding mental health and substance abuse, much of the literature focuses on people with these conditions. As Arrigo (1998) writes, there is no mention of "modest or moderate needs" homeless families. Although efforts to identify and understand families with the greatest needs make sense for agencies that want to intervene with those most in need, these studies may distort the understanding of the levels of need in the overall population.

Finally, few studies have had a longitudinal perspective that could provide insight into the trajectories families take into and out of homelessness. Little is known about families that become homeless only once or that are residentially unstable for long periods of time.

2.6 Summary of Implications From the Literature Review

The research studies conducted on homeless families have largely focused on the characteristics and needs of homeless mothers and their children (Bassuk and Rosenberg, 1988; Wood et al., 1990; Goodman, 1991a, 1991b; Shinn et al., 1998; Weitzman et al., 1992; Rog et al., 1995a, 1995b; Bassuk, 1996; Rossi, 1989). As already noted, these studies and others that have contributed to the literature vary considerably in the definitions used, the samples selected, the designs used, and the study domains examined. Few are longitudinal in nature, only a handful use comparison groups of other poor women to contextualize the results, and the geographic areas involved are limited.

Despite the differences among these studies, this small body of research has produced the following consistent findings:

- Homeless families are almost always headed by a single woman who on average is in her late 20s with approximately two children, one or both under 6 years of age;
- Families at greatest risk of homelessness, as well as poverty in general, belong to ethnic minority groups;
- Homelessness is highly linked to family separations, including foster care and involvement with child welfare services;
- Homeless mothers have significant human capital needs, with insufficiencies in education, employment history, and income;

- Homelessness may exhaust the social networks that some families have and may also be the source of conflict, trauma, and violence;
- Families who become homeless often have residential histories marked by considerable mobility and instability;
- Homeless mothers report high rates of health problems but also report high rates of access to health care;
- Mental health problems for homeless mothers mirror those of poor women in general and are largely unmet;
- Substance abuse reports for homeless mothers, though likely underestimates, are higher than for other women in poor families but lower than for single homeless adults;
- Children in homeless families also have high rates of acute and chronic health problems, and the majority have been exposed to violence; and
- The long-term effects of homelessness on children's behavior may be less than expected, but the effects on school performance appear significant and long-lasting.

Significant gaps in knowledge continue to make it difficult to know the external validity of the current base of knowledge. These gaps include the following:

- Knowledge of homeless families across the country, especially in Midwestern, Southern, and rural areas;
- Key population groups, including families at risk for homelessness; moderate-need families; families who fall back into homelessness after receiving interventions; families who are working but continue to be homeless; two-parent families; families living in extended family networks; and single homeless adults who are noncustodial parents; and
- Understanding the course of residential instability and homelessness over several years and the factors that influence this course (including individual factors, contextual factors, and intervention factors).

The review of the literature suggests that a great deal is known about homeless families and their needs. There are ranges of health, mental health, child welfare, substance abuse, and other service needs and involvement, though little is known about the various responses to interventions in these areas. The literature provides guidance in the variables that may be important to include in developing a typology and the specific measures that may be most valid.

The lack of comprehensive population coverage indicates that other efforts need to be made to develop a meaningful typology. Because little is known about families prior to entering homelessness or after they leave shelter, and less is known about specific subgroups of the broader population, initial steps in conceptualizing a typology need to consider how to fill these gaps in knowledge.