Appendix A

Impact of Homelessness on Children: An Analytic
Review of the Literature

Impact of Homelessness on Children: An Analytic Review of the Literature

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This paper reviews published research conducted in the United States pertaining to the effects of homelessness on the mental health, behavior, health, and academic performance of children who are homeless with their families. This has been the central aim of most of the studies involving homeless children that have been conducted to date. A primary intent of the chapter is to describe what has been learned as well as to discuss some of the issues that may have led to inconsistent study findings over the years. In addition, the paper identifies gaps in the understanding of homeless children, one of which is the lack of information on different subgroups of homeless children based on varying constellations of problems or needs.

Part I: Literature Review

Using data from the National Survey of Homelessness Assistance Providers conducted in 1996, The Urban Institute (2000) estimated that families with children account for about 39 percent of the homeless population in this country on any given night.[1] Based on this survey, researchers at The Urban Institute estimated that somewhere between 874,000 and 1,360,000 children experienced a homeless episode[2] at some point in 1996. This implies that about 9 percent of poor children in the United States had a spell of homelessness that year. In most cases, a homeless family is comprised of a single mother with one or two young children in tow. This is particularly true in the Northeast, where, for instance, in Massachusetts about 95 percent of homeless families are single parent female headed (Bassuk et al., 1996). In some parts of the country it is more common to also encounter two-parent (or couple) families or families headed by a single father (U.S. Conference of Mayors, 2001).

The research literature on homeless children now spans about 18 years, with the earliest studies having been published around 1987. One approach to reviewing empirical studies of homeless children is to summarize findings according to topical domain (e.g., mental health, health, education). To some extent, this chapter adopts this approach as well as it facilitates meaningful comparisons and inferences across studies. However, in an effort to make better sense of incongruities in various investigations of homeless children that have made their way to the published literature, it is also helpful to organize them in chronological order. Toward this end, it is useful to distinguish between a set of "first generation" studies and a second stage of research investigations on homeless children. Not all studies in the literature

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[1] This estimate is children who are part of families and does not include unaccompanied adolescents.

[2] This is a period (e.g., 12-month) prevalence estimate for a homelessness episode of any duration. A point prevalence estimate (e.g., the number of children homeless on any given night) would be a substantially smaller number.

can be grouped so neatly, but such a distinction is reasonable in most cases. This review is not an exhaustive attempt to describe every study that has been published but covers many of the empirical investigations, particularly those that have included a housed comparison group children as it is very difficult to gauge the impact of homelessness, per se, on children by only involving homeless children in a study.

The first studies that were conducted on homeless children sounded an alarm (cf. Alperstein, Rappaport, and Flanigan, 1987; Bassuk and Rubin, 1987; Miller and Lin, 1988; Rescorla, Parker, and Stolley, 1991; Wood, Valdez, Hayashi, and Shen, 1990). Their findings indicated that homeless children had a range of health and mental health problems that called for immediate attention. Data for these investigations were collected in the mid-1980s, not long after the issue of homelessness for families became apparent. Families who required emergency shelter during this period in time encountered a shelter system in the United States that was only beginning to determine how to handle the needs of parents with young children and it is conceivable that shelter conditions were at their worst during the period in which these studies were conducted.

A second generation of studies on homeless children followed in the early 1990s spearheaded by these earlier findings. Some of these studies were funded by the National Institute of Mental Health (NIMH), while others were supported by foundations and local grants. Investigators who included homeless children in their studies attempted to advance an understanding of the impact of homelessness on children by involving larger study populations, a greater breadth and quality of assessment instruments, and more advanced statistical techniques with which to analyze the data (cf. Bassuk, Weinreb, Dawson, Perloff, and Buckner, 1997; Buckner and Bassuk, 1997; Buckner, Bassuk, Weinreb, and Brooks, 1999; Buckner, Bassuk, and Weinreb, 2001; Garcia Coll, Buckner, Brooks, Weinreb, and Bassuk, 1998;; Masten, Miliotis, Graham-Bermann, Ramirez, and Neemann, 1993; Masten, Sesma, Si-Asar, Lawrence, Miliotis, and Dionne, 1997; Rafferty, Shinn, and Weitzman, 2004; Rubin, Erickson, San Agustin, Cleary, Allen, and Cohen, 1996; Schteingart, Molnar, Klein, Lowe, and Hartmann, 1995; Weinreb, Goldberg, Bassuk, and Perloff, 1998).

Mental Health and Problem Behaviors

The mental health of homeless children has been a central concern for service providers as well as researchers. The most widely used instrument in homelessness research with children has been the Child Behavior Checklist (CBCL) (Achenbach, 1991; Achenbach and Rescorla, 2001). The CBCL is an instrument that is administered to the parent of a child and assesses the *signs* (i.e., observable manifestations) as opposed to the *symptoms* of mental health problems. The CBCL has two versions, one intended for preschoolers and the other for school-age children. Both versions of the CBCL are comprised of specific syndrome scales as well as composite "internalizing" and "externalizing" global scores.[3] The internalizing dimension of the CBCL assesses observable behaviors that are indicative of anxiety and depression as well as withdrawn behavior and somatic complaints. The externalizing dimension is derived from items that assess delinquent and/or aggressive behavior in older kids and attention problems and aggressive behavior in younger children. Raw scores on the syndrome and global scales can be converted into *T*-scores with the mean set to 50. Higher scores are indicative of more problematic behaviors.[4]

Bassuk and Rosenberg (1990) published the first study comparing homeless and housed children in which the CBCL was employed. Homeless children were enrolled from emergency shelters in Boston during 1985 and a comparison group of families living in low-income housing were interviewed a year later. Bassuk and Rosenberg (1990) used the CBCL to assess children ages 6 to 16 in their study and found that 39 percent of the 31 homeless children and 26 percent of the 54 housed children scored in the clinical range. This difference did not reach statistical significance, most likely a function of the relatively small sample size. Homeless girls had higher scores than homeless boys and older homeless youths (ages 12–16 years) were more likely to score in the clinical range than younger children (ages 6–11 years). A widely used self-report measure of depression, the Children's Depression Inventory (CDI), was also part of the assessment protocol in this study and homeless children averaged 10.3 on this measure compared to 8.3 for the housed children. While this difference was also not statistically significant, such levels on the CDI are of some clinical significance and represent depressive symptoms of moderate severity.

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[3] There is some minor variation in syndrome scales for the two age groups, but the composite internalizing and externalizing global scores can be calculated for each version thereby providing a useful means for aggregating data across the two age ranges.

[4] Children are considered in the clinical range of the instrument, suggesting the need for further assessment and possibly treatment by a mental health care provider, with T-scores of 64 or greater. T-scores from 60 to 63 are considered to be in the "borderline-clinical" range.

In Philadelphia during the late 1980s, Rescorla, Parker, and Stolley (1991) conducted a study involving 83 homeless children between the ages of 3 and 12 years who were living in 1 of 13 shelters throughout the city and compared them to 45 children whose families were randomly selected from the waiting room of a pediatric clinic. The children were given an assessment battery that included the CBCL and various measures of cognitive abilities (IQ) and reading achievement. The authors compared preschool and school-age children separately. Across the various indices of intelligence and achievement, homeless children in both age groups scored lower than the clinic group although only some of the differences reached statistical significance. If the study had had a greater sample size, it would have found more differences between the two groups reaching statistical significance. Similarly, on the CBCL, homeless children in both age groups had more elevated indices of internalizing and externalizing problems compared to the clinic enrolled children, with differences particularly acute among the preschool-age children.

The authors did not use multivariate statistics to control for potential imbalances on other explanatory variables and collected very little data on the mothers of children in these two groups, making it hard to discern how well the two groups were matched. Thus, it is not possible to determine to what extent the differences found between homeless and housed children is a function of housing status or other family/mother factors that are associated with both vulnerability to becoming homeless and child outcomes. Despite the difficulty of making causal inferences about whether housing status or other unmeasured variables accounted for the differences seen between the homeless and clinic children in this study, the *absolute* scores that Rescorla et al. (1991) reported for the homeless children on measures of intelligence, achievement, and problem behaviors are the most problematic that can be found in the published literature. Indices of IQ and achievement were a good one standard deviation below the national average (e.g., 85 instead of the norm of 100) and CBCL scores, on average were in the high 50s, with internalizing and externalizing CBCL scores at 59 for the homeless preschool group (the borderline clinical range begins at 60).

In a study conducted in the early 1990s in New York city involving 82 homeless and 62 housed children ages 3 to 5 and their mothers, Schteingart, Molnar, Klein, Lowe, and Hartmann (1995) found that the two groups had equivalent scores on both the internalizing and externalizing dimensions of the CBCL as well as on a measure of developmental status. In multivariate analyses, maternal depressive symptoms predicted internalizing CBCL scores, but housing status did not. Overall, CBCL scores for this group of

low-income preschool-age children were in the low 50s, indicating slightly more problem behaviors than would be expected based on the instrument's standardization group.

A study with similar no difference findings involved 145 homeless and 142 housed school-age children in Madison, Wisconsin. Using the teacher-report version of the CBCL, Ziesemer, Marcoux, and Marwell (1994) found that both groups scored appreciably higher than test norms on the total problem behaviors index (*T*-scores of about 58 on average for the homeless and 60 for the housed children). Also, the two groups were comparable on a measure of self-esteem and academic functioning. The authors stressed that broader issues of poverty, rather than homelessness per se, accounted for these results (Ziesemer, et al., 1994).

Several years after her Boston study, Ellen Bassuk and colleagues mounted a "second generation" study of 220 homeless and 216 housed single parent, female-headed families, which took place in Worcester, Massachusetts. These families were enrolled into this longitudinal study and received their initial (baseline) interview between1992-95. The findings to follow predominantly come from the data collected during this cross-sectional phase of the study. Homeless mothers were enrolled from nine of Worcester's emergency shelters while the comparison group consisted of low-income, never homeless, mothers who were receiving public assistance in the form of Aid to Families with Dependent Children (AFDC). The CBCL was administered to the mothers of both preschool-age (2-½ – 5 years old) and school-age (6–17 years old) children and data for the two age groups were analyzed separately due to different assessment protocols for these two cohorts.

As reported in Bassuk, Weinreb, Dawson, Perloff, and Buckner (1997), for the preschool children, scores on both the internalizing and externalizing dimensions of the CBCL were slightly higher for homeless children compared to their housed peers (52.5 vs. 49.9 on the internalizing dimension and 54.8 vs. 51.2 for the externalizing score). Only the difference in externalizing scores was statistically significant between the two groups. Approximately 12 percent of children in both groups were in the clinical range on the internalizing score and 15 percent in both groups on the externalizing dimension. This compares to about 10 percent in the general population based on CBCL test norms. Importantly, the two best predictors of children's CBCL scores were a measure of mother's psychological distress and a measure of her parenting practices (negative parenting practices were associated with more elevated

CBCL externalizing scores).[5] Housing status (whether the child was homeless or housed) was also predictive of externalizing scores, but to a lesser degree.

Among school-age children ages 6 to 17 years in the Worcester study, Buckner, Bassuk, Weinreb, and Brooks (1999) found a similar pattern of findings; although homeless children in this older age group were evidencing more problem behaviors than their low-income housed counterparts.[6] On the internalizing dimension of the CBCL, the 80 homeless school-age children scores averaged 56.1 compared to 50.2 for their 148 housed peers. About 47 percent of the homeless school age children were in the borderline-clinical or clinical range on the internalizing subscale of the CBCL as compared to 21 percent of the youths in the housed group and 16 percent in the general population. Controlling for other explanatory variables such as negative life events, abuse history, mother's distress, and social support, housing status remained a significant predictor (Buckner, et al., 1999).

On the externalizing dimension of the CBCL, homeless children also were reported to have elevated behavior problems compared to the general population but their scores were only slightly higher than the housed poor comparison group (53.7 vs. 51.4). Supporting the CBCL internalizing dimension finding, homeless youths were also more symptomatic on *self-reported* measures of depression and anxiety. For instance, CDI scores for homeless youths averaged 10.9 versus 9.2 for housed children.[7] This difference in CDI scores was not statistically significant, and both levels indicate depressive symptoms of moderate severity. Among school-age children in the Worcester study there was some evidence of a link between homelessness and mental health/behavioral problems. This link was not evidenced among preschool children, however.

Among homeless school-age children, there was some indication that a "dose-response" relationship existed between length of time in shelter and children's internalizing CBCL scores (Buckner et al., 1999). Such problem behaviors appeared to gradually increase the longer a child had been homeless and peak at about 15 weeks and then were less for those children who had been homeless a longer

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[5] The association between mothers' psychological distress and CBCL ratings of their children's problem behavior is a consistent finding in the literature. However, the nature of the link is unclear. One possibility is that a mother's mental health influences her child's behavior but the reverse could also be true. Furthermore, a mother who views the world in negativistic terms may report herself as having more distress as well rate her child's behavior as more problematic.

[6] This is consistent with anecdotal reports and conjecture that older children experience more distress as a result of being homeless as compared to younger children. Possible reasons include older children's increased awareness of their external surroundings and the greater likelihood of encountering stigmatization from peers.

[7] These CDI scores are nearly identical to those found by Bassuk and Rosenberg (1990) about 8 years earlier in Boston.

duration (e.g., 18-45 weeks). While this curvilinear (rainbow-shaped) trend was rather apparent in the data, the finding was a tentative one as it involved a cross-sectional comparison of separate children who had been homeless for different lengths of time. Stronger evidence for such a dose-response curve could be had if a group of children were repeatedly measured during their shelter stays and the same trend was noted in their individual "change trajectories." The meaning of this curvilinear trend, if valid, is not clear. It could suggest that children habituate some to shelter conditions over time and have fewer internalizing problems once they get used to living there. It might also be the case that after several months of observation, shelter staff pick up on the problems of some children and take measures to ameliorate their distress. It might also be the case that mothers' perceptions of their children's behavior changes over time as they become more accustomed to living in a shelter.

Buckner and Bassuk (1997), assessed the mental health of homeless and housed youths in the Worcester study using a diagnostic instrument. Both parent and self-report versions of the Diagnostic Interview Schedule for Children (DISC Version 2.3) were administered to 94 children 9 to 17 years of age (and their mothers) in the Worcester study.[8] To meet criteria for a disorder, a child needed to fulfill the specific DSM-III-R criteria and have impairment in functioning as a result of that disorder. About 32 percent of youths in each of the homeless and housed groups (i.e., the proportions were nearly identical in the two groups) met criteria for one or more disorders in the past 6 months (Buckner and Bassuk, 1997). This compares to a rate of 19 percent that has been reported for children of similar age in the general population (Shaffer, Fisher, Dulcan et al., 1996). The most prevalent disorders for these low-income children were anxiety, mood, and conduct problems. Differences found between homeless and housed youths on the CBCL (Buckner et al., 1999), were not apparent when examining these youths in terms of diagnostic criteria, whether looking across all assessed disorders or only those pertaining to disorders of an internalizing (e.g., depressive and anxiety disorders) nature.[9] The more important finding was that these low-income children had much higher prevalence rates of mental health problems than has been found among youths of similar age in the general population (32% versus 19% prevalence rate for meeting criteria in the past 6 months for at least one disorder that was causing impairment).

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[8] Children ages 6 to 8 years who were included in the Buckner et al. (1999) report were not part of this paper because they were too young to be directly administered the DISC.

[9] A possible explanation is that the CBCL is better at picking up the effects of recent events than is the DISC, although both assessments use the same 6-month retrospective time frame. Also, diagnostic criteria for mental disorders versus behavior problem checklists do not correspond exactly, so the instruments may be assessing somewhat different things. The discrepancy could also be due to the source of the information (the CBCL is based on parent report, whereas the information taken to arrive at diagnoses for children regarding internalizing disorders came from the youth him or herself).

The Worcester study also involved a longitudinal component in which followup data were collected on study participants at 12 and 24 months following their baseline interviews. Among children in the school-age cohort, the longitudinal interviews found all formerly homeless children now living in permanent housing. At followup, the impact of this homeless experience seemed to have dissipated, whereas other negative life events, particularly exposure to violence in the home or community, was much more associated with mental health symptoms (Buckner, Beardslee, and Bassuk, 2004). Unpublished results from the Worcester study's preschool cohort showed a similar pattern with initial differences between homeless and housed children at baseline assessment converging at followup when most children were living in permanent housing.

An entirely separate study to the Worcester investigation, but somewhat similar in its methodology, is that of Masten, Miliotis, Graham-Bermann, Ramirez, and Neemann (1993). They interviewed 159 homeless children ages 8 to 17 years who were living in a large emergency shelter in Minneapolis during the summer of 1989 and compared them to 62 low-income children of similar age living in permanent housing. The CBCL and CDI were their principal outcome measures. On the internalizing CBCL score, homeless children scored 52.2 on average compared to 49.4 percent for the housed group. Twenty-seven percent of homeless youths had *T*-scores of 60 and higher (borderline clinical range and above) compared to 17 percent of housed youths and 16 percent in the general population based on the tests normative data. On the externalizing dimension, homeless youths had scores that averaged 56.0 (40% had a *T*-score of 60 or higher) versus 53.4 for housed youths (with 30% having a *T*-score of 60 or higher). For homeless youths, these internalizing scores are lower than those reported by Buckner et al. (1999) in the Worcester study but about the same for externalizing scores. Controlling for other explanatory variables, Masten et al. (1993) did not find that housing status was a significant predictor of either internalizing or externalizing CBCL scores. Scores on the CDI were equivalent between the two groups and of similar magnitude in severity (mild to moderate) to what was found by Buckner et al. (1999) in the Worcester study.

In summarizing their findings with an eye toward the bigger picture, Masten et al. (1993) described a "continuum of risk." By this they meant that behavior problems seemed to be more severe according to how much "risk" children had experienced. Based on indices of adversity such as stressful life events, homeless children in the Minneapolis study had the most risk, followed by low-income housed children who, in turn, looked worse off than children from more advantaged backgrounds. This

continuum-of-risk concept is an appropriate summary of the Worcester study's findings, with both homeless preschool and school-age children experiencing the most adversity and having more problem behaviors.

Developmental Status

Among infants and preschool age children, assessing cognitive and motor development in relation to specific developmental milestones is useful in understanding a child's "developmental status" and whether the child appears to have developmental delay(s) in one or more realms. For instance, a child who is not walking by the age of 2 or not speaking simple sentences by the age of 3 may be delayed in this sphere of development compared to the majority of children of similar age. Three studies examined young homeless children on this dimension. Two of the studies, Wood et al. (1990) in Los Angeles, and Bassuk and Rosenberg (1990) in Boston used the Denver Developmental Screening Test (DDST), whereas the third study, Garcia Coll, Buckner, Brooks, Weinreb, and Bassuk (1998), which involved the infant and toddler cohort from the Worcester study, used the Bayley Scales of Infant Development ("Bayley"). As the name implies, the DDST is an easy-to-use screening instrument for identifying developmental delays in children. The Bayley is the gold standard measure of developmental status in infants and young children and requires specialized training to administer. The DDST is a set of questions asked of a parent or guardian about the child (usually with the child present), whereas the Bayley is administered by a trained tester via direct observation and interaction with the child.

Both the Los Angeles and Boston studies found that homeless preschool children were experiencing a greater proportion of developmental delays than the comparison groups of poor housed children. In the Wood et al. (1990) study, 15 percent of homeless children were found to have one developmental delay and 9 percent had two or more. These rates are significantly higher than that found in the general child population.[10] The most common type of delay was in language. Bassuk and Rosenberg (1990) found much higher rates of developmental delay in their Boston study, with 54 percent of homeless children evidencing at least one delay versus 16 percent for children in the housed comparison group. Developmental tasks in the areas of language and social behavior were the two areas in which homeless children were having the most difficulty. In contrast to these two studies, Garcia Coll et al. (1998) found no differences between homeless and low-income housed infants/toddler's

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[10] The DDST was not administered to housed children in this study.

developmental status on the Bayley. In fact, homeless children looked slightly better on both the mental and motor development subscales of this instrument (scores of 105 in both realms vs. about 101 for the housed comparison group). Moreover, scores on the Vineland Screener (a measure of adaptive behavior that asks a parent about a child's communication, daily living, socialization, and motor skills) were almost identical. These low-income infant and toddlers' scores were in the low-normal to normal range based on normative data for this instrument.

Health Outcomes

The early studies of homeless children that assessed health outcomes found a higher prevalence of health-related problems compared to low-income housed children or children in the general population. For instance, Alperstein et al. (1987) in a study of outpatient medical records in a New York City pediatric clinic, compared 265 homeless children under the age of five in New York City with poor housed children attending the same clinic. Homeless children were behind in their immunizations and had elevated blood lead levels compared to housed children. Homeless children also had higher rates of hospital admissions and reports of child abuse/neglect. The two groups were comparable in terms of height, weight, and free erythroprotoporphyrin (FEP) levels (a measure of iron deficiency).

Miller and Lin (1988) conducted a survey in King County, Washington, involving a representative sample of 82 homeless families living in emergency shelters. A total of 158 children ranging from 1 month to 17 years of age were assessed, and the investigators compared their findings on these homeless children to normative data in the general population. Although Miller and Lin (1988) found that the majority of children were described as in "good" or "excellent" health, the proportion whose health was described as "fair" or "poor" was 4 times that of the general U.S. pediatric population (13% vs. 3.2%) and 2 times higher than low-income children (13% vs. 6.5%). Homeless children in this study were also found to lack a regular health care provider (true for 59%), use emergency rooms a rate 2 to 3 times higher than in the general population, and were more likely to lack standard immunizations and preventative health care.

Another health outcome study took place in Los Angeles and involved a comparison of 196 homeless families to 194 stably housed poor families (Wood et al., 1990). Children in both groups had compared global ratings of their health status (i.e., excellent, good, fair, poor) and similar rates of

symptoms (e.g., fever, cough, vomiting, diarrhea) indicative of an illness during the past month. However, these rates were 2 to 5 times higher than those reported in the general child population. Children in both groups had poor dietary intakes and problems with obesity. Homeless children were more likely than housed children to have experienced an episode of hunger in the past month (21% vs. 7%).

The only second generation study involving health outcomes is that of Weinreb, Goldberg, Bassuk, and Perloff (1998), which was part of the Worcester study that took place during the mid 1990s. They compared 293 homeless children ranging from 2 months to 17 years of age to 334 low-income housed (never homeless children). Their results are fairly consistent with prior studies, although the study is more rigorous because they used multivariate analyses to statistically control for imbalances between the two groups in order to better isolate genuine differences between the two groups. Eighty-eight percent of the homeless children and 94 percent of low-income housed children were reported to be in "good" to "excellent" health, while about 12 percent of the homeless children and 6 percent of the housed children's health were rated as "fair or poor." Overall, the difference in health ratings between the two groups was statistically significant at the $p <.05$ level. Rates of acute illnesses in the past month were generally comparable between the two groups although homeless children had higher rates of ear infections and asthma. Homeless children had higher service use rates, including visits to an emergency room and outpatient clinic visits.

Education-related Outcomes

When the crisis of family homelessness emerged in the 1980s, most school systems were unprepared to deal with the complex needs of homeless children. Many homeless children were denied access to education with school districts claiming that families living in shelter did not meet permanent residency requirements and, therefore, were not eligible for enrollment (Rafferty, 1995). The most frequent impediments to adequate education for homeless children were residency, guardianship, immunization requirements, availability of records, and transportation to and from school (Stronge, 1992). It is not difficult to imagine that if homelessness causes children to miss school, such absence will likely be detrimental to their academic performance.

Part of The Stewart B. McKinney Homelessness Assistance Act, which Congress passed in 1987, was the establishment of the Education of Homeless Children and Youth (EHCY) program to ensure that

homeless children had the same access to public education as all other children. Since then, the EHCY program has provided formula grants to state educational agencies to review and revise policies that may act as barriers to school enrollment and attendance as well as to fund direct services such as transportation and tutoring. Anderson, Janger, and Panton (1995) conducted a national evaluation of the EHCY program and found that over 85 percent of homeless children and youth were regularly attending school, indicating a marked improvement in school access compared to pre-EHCY program attendance rates.

Studies of homeless children that were conducted prior to and shortly after the creation of the EHCY program have consistently documented disrupted school attendance and academic underperformance. For instance, Bassuk and Rubin (1987) reported that 43 percent of students living in Massachusetts shelters had repeated a grade, 25 percent were in special classes, and 42 percent were failing or doing below-average work. Masten et al. (1993) found that 64 percent of the homeless children they surveyed in Minneapolis in 1999 had changed schools in the past year, significantly higher than the 40 percent rate experienced by housed poor children. In a separate study of 73 homeless children ages 6 to 11, Masten and colleagues determined that academic achievement scores were lower on average than would be expected among children in the general population (Masten, Sesma, Si-Asar, Lawrence, Miliotis, and Dionne, 1997).

Zima, Wells, and Freeman (1994) reported that 16 percent of their sample of school-age homeless children in Los Angeles had missed more than 3 weeks of school over the past 12 weeks. Thirty-nine percent exhibited reading delays and almost half were at or below the 10th percentile on a measure of receptive vocabulary. Zima and colleagues also found a high level of unmet need for special education evaluations (and perhaps special education programs) based on the high proportion of children with a probable behavioral disorder, learning disability, or mental retardation (Zima, Bussing, Forness, and Benjamin, 1997).

In a longitudinal study in New York City, Rafferty, Shinn, and Weitzman (2004) compared the academic achievement scores of 46 youths who had a history of homelessness with 87 housed (never homeless) adolescents at three time points during the early to mid-1990s. They found an apparent detrimental effect of homelessness on achievement scores over the short term but not 5 years later. A subtest of the Wechsler Intelligence Scale for Children-Revised was equivalent between the two groups.

Youths who had previously been homeless had more school mobility and grade retention than their housed peers (Rafferty et al., 2004).

Between 1990-92, Rubin, Erickson, San Agustin, Cleary, Allen, and Cohen (1996) conducted a comparative study of homelessness and poor housed children ages 6 to 11 in New York City to examine the relation among housing status, cognitive functioning, and academic achievement. Similar to other studies, they reported that homeless children had missed more days of school in the past year and were more likely to have repeated a grade compared to low-income housed children. Controlling for sociodemographic variables, Rubin et al. (1996) did not find differences between the two groups on measures of verbal and nonverbal intelligence. However, academic achievement scores (reading, spelling, math) were worse for homeless children compared to their housed counterparts, adjusting for demographic factors. Rubin et al. (1996) reported that the effect of housing status on reading achievement was mediated by the number of school changes a child had experienced in the previous 2 years, whereas housing status was linked to spelling achievement through having repeated a grade.

In contrast to some of these studies, Buckner, Bassuk, and Weinreb (2001) found no evidence of higher school absenteeism or lower academic achievement scores among homeless school age children in the Worcester study as compared to low-income housed children. Children in each group had missed an average of 6 days of school in the past year and scores on a composite measure of academic achievement were identical for both groups (92.8 with 100 the average in the general population). IQ scores were also equivalent in the two groups (92.5 for homeless children vs. 93.5 for housed youths with a score of 100 the norm). Rates of school suspension, grade retention, and special classroom placement were actually higher in the housed comparison group. The only notable difference in the "expected" direction was that homeless children had been enrolled in more schools in the past year (a median of 2 vs. 1 for housed school-age children).

It is likely that the lack of differences in the Worcester study between homeless and housed school-age children on school and education-related variables had to do with successful implementation of the EHCY program in that city. For the most part, data collection for the other investigations cited above occurred prior to the full implementation of EHCY programs in cities in which these studies were conducted. Since EHCY programs target likely mechanisms by which homelessness could adversely impact academic achievement—namely school access and school attendance—it is not surprising that

subsequent studies of homeless children that took place after EHCY programs had been actively implemented (such as in Worcester) would find fewer differences between homeless and housed children on measures of school-related problems and achievement. The findings offer encouraging evidence that it may be possible to eliminate education-related problems for homeless children if barriers to accessing education can be removed.[11]

A summary of all the studies described above is presented in Table 1-1. The "Findings" column of this table gives a simplified synopsis of the results of the study in terms of how homeless children looked on the main outcome measure(s) compared to housed children and children in the general population. As can be seen by reading down this column, past studies that can speak to the matter of if and how homelessness has an impact on children are decidedly mixed in their findings, particularly when comparing homeless to low-income housed children.[12] In virtually all instances, these two groups of low-income children look worse on various outcome measures compared to children in the "general population" (i.e., for whom the tests were normed). However, overall it appears that homelessness is associated with worse outcomes, particularly those pertaining to health and education-related measures. Study results in the areas of mental health, problem behaviors, and developmental status are somewhat less consistent, both within and across investigations. The magnitude of severity of problems found among homeless (and low-income housed) children tend to be in the mild to moderate range.

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11 In contrast, one could speculate that the results of Rubin et al. (1996) and that of Rafferty et al. (2004) (both which were conducted in New York city at about the same time), which each found higher school absences and lower academic achievement among homeless children, suggest that the EHCY program in this city was not as successfully implemented as compared to in Worcester 5 years later.

12 As shown in Table 1-1, the "Ho > Hou > GP" abbreviation can be interpreted to mean that the "homeless group had more problems on the outcome measure(s) than the low-income housed comparison group, which in turn had more problems than children in the general population/normative data."

Table 1-1.   Summary of published homelessness studies 1987-2004 by domain

Mental health/behavior problems

Publication	Location	Sample	Age	Outcomes	Findings	Comments
Bassuk and Rubin (1987)	Massachusetts	156 homeless children	0-18 years	CBCL, CDI	Hom > GP	First study to involve homeless children
Bassuk and Rosenberg (1990)	Boston	134 homeless children 81 housed children	0-18 years	CBCL, CDI, etc.	Hom > Hou > GP	Mostly the same homeless sample as Bassuk and Rubin (1987)
Rescorla et al. (1991)	Philadelphia	83 homeless children 45 housed/clinic children	3-12 years	CBCL, etc.	Hom > Hou > GP	Homeless children much worse on CBCL than housed peers
Masten et al. (1993)	Minneapolis	159 homeless children 62 housed children	8-17 years	CBCL, CDI	Hom = Hou > GP	Multivariate analyses controlled for other explanatory variables
Zima et al. (1994)	Los Angeles	169 homeless children	6-12 years	CBCL, CDI	Hom > GP	
Ziesemer et al. (1994)	Madison, WI	145 homeless children 142 housed children	School-age	CBCL-Teacher	Hom = Hou > GP	Teacher version of CBCL used, not parent version as in the other studies
Schteingart et al. (1994)	New York City	82 homeless children 62 housed children	3-5 years	CBCL	Hom = Hou > GP	Multivariate analyses controlled for other explanatory variables
Bassuk et al. (1997)	Worcester, MA	77 homeless children 90 housed children	2-5 years	CBCL	Hom > Hou > GP	Multivariate analyses. Difference between Homeless/housed on CBCL-Externalizing only
Buckner et al. (1999)	Worcester, MA	80 homeless children 148 housed children	6-17 years	CBCL, CDI, etc.	Hom > Hou > GP	Multivariate analyses. Difference between Homeless/housed on CBCL-Internalizing only
Buckner and Bassuk (1997)	Worcester, MA	41 homeless children 53 housed children	9-17 years	DISC (DSM-III-R diagnoses)	Hom = Hou > GP	Children age 9 and older in Worcester study. Only study to report DSM diagnoses

Table 1-1.   Summary of Published homelessness studies 1987-2004 by domain (continued)

Developmental-related problems

Publication	Location	Sample	Age	Outcomes	Findings	Comments
Bassuk and Rosenberg (1990	Boston	134 homeless children 81 housed children	0-5 years	DDST	Hom > Hou > GP	DDST is a brief screening instrument
Wood et al. (1990)	Los Angeles	194 homeless children	0-5 years	DDST	Hom > GP	Housed children were not assessed
Garcia Coll et al. (1999)	Worcester, MA	127 homeless children 91 housed children	0-3 years	Bayley	Hom = Hou = GP	Bayley is the "gold-standard" measure of Developmental status

Health-related problems

Publication	Location	Sample	Age	Outcomes	Findings	Comments
Alperstein et al. (1987)	New York City	265 homeless children 1600 housed children	0-5 years	Miscellaneous	Hom > Hou> GP	
Miller and Lin (1988)	King County, WA	158 homeless children	0-17 years	Miscellaneous	Hom > GP	
Wood et al. (1990)	Los Angeles	194 homeless children 193 housed children	0-5 years	Miscellaneous	Hom > Hou > GP	
Weinreb et al. (1998)	Worcester, MA	293 homeless children 334 housed children	0-17 years	Miscellaneous	Hom > Hou > GP	Multivariate analyses.

Table 1-1.   Summary of Published homelessness studies 1987-2004 by domain (continued)

Education-related problems

Publication	Location	Sample	Age	Outcomes	Findings	Comments
Bassuk and Rubin (1987)	Massachusetts	156 homeless children	0-18 years	Attendance, etc.	Hom > GP	
Rescorla et al. (1991)	Philadelphia	83 homeless children 45 housed/clinic children	3-12 years	WRAT-Reading	Hom > Hou > GP	Homeless children worse in reading achievement than housed peers
Masten et al. (1993)	Minneapolis	159 homeless children 62 housed children	8-17 years	Changes in school	Hom > Hou	
Masten et al. (1997)	Minneapolis	73 homeless children	6-11 years	WIAT-S, etc.	Hom > GP	Compared to children for whom the test was normed, homeless children scored lower in achievement
Ziesemer et al. (1994)	Madison, WI	145 homeless children 142 housed children	School-age	CBCL-Teacher	Hom = Hou > GP	Ratings of academic performance using teacher version of CBCL
Zima et al. (1994; 1997)	Los Angeles	169 homeless children	6-12 years	Attendance, reading delays, unmet need for special ed., etc.	Hom > GP	Homeless children have elevated rates of academic problems, unmet need for special education, etc.
Rubin et al. (1996)	New York City	102 homeless children 178 housed children	6-11 years	WRAT-R	Hom > Hou > GP	Multivariate analyses. No differences between homeless and housed on IQ measure
Buckner et al. (2001)	Worcester, MA	80 homeless children 148 housed children	6-17 years	Attendance, WIAT-S, KBIT-Non-verbal	Hom = Hou = GP	Multivariate analyses. No differences between homeless and housed on any measure, including IQ
Rafferty et al. (2004)	New York City	46 formerly homeless children 87 permanently housed children	11-17 years	Changes in school, WISC-R Similarities, Reading achievement	Hom > Hou	No differences on IQ measure

Key:

Hom = Homeless group; **Hou** = Low-income housed comparison group; **GP** = Children in the general population; **">"** means "greater problems than"

CBCL = Child Behavior Checklist; **CDI** = Children's Depression Inventory; **DISC** = Diagnostic Interview Schedule for Children;

DDST = Denver Developmental Screening Test; **Bayley** = Bayley Scales of Infant Development;

WRAT-R = Wide Range Achievement Test – Revised; **WIAT-S** = Wechsler Individual Achievement Test- Screener; **KBIT** – Kaufman Brief Intelligence Test;
WISC-R = Wechsler Intelligence Scale for Children-Revised.

The notion of a continuum of risk is a useful in describing how results tend to fall out when comparing homeless to low-income housed children as well as children in the general population. That is, compared to children in the general population, low-income housed children appear to be doing worse on most outcome measures with homeless children looking the most problematic. (In the next section a range of different factors are discussed that might account for the lack of dependable findings in studies that have compared homeless to housed children.) In addition to the table, Figure 1-1 provides a means by which to summarize both the intentions and the findings of the studies discussed in this section. It is intended as an explanatory device: The figure does not portray actual findings from any particular study and the quantitative values suggested by the lines on the y axis should *not* be taken literally. The figure portrays the continuum-of-risk concept mentioned by Masten et al. (1993), which is a consistent pattern of results across studies involving homeless and low-income housed children. In the figure, an "average degree of problem severity" is assigned to each of three different grouping of children: children in the general population, housed children living in poverty, and homeless children. Each group's level of "problem severity" is apportioned to up to three different sources or risk. Children in the general population have just one source of risk ("normative stressors"), those who are from low-income families living in housing have two sources of risk (normative stressors plus "non-homeless, poverty-related" stressors) and homeless children have three sources (normative, poverty-related, and "homelessness-specific" stressors).

Figure 1-1: Continuum-of-Risk Concept
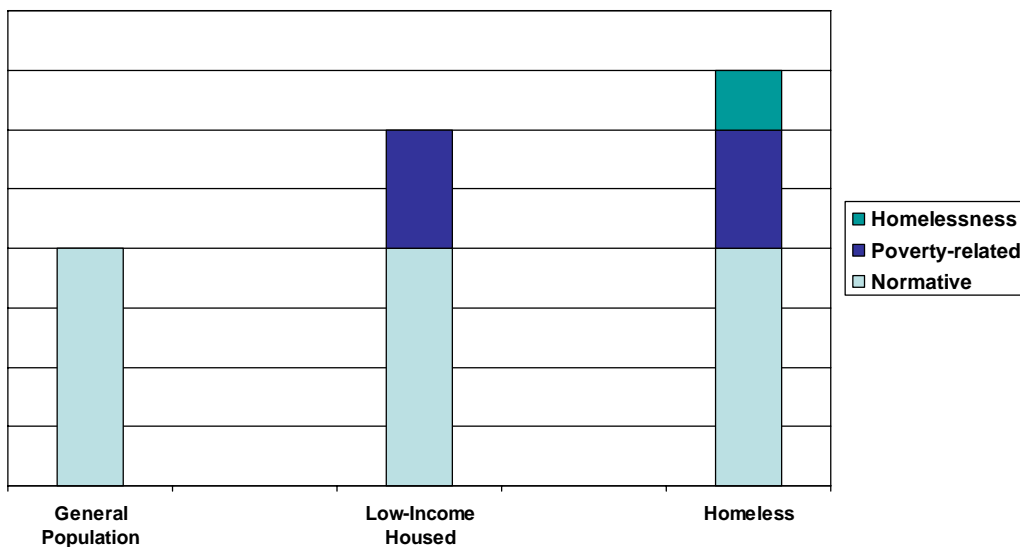
To interpret this graph, assume that the y axis refers to values indicative of a problem of some sort, with higher values indicating greater severity. The graph illustrated a finding that is typical across the studies reviewed earlier, namely that the degree of problem severity is highest for homeless children, followed by low-income housed children, with children in the general population (based on test norms) scoring lowest. The continuum-of-risk notion posits that those with exposure to greater risk have heightened problems, with homeless children experiencing the most risk, hence more severe problems followed by poor housed children, followed by children in the general population. An implicit assumption is that all three groups of children share some common risk factors that are not related to poverty. These are labeled problems attributable to "normative risk factors" and assigned equal values in all three groups. Children in the low-income housed and homeless groups share in common a set of "poverty-related" risk factors. These would be mostly environmental and family variables that children from more advantaged backgrounds are rarely or never exposed to. Furthermore, these poverty-related risk factors are not related to homelessness. Equal values are assigned to both the low-income housed children and homeless children, but no value to children in the general population. Lastly, a value of risk exposure is assigned to the group of homeless children that represents their exposure to risks that are "homelessness-related." Of course, only children in the homeless group receive such exposure.

Some of the studies reviewed earlier reveal a pattern of results that match up nicely to this figure. For instance, those studies listed in Table 1-1, in which the finding "Homeless Group > Housed > General Population" seems to fit a pattern of findings consistent with the continuum-of-risk notion.[13] As described earlier, a goal of many of the studies, especially those involving both homeless and housed children and multivariate statistics, was to determine whether homeless children had heightened problems; and, if so, whether these could be attributed to homelessness or if it were simply the case that homeless children got a higher dose of poverty-related risk exposure than the low-income housed group. So, for example, Buckner et al. (1999) found that homeless school-age children had more internalizing mental health problems than their low-income housed counterparts. Furthermore, through the measurement and statistical control of other risk factors (such as negative events, chronic strains, abuse history, mother's mental health), the study determined that homelessness, per se, seemed to be playing a role in these elevated internalizing problems. Put another way, it was *unlikely* that this was a spurious association between housing status and internalizing problems brought about by homeless children having been exposed to more poverty-related (non-homeless) risks than the low-income housed group. This is one of the few studies that has found both an elevated problem severity in homeless children and has been able

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[13] However, only some studies collected assessments of a range of adversities that children living in poverty experience, so it is not always possible to document how much risk children in the homeless and housed groups were exposed to.

to convincingly demonstrate that this heightened degree of problem severity is likely the result of homelessness-related stressors and not non-homeless poverty-related factors.

Part II: Why Studies of Homeless Children Have Produced Inconsistent Findings

The previous section reviewed many of the published empirical articles that address the potential impact of homelessness on children. The continuum-of-risk figure (Figure 1-1) is helpful in summarizing various study findings. A rather consistent result across studies is noting elevated problems among homeless and low-income housed children compared to children in the general population. In essence, most studies have documented an apparent negative effect caused by exposure to a common set of "poverty-related" risks. What is less consistent across studies is whether an additional elevation in problems among homeless children as compared to low-income housed children is also found. Moreover, when differences are detected, limitations in methodology (such as not adequately measuring additional risk factors and/or not using multivariate analyses to control for them) call into question whether homelessness, per se, is behind the heightened severity of problems. In other words, it is hard to demarcate where poverty-related sources of risk end and homelessness-specific risks begin.

While the overall pattern of findings across studies does suggest that, more often than not, children's exposure to homelessness increases their risk of adverse outcomes, it is difficult to make strong and definitive assertions about the impact of homelessness on children due to inconsistent study results. Rather, the effect that homelessness appears to have on children would seem to be dependent on a range of contextual factors and "effect modifiers." Put simply, whether homelessness has an impact on children may depend. On the other hand, studies are much more consistent in discerning a negative impact of poverty on children (i.e., both low-income housed and homeless) across outcome domains and among different age groups within domains.

The remainder of this section offers some explanations as to why various studies involving homeless children have not been able to reliably produce findings suggestive of a negative impact of homelessness above and beyond the effects of broader poverty-related risks.

<u>Methodological Differences</u>

Studies of homeless children have differed in terms of the assessment instruments employed, the degree of statistical power afforded by sample size, selection of comparison groups, enrollment procedures, and other factors. While there are methodological shortcomings in some studies, this probably

is not a major reason for the inconsistencies in study findings. For one, some of the more methodologically rigorous studies are internally inconsistent. For example, in the Worcester study, differences were found between homeless and housed children on behavior problems (but only for internalizing problems in school-age children and externalizing problems for preschool children). Infants and toddlers in both groups appeared equivalent and no differences were found on measures of academic achievement among the older children. The Rescorla et al. (1991) study in Philadelphia made the questionable choice of having children in a health clinic serve as the housed comparison group. Yet, the magnitude of problems they assessed in their sample of homeless children was very high and they were likely to have found statistically significant differences between this group and whichever comparison group they might have selected.

Pointing out methodological differences between studies (or problems within studies) yields an uncompelling argument for why studies of homeless children paint such a confusing picture as to the impact of homelessness on children. Rather, inconsistencies across these studies may have more to do with the fact that these investigations have involved different study groups in different communities at different points in time during the fast changing history of family homelessness in America. These other factors, which are largely outside the realm of what is described in an article's methodology section, are discussed in the pages to follow.

Historical Factors

The early studies of homeless children took place in contexts in which the problem of family homelessness had recently emerged and where communities had not had sufficient time nor had marshaled adequate resources to address the needs of this new homeless subgroup. While difficult to document, it is likely that shelter conditions for families have improved in most cities between the mid-1980s and mid-1990s. What a typical child who was homeless in Washington, DC, in 1985 experienced versus what a child who was homeless in Worcester, Massachusetts, encountered in 1995 are very likely quite different. The contrast to 1985 is probably even greater now. The Stewart B. McKinney Act, which was passed in the late 1980s, has funneled hundreds of millions of dollars each year to communities to use in improving housing options and services available to homeless single adults, families, and unaccompanied youths. Legal changes and funding to reduce educational obstacles for homeless children could have made a difference in some communities as evidenced by findings in Worcester (Buckner et al., 2001) and more broadly (Anderson et al., 1995). It is safe to say that, were it not for Federal, state, and local funding to address the needs of homeless individuals and families, their plight would clearly be much worse.

One can make a bit more sense out of the inconsistencies across studies of homeless children by recognizing that the time span between some of these investigations was long enough that what investigators were observing in the later studies entailed a much greater societal response to the issue of homelessness that what the earliest studies had witnessed. For instance, it is probable that the "null" findings regarding school and education-related outcomes for homeless children in Worcester in the mid-1990s (Buckner et al., 2001) would not have emerged had the same investigation in the same city been conducted a decade earlier, before implementation of the McKinney Act and other responses, which began to rectify difficulties that homeless children were having in attending school.

Contextual and Policy-related Factors

Across communities at any given moment, the extent of structural imbalance between the supply of affordable housing and its demand will vary with some areas having greater disequilibrium between the supply of housing and demand than others. Likewise, within any given community over time, the degree of structural imbalance is not static but in a state of flux. For instance, Massachusetts, like many other regions of the United States, has had a shortage of affordable housing for many years and this structural imbalance between supply and demand has worsened over the past 10 years. Evidence of this has been increased length of time on waiting lists for eligible households to receive Section 8 housing assistance and longer average duration of shelter stays before families can secure permanent housing (U.S. Conference of Mayors, 2001). Interestingly, it is quite possible that changes in this structural imbalance, for better or for worse, may have ramifications for what researchers uncover at the individual-level among homeless individuals and families. How could this be so?

In understanding the root causes of homelessness, it is important to differentiate between a structural imbalance in the supply and demand for housing, which is the fundamental cause of homelessness, from individual-level vulnerability factors. As a structural imbalance emerges within a locale, such that there is a shortage of affordable housing, it is those who are least able to "compete" who are first to become homeless. Such persons may have multiple vulnerability factors so that, compared to a broader group of persons at risk, they are the least competitive (Buckner, 1991; Buckner, Bassuk, and Zima, 1993; Shinn, 1992). For instance, among families, where caring for children in and of itself leaves adults more vulnerable to homelessness, this could include having health, mental health, or substance use problems as additional risk factors. As the structural imbalance progresses, those who become homeless next will have fewer vulnerabilities than the earliest victims. In other words, when a community begins to encounter a lack of affordable housing appropriate for families, it will be the most vulnerable families

who become homeless first. If the problem worsens over time, those families who become homeless thereafter will increasingly look less susceptible compared to the first entrants into homelessness.

The implication this has for homelessness research is that, all other things being equal, in a gradually worsening housing market, early studies may reveal greater problems among shelter residents (adults and children) than do later studies. The rationale being that a gradually tightening housing market "selects" out those families first with the most vulnerabilities (i.e., least ability to compete successfully for housing) followed by families with fewer vulnerabilities. Over time, early disparities between homeless and low-income housed families would tend to lessen. Hence, a comparative study conducted shortly after a structural imbalance in the supply and demand for housing emerges may end up seeing starker differences between the homeless and housed group (e.g., more ADM disorders with the mother). However, these may be factors that entered into the selection process for which families became homeless. If these factors also have a role in influencing a children's mental health (or other aspect of child functioning) then it may appear as though housing status is the reason for heightened problems among children, when in fact the association is not a causal one. For this reason, it is important to measure other factors that can influence a child's mental health (or other relevant outcome) so as to make a clearer determination about the specific contribution of housing status (i.e., homelessness) to such outcomes.

Housing assistance policy is another area that could change the complexion of sheltered homeless families over time. If housing policy is such that being homeless reduces a family's wait for a Section 8 housing certificate/voucher or some other form of housing assistance, then some families may decide it is worth it in the long run to seek admittance to a family shelter. A situation then arises where homelessness is not something that is avoided by all. Should a modest proportion of families in shelter be there as a matter of "choice" rather than necessity, a comparison of homeless to low-income housed families would most likely reveal fewer differences than if all families in shelter were in shelter unwillingly.[14]

Conceivably, some of these contextual and/or housing policy-related factors could have played a role in accounting for different results between Ellen Bassuk's and colleagues study of homeless and housed families in Boston during the 1980s (Bassuk and Rosenberg, 1988; Bassuk and Rosenberg, 1990) and a similar but more comprehensive investigation of homeless and housed mothers in Worcester that

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[14] In Massachusetts, the Department of Transitional Assistance (DTA), which is in charge of the emergency shelter system (as well as other assistance programs for persons with low-income), refers to this as "rendering oneself homeless." This term is an acknowledgement of the reality that some families decide a temporary stay in a family shelter may be worth it if it speeds up the process of securing permanent housing; especially if the alternative is to continue living in crowded, "doubled-up" quarters with relatives or friends. In general, DTA disapproves of rendering oneself or family homeless.

she led 8 or so years later (Bassuk, Weinreb, Buckner, Browne, Salomon, and Bassuk, 1996; Bassuk, Buckner, Weinreb, Dawson, Browne, and Perloff, 1997; Bassuk, Buckner, Bassuk, and Perloff, 1998). In the earlier study, homeless mothers had greater difficulties than a comparison group of low-income mothers on a range of factors, including history of abuse in childhood and adulthood, greater psychiatric problems, and less supportive social networks (Bassuk and Rosenberg, 1998). In contrast, in the Worcester study, the two groups were quite similar across many different measures, including abuse histories, alcohol, drug, and mental health problems, health conditions, and social networks. In fact, the two groups were similar enough on so many different dimensions, especially histories of violent victimization and mental health problems, that it was almost as if they had been sampled from the same population. Conceivably, this contrast in study findings between Boston in the 1980s and Worcester in the 1990s is partly explained by a gradual worsening of the housing market in Massachusetts. Or perhaps housing policy shifted appreciably such that more low-income families were entering shelter to accelerate receiving housing assistance. Either way, what was observed in mothers in each of the two studies likely related to what was assessed in their children. In other words, the greater differences between homeless and housed children in the Boston study as reported by Bassuk and Rosenberg (1990) as compared to the Worcester study (Bassuk et al., 1997; Buckner and Bassuk, 1997; Garcia Coll et al., 1998; Buckner et al., 1997) could have partly been a function of there being more troubled families in the Boston homeless sample than the Worcester homeless sample.

While the above discussion is somewhat speculative, there are compelling reasons to warrant researchers taking a step back and evaluating possible contextual and/or policy-related factors that may play a role in study findings of homeless individuals and families. This is not to argue that differences in contextual or policy factors explain all the inconsistencies seen across the different investigations of homeless children (and families), but that they could account for some portion of the variability in results.

Homelessness is Not a Homogenous Experience

It is important to recognize that people experience homelessness in many different ways. For example, if one were to examine the residential histories of those children (or adults) who are homeless across the United States on any given night, one would find that a number of different circumstances have led to their present situation. Likewise, the ultimate pathways they shall take out of homelessness will vary as well. While homeless, these children will experience different durations of shelter stay, the conditions of shelters will vary both within and across cities, and shelter rules will be quite different. For instance, a few shelters require a family to leave during the daytime while others do not force such a requirement (U.S. Conference of Mayors, 2001). As such, homelessness is not a homogenous experience

for children and it can be challenging to make generalized statements about the impact of "homelessness" on children because "homelessness" is not the same thing for all those who experience it. This can be the case as well for other stressful events, but there may be an especially high degree of variation in what homeless children encounter, both within and across locales and time periods.

Shelter conditions are probably an especially important factor in moderating the impact of homelessness for a child. Yet, previous investigations involving homeless children have not sought to measure attributes of a shelter or ecological indices to see if they relate to child outcome. No doubt this would be a challenging task and most studies have not had enough contrast in shelters from which families were enrolled to examine such issues. Nonetheless, it stands to reason that there are important qualities to shelters that may worsen or buffer a child's experience while living there. These could include the amount of privacy accorded to families, the crowdedness of the facility, the extent to which rules are strictly enforced, the warmth of shelter staff, the size of the facility, its location, and whether families are asked to leave during the day or can remain on the premises.

Shelter as an Intervention

On the surface, a shelter stay may seem like a negative experience for a child in a low-income, but as Bassuk and Rosenberg (1990) remarked, *"for some children, their stays in a neighborhood-based family shelter have been the most stable and predictable experiences of their young lives (p.261)."* In fact, a stay in a family shelter (especially if it is neighborhood based and not a barrack-like shelter or a motel) accords some families the opportunity to receive assistance from case management staff in applying for assistance programs for which they may be eligible as well as referrals to professionals for treatment of one sort or another. As a general rule, the staffs of family shelters have good intentions and, over time, shelter staffs aim to improve their programs and be more responsive to their guests. Hence, some shelters may be providing useful assistance to families, thereby ameliorating other factors that can have a negative impact. In contrast, low-income families who have never been homeless can sometimes be quite isolated and far removed from a range of services and treatment programs that may be beneficial. The implication for research on the impact of homelessness on children is that a shelter stay is not always a negative event for a child. Were it the case in studies that homeless children had been literally without shelter (e.g., living in a car or in campgrounds), than the contrast in living conditions would be much more striking than is sometimes the case. In reality, studies that compare sheltered homeless versus low-income housed children are dealing with a much more complex underlying set of residential circumstances in the lives of each group of children than is generally appreciated. Said differently, the living conditions of children

living in shelter are not always as bad as they might seem while the conditions of children in low-income housed settings can be much worse than imagined.

Similarities Between Homeless and Low-income Housed Children

As stated at the beginning of this section, it seems easier to discern a poverty-related effect in studies of homeless and low-income children than a homelessness-specific effect. A simple explanation is that both groups tend to differ far more from children in the general population, in terms of exposure to risk factors detrimental to various measures of outcomes than they do to one another. Despite differences in current housing status, homeless children and low-income housed children have more similarities than differences in what they have been exposed to. Even on housing status, it is important to note that homelessness is a temporary state through which people pass, not a permanent trait emanating from individual deficits (Shinn, 1997).[15] Also, the living conditions of *housed* low-income children can be quite decrepit thereby attenuating the contrast between them and children who are living in shelter.

Children from low-income families, whether homeless or housed, face an array of chronic strains and acute negative life events that stem from the broader conditions of poverty.[16] These adversities may loom large over the specific detrimental effects that homelessness can have on a child (especially when looked at over the long term). In other words, problems attributable to poverty-related stressors may be much greater than those that are homelessness specific. When viewed in the context of a much broader range of adversities, it is apparent that *homelessness is but one of many stressors that children living in poverty all too frequently encounter*. For most children, homelessness as a stressful event, may rank somewhere in the moderate range in terms of severity. It has the potential to be more stressful than many experiences, but not to the degree that some events hold, such as witnessing or being the victim of abuse or violence; events that are not uniquely experienced by children when homeless.

Part III: Future Directions for Research

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[15] As illustration of this, in the Worcester study when families in both groups were re-interviewed a year after the initial baseline interview, 92 percent of the initially homeless families were now in permanent housing and 8 percent were still homeless. By the same token, 92 percent of the housed families were still in permanent housing but 8 percent were now homeless. In other words, one year after enrollment, exactly the same proportion of "homeless" and "housed" families in our longitudinal study were living in permanent housing.

[16] Chronic strains include such things as feeling hungry, being cold in the winter, worrying about the safety of one's relatives, feeling a lack of privacy. These are circumstances that can be experienced on a regular basis, and children were asked if they had experienced a strain, how frequently, and how much they were worried or bothered by it. Life events are more acute in nature and tend to have an onset and endpoint. They can include extreme events, such as witnessing violence, having a relative die, having a parent be arrested, and more normative events, such as changing schools or having a new sibling born into one's family.

Research conducted to date on homeless children has illuminated the knowledge on current needs and the impact of homelessness. Additional studies of homeless and housed children along the lines of previous investigations may do little to clarify the inconsistencies in findings. If future research is conducted that specifically addresses the question of how and to what degree homelessness impacts children, it should address some of the issues brought up earlier. However, this is no small task because it would be impossible to control on historical factors that may have affected past results and it would be very difficult to account for contextual factors, such as the extent of a housing shortage in a community or shelter conditions, without conducting a large multisite study. Clearly there are variables that moderate the relationships between housing status and important indices of children's well-being, but many of these variables may be at levels of analysis higher than the individual (e.g., shelter, community, etc.) and are difficult to investigate. Nonetheless, to advance this area of research to be more practical for policymakers and service providers, it would be helpful to understand some of the contextual, moderating influences raised here.

Topics for Further Inquiry

There is sparse data concerning some issues on homeless and low-income children. One issue is to better understand homelessness in the context of other adversities that children living in poverty frequently encounter. As mentioned previously, in comparing homelessness to other stressors that children living in poverty may encounter, homelessness is a moderate stressor, not as problematic as exposure to violence but capable of causing mental health and educational problems in children under certain circumstances (Buckner et al., 2004). Future studies to clarify the negative life events and chronic strains that are the most problematic for children would be helpful in targeting treatment resources and preventive efforts to those children living in poverty who are the most in need.

It is also useful to understand factors both internal and external to a child that lead to positive outcomes despite the adversities of poverty. Such findings lend themselves to more strengths-based interventions, which attempt to promote positive factors as opposed to only trying to eliminate risk factors. Two characteristics of children were identified in the Worcester research that were quite useful in distinguishing those who were resilient from those who were not doing as well on multiple indicators of mental health and adaptive functioning (Buckner, Mezzacappa, and Beardslee, 2003). One of these factors, which is external to a child, was parental monitoring. A child whose parent(s) engaged in active awareness of where and with whom there child was on a daily basis tended to exhibit more resilience. Another, even more important, factor distinguishing resilient from nonresilient children was an internal set of cognitive and emotion regulation skills that researchers refer to as "self-regulation." Self-regulation

comprises a set of skills that are invoked in order to accomplish goals, whether they are fairly proximal or distal in nature. In the Worcester study, children high in self-regulation looked much better on measures of mental health, behavior, adaptive functioning, and academic achievement than children low in self-regulation (Buckner, Mezzacappa, and Beardslee, paper in review). Furthermore, those high in self-regulation appeared to be better able to cope with stressors in their lives. Variables such as parental monitoring and self-regulation may offer promising leads for positive or strengths-based interventions to promote resilience in homeless children and other children living in poverty.

An additional area of importance to homeless children for which relatively little is known concerns the issue of children who are separated from their parent(s) due in part to a homeless episode. Such separation is sometimes the choice made by a parent, usually the mother, in deciding the best interests of a child or can be a decision forced upon her by the child welfare system, shelter staff, or relatives (Cowal, Shinn, Weitzman, Stojanovic, and Labay, 2002; Park, Metraux, Brodbar, and Culhane, 2004). Cowal et al. (2002) conducted the most involved investigation to date on this issue. Their study, which took place in New York City during the early 1990s involved 543 poor families, 251 of whom had experienced homelessness at some point in the 5 prior years. They found that 44 percent of the homeless families had had a child separation compared to only 8 percent of low-income never homeless families. Even when accounting for histories of mental health and substance abuse problems as well as domestic violence (directed at the mother), homelessness was strongly associated with a family experiencing such a separation (Cowal et al., 2002). The reasons why the risk of parent-child separation increases when a family becomes homeless is not entirely clear but it is likely there are multiple factors at work. The "fishbowl hypothesis" (Park et al., 2004) posits that shelters scrutinize the parenting practices of adult family members much more so than what they would experience if living in housing, and this poses a risk for child welfare placement. Alternatively, in some cases, a soon-to-be homeless mother will ask that relatives care for a child of hers so that the child can continue attending the same school. In other instances, shelters may not allow adolescents, especially males, to stay in their shelter, thereby forcing a family-child separation.

Looking at this matter of parent-child separation within the parameters of families living in homeless shelters masks an even larger issue because residents of family shelters must include at least one parent and at least one child. What about parents who are separated from their only child or all of their children? They would not be welcomed at a family shelter and instead would be placed in a shelter for "single" adults. Hence, the residents of shelters intended for single adults can and do include some individuals who would otherwise be in a family shelter if they were presently caring for their child(ren). This is borne out in a study conducted in Alameda County, California by Zlotnick, Robertson, and Wright

(1999), who interviewed 171 homeless women drawn from a countywide probability sample. Of these women, 84 percent were mothers and 61.5 percent of these homeless mothers had a child under the age of 18 living either in foster care or some other out-of-home placement.

Another topic for future inquiry involves the issue of residential instability as a predictor of adverse outcomes in low-income children. Moving from place to place is certainly a common event for homeless children in the months before and sometimes after a shelter stay, but such residential instability can also be experienced among children who remain in permanent housing and do not ever spend time living in a homeless shelter. The impact that residential instability has on child outcomes is not presently well understood.

Overlapping Issues of At-risk Groups

Homeless children, because of their impoverished circumstances and residential instability share commonalities with another at-risk group of children, namely dependents of migrant farm workers. Mostly Latino of Mexican and Central American heritage, migrant farm workers provide a low-cost source of labor for American farmers who seasonally require large numbers of temporary workers to harvest their crops. About one-third of such workers lead a transient lifestyle as they travel from one state to another in the course of a year, laboring to harvest the different types of produce grown in each region. They are paid low-wages, usually with no or minimal benefits and must live in crowded makeshift abodes. It is estimated that about 42 percent of the 2 million farm workers in the United States are migrant workers. The National Commission on Migrant Education (1992) estimated that about 600,000 children belong to migrant farm worker families. Older children sometimes work alongside adults in the fields while younger children are loosely supervised during working hours. Studies of children of migrant farm workers have observed problems of a similar nature to that of homeless children, including higher rates of health and mental health problems compared to children in the general population, elevated rates of physical abuse, and academic problems (Kupersmidt and Martin, 1997; Larson, Doris, and Alvarez, 1987; Research Triangle Institute, 1992; Slesinger, Christenson, and Cautley, 1986). While the residential instability of migrant workers is somewhat more elective and predictable than for homeless families, it nonetheless can lead to similar problems, particularly difficulties in attending school and graduating (National Commission on Migrant Education, 1992).

<u>Typology Efforts</u>

As previously characterized, the emphasis on research to date involving homeless children has been to discern the nature and extent of impact that homelessness can have on children. Referring back to Figure 1-1, studies have tried to identify and quantify, to some extent, a homelessness-specific effect on children above and beyond a poverty-related impact. Because of this focus, much less is understood about homeless children themselves in terms of having different constellations of needs. For instance, studies of homeless children typically use measures of central tendency when summarizing results rather than focusing on a range (or extremes) in outcomes. There is work to be done on better understanding the needs of subgroups of homeless children who have significant problems in one realm and/or across different dimensions of functioning. For instance, it could be the case that a subgroup of homeless children with demonstrable needs require much more in the way of services than they are presently receiving while in shelter; whereas other homeless children, those with fewer problems, do not stand to benefit from the services than they presently getting. A better understanding of this issue would help in allocating preventive and treatment services for homeless children in the most sensible manner possible.

The studies that have been conducted to date on homeless children can be characterized as having predominantly taken a *variable-centered* approach to analyses. In other words, variables in specific domains (e.g., CBCL scores as indices of mental health and problem behaviors; academic achievement scores; indices of developmental status) are highlighted. In such analyses, little if any attention is paid to how, for instance, there may be subgroups of children with quite different patterns in the type and severity of their problems or needs. In contrast, a *person-centered* approach to data analysis (e.g., cluster analysis) would be needed to empirically identify different subgroups of children based on a range of outcome measures.[17] Fortunately, the data sets of many existing studies of homeless children could be reexamined to better understand these different clusterings, but it would require a person-centered approach to data analyses. Little, if any, work in this area has been done to date, for the simple reason that it has not been a question that researchers have been trying to address (at least in the published literature), although it could have been examined. Nonetheless, those data sets from studies of homeless children that have a range of relevant outcome measures could be analyzed using cluster analytic and other person-centered procedures to rather readily identify subgroups based on problems or needs.

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[17] A primary goal of cluster analysis is to take a group of variables (e.g., indices of mental health and other outcome measures) and try to identify subgroups where members are similar to one another but different from other subgroups. A goal is to minimize within-group variation on the values of variables used in the clustering, but maximize differences between groups. This yields an empirical typology.

What are some of the things that might be found by looking at how problems in homeless children cluster together? Internalizing and externalizing mental health problems co-occur as can be seen in the high correlations ($r = .40 - .50$) between CBCL indices as well as in children who come to an outpatient clinic presenting with disruptive behavior problems and with internalizing issues (e.g., a child who is acting out but also manifests symptoms of depression and anxiety). In terms of how school-age children present with problems, it is common to see co-occurring difficulties in the realms of mental health and academic functioning, although it is difficult to discern if one is the cause of the other (e.g., is a child doing poorly in school because she is depressed or is her low self-esteem and dysphoric mood the result of poor academic performance?). Most of the time, mental health issues and academic performance influence each other in a reciprocal manner.

Conclusion

In summary, the literature on homeless children conducted over the past 18 years has focused on trying to understand if, how, and to what extent homelessness has an impact on children. Studies involving both homeless and low-income housed children have consistently found evidence for a poverty-related impact on children; that is finding that both groups have more problems on measures compared to children from nonpoverty backgrounds. Discerning an additional, homelessness-specific, impact in different realms of child functioning has been more difficult; although, not surprisingly, the preponderance of the evidence does suggest that homelessness is detrimental to the well-being of children across various realms of functioning. Yet, enough studies having the methodological capability of finding effects of homelessness (above and beyond poverty) on children have not done so, making it seem that a range of potential effect modifiers and contextual variables are operating, such that homelessness-specific effects are sometimes, but not always, detected by researchers. Additional areas in which further research is needed include trying to better understand parent-child separations that can occur because of a homeless episode and the effects this has on family members. Also, very little attention has been given to understanding whether there are distinct subgroups of homeless children based on different constellations of problems or needs.

As studies have indicated, homeless families are not a static and isolated group. Homeless families emerge from a broader population of low-income families living in housing and eventually return to this larger group. Because homelessness is but one of many stressors that children living in poverty must encounter, it is wise to always be mindful of the broader context of poverty in terms of understanding the needs and issues of homeless children. Many of their problems and needs will be quite

similar to housed children who are living in poverty. That said, it is also vitally important to appreciate the specific problems that children encounter when homeless and attempt to rectify them.

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