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Families with children, the fastest growing homeless subgroup in the U.S., have recently expanded in size by 35% in North Carolina and 24 other states. Sheltering facilities provide housing and other social supports to 67% of this group. Research indicates that extant shelter policies either enhance or further erode family integrity, that is, the ability of these challenged families to stay together and move forward as a cohesive unit.

This study used qualitative and quantitative techniques to gather data and determine the standard shelter policies utilized in north central North Carolina. William N. Dunn's applied policy analysis model provided the conceptual framework to analyze the potential impact of shelter policies on homeless family structure and function. The model includes a thorough review of the background and significance of the policy problem, the collection and analysis of data, and the presentation of conclusions and policy recommendations for an improved shelter setting. Data analyzed included the responses of five managers of eight shelters to a survey questionnaire, content from the resident's rule and regulation handbook for each site, resident lease agreements, archived information (including reports) about the facility; federal and state guidelines, and the mission statement of each facility.

Policies at most facilities required that children be kept under constant supervision by their parents. Random drug and alcohol tests and curfews for all residents with set bedtimes for children were mandated policies in most facilities. Two sites had

bedtimes for adults as well. Daily or weekly cleanliness inspections of rooms and apartments were also conducted at the facilities. Most managers gave *lack of space* as the primary reason for turning away families, but had no record of whether family size or lack of available rooms/apartments was causative. Official identification such as social security cards for all family members was required before enrollment in all but the domestic violence shelter. None of the facilities allowed residents to participate in setting rules and regulations.

In conclusion, a number of shelter policies that impact homeless families were found to erode family integrity both before and during the sheltering experience. Preadmission requirements of fees and official documents that may have been unavailable for all or some members of the homeless family may have caused the family to seek other options for shelter. Rules and regulations at the shelters that deny resident input and require resident attendance at meetings and workshops unrelated to their particular growth needs may have undermined residents' self-esteem and sense of empowerment as competent adults and decision makers. Recommendations for policy change include: Entrance fees that may be paid over an extended time after entry; a shared governance approach to residential rule setting; a focus on family strengths and factors of resilience when setting learning goals; and more collaboration between homeless care providers. Ongoing research is suggested that would provide additional information on outcomes for families denied shelter due to large family size. The impact of some policies remains difficult to ascertain due to the lack of feedback from former

residents; however, the Homeless Management Information System can potentially be used to assist with this task.

AN ANALYSIS OF NORTH CAROLINA HOMELESS SHELTER POLICIES:  
POTENTIAL FOR FRACTURING THE INTEGRITY OF  
HELP-SEEKING HOMELESS FAMILIES

by

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Approved by

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This dissertation is dedicated to all of my ancestors and elders who stood and lived and loved and dreamed and created and died so that I, too, could stand. I also dedicate this dissertation to my grandparents: Will and Ophelia Collier and Albert and Betty Hightower Fuller; to my parents, Grady and Mae Collier Fuller; to my sisters and brother, Greta Fuller Miller, Jewele Fuller Williams, and Albert Alonzo Fuller; and, to my niece, Cherilyn—You will live forever in my heart, in my spirit, and in my work. Ninakupenda to all of my friends and family who visited, called with encouragement, and sent prayers of love and hope into the heavens during my academic journey.

May the Master of the Universe continue to find you all worthy of love and grace!

*Adiedo*

APPROVAL PAGE

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## **CHAPTER I**

### **INTRODUCTION**

#### **Background**

On any given night in the United States since 2010, there are approximately 637,017 homeless people who sleep in places such as the streets, cars, or abandoned buildings, and seek refuge in shelters or transitional housing facilities (Witte, 2012). Included in that number are 77,186 families. While today's homeless population consists of people from every race, ethnicity, creed, gender, age group, and geographic locale, the fastest growing subgroup within this population is nonwhite female-headed families who now make up 41% of the total homeless (National Coalition for the Homeless, 2012).

From Colonial times through the early 1980s, single adult white males comprised the overwhelming majority of the homeless population while single Black males, single Black, white, and Hispanic women, and runaway or castaway youth made up the remainder. The economic recession of the middle and late 1980s caused an upsurge in the overall homeless population (U.S. Conference of Mayors, 2006, 2010, 2011); and, driven by unemployment, lack of affordable housing, poverty, low paying jobs, and domestic violence, homeless women with children slowly became a highly visible presence. Their numbers have been accelerating ever since (Culhane, Webb, Grimm, Metraux, & Culhane, 2003; Macy-Hurley & Tull, 2009; Meadows-Oliver, 2003; Zugazaga, 2004).

American adults recognize that homelessness is a serious problem and are aware that the homeless population includes many women and families (Toro et al., 2007). They also say they are willing to pay more in taxes to address the issue of homelessness. Yet, Americans are also much less compassionate and more willing to blame individual failings for homelessness than their counterparts in European countries such as Germany and Belgium that perhaps not coincidentally have more effective social policies for preventing homelessness (Toro et al., 2007).

The individualist nature of American culture plays some role in the attitudes of the American public toward homeless people. Research on homelessness has been criticized for focusing unduly on individual risk factors but failing to effectively link them with prevention and intervention (Alexander-Eitzman, 2006; Zlotnick, Tam, & Bradley, 2010). U.S. government programs and services for dealing with homelessness are heavily fragmented and redundant (GAO, 2010, 2012). Compounding the problem, definitions of homelessness vary across agencies, with the result that individuals can be excluded from programs that would provide them with needed services. Homeless families and children and unaccompanied youth are most likely to fall into that category. It is only recently that efforts are underway to create a coordinated system of services with a common and expanded definition of homelessness that recognizes the needs of homeless families, children, and adolescents.

Based on the scholarly literature, the term “homeless families” is something of a misnomer. Virtually all research on homeless shelter clients has been conducted with women who have minor children. The role of domestic violence in driving many women

from their homes is certainly one reason for this phenomenon. Additionally, poor single mothers are at high risk for becoming homeless. An additional reason lies in the policies of many homeless shelters. Shelters with spaces for families are scarce (Hicks-Coolick, Burnside-Eaton, & Peters, 2003). There are few shelters in U.S. cities that accommodate two parent families and fewer that accommodate families headed by single men (U.S. Conference of Mayors, 2006). Most shelters separate adult men from women and children. Some shelters specify that only younger boys can stay with their mothers. In Los Angeles, for example, more than one-third of the shelters do not allow boys over a certain age, with an average maximum age of 11.4 years (Macy-Hurley & Tull, 2009).

In response to the rigid shelter admissions policies, families frequently send their adolescent sons to live with relatives or friends or try to find other living arrangements (Macy-Hurley & Tull, 2009). One consequence of such policies is a false dichotomy between homeless women with children and unaccompanied homeless women (Barrow & Laborde, 2008; Shinn, 2007). In reality, most homeless women are mothers of dependent children. Barrow and Laborde (2008) use the term *invisible mothers* to refer to homeless women who have minor children but are separated from them. Many attempt to maintain contact with their children and most desire to be reunited with them. Lack of available, affordable housing presents a formidable obstacle to the reunification of homeless mothers and their children. Paradoxically, the lack of available housing has traditionally been downplayed as a cause of homelessness (Quigley, Raphael, & Smolensky, 2001). Not only is the absence of affordable housing finally being recognized as a dominant cause of homelessness but there is also evidence that housing subsidies

may be pivotal to the housing stability of formerly homeless families (Nemiroff, Aubrey, & Klodawky, 2010; Shinn et al., 1998; Stojanovic, Weitzmann, Shinn, Labay, & Williams, 1999). Without, subsidies, there is a 50% chance that the families will return to the shelter (Stojanovic et al., 1999). Among homeless mothers separated from their children, lack of available housing poses a major barrier to family reunification (Barrow & Laborde, 2008).

Homeless families have been described as a forgotten group (Yousey, Leake, Wdowik, & Janke, 2007). Recent changes to the McKinney-Vento Act and efforts to coordinate services for the homeless across government agencies are slowly removing obstacles to needed programs and services for homeless families with children (GAO, 2012). However, the policies of emergency shelters continue to threaten the integrity of families of some of the nation's most vulnerable families. The escalating problem of homelessness must be examined at multiple levels of analysis to improve coordination and collaboration across agencies (Shinn, 2007).

### **Statement of the Problem**

Homelessness in the U.S. has been fittingly described as a “complex, often misunderstood, social problem” (Hicks-Coolick et al., 2003, p. 197). Individuals and families who have lost their homes and are living in shelters or temporary living arrangements are acutely aware of negative cultural stereotypes about homeless people. Feelings of stigma and shame may be especially powerful in parents caring for children (Meadows-Oliver, 2003; Cosgrove & Flynn, 2005; Wingate-Lewinson, Hopps, & Reeves, 2010). The design and structure of homeless shelters and the policies they

employ have not kept up with the reality that families with children represent the fastest growing segment of the homeless population.

According to the point-in-time (PIT) census taken in January 2011, the numbers of homeless individuals in families declined by 1% at the national level (Witte, 2012). At the state level, there are numerous individual variations. The site of this study, North Carolina, is among a substantial number of states that experienced an increase in the number of homeless people in families. According to the National Coalition to end Homelessness (NCEH, 2013), in 2009, there were approximately 3,759 homeless people in families in the state and in 2012 there were 5,065, for an increase of 34.7%. Among homeless populations, families with children are least likely to remain on the streets or seek shelter in other public spaces and most likely to turn to emergency shelter programs for help. However, there are few shelters equipped to accommodate families with children. The U.S. Conference of Mayors (2006) reported that 55% of homeless families may have to split up in order to stay at emergency shelters.

In some cases, families cannot be accommodated due to lack of room at shelters that could accommodate families. Chicago stands out as one of the cities where homeless program providers under the auspices of the Department of Human Services strive to keep families intact and only separate them when there are no other options or under other extenuating circumstances (U.S. Conference of Mayors, 2006). However, according to the 23-city mayors' report, the policy adopted by the Chicago shelter system was, at the time, a rare exception. Ohio has made changes to the state criteria for entry into emergency shelters and now forbids publicly funded shelters from extending policies that

separate adolescent boys from their mothers and younger siblings. Many states, however, continue to enact such policies. In some cities, Louisville, for example, boys who are 14 or older are separated from female caregivers. In other cities, boys as young as 11 have to sleep in shelters with single men or else families have to find alternative accommodations for their older boys. Even where such policies are not in place, families are frequently forced to split up due to a dearth of accommodations for couples or families (U.S. Conference of Mayors, 2006).

Contact with the child welfare system, including foster care placement, is extremely high among homeless families and in many cases predates their precarious housing situation (Culhane et al., 2003). These fragile families are in need of intensive services that extend beyond the provision of housing. However, rather than helping the families stay together, the policies of many shelters force them apart. Especially troubling is the separation of adolescent boys from their mothers. Children of homeless families are at risk for emotional, behavioral, and developmental problems (Coker et al., 2009). The existing shelter policies place adolescent boys at further risk. Stress and depression are serious problems among mothers living in shelters, much of it due to concern over their children (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003). Policies that separate mothers from sons exacerbate feelings of stigmatization and guilt among homeless mothers who feel that due to their homelessness they are viewed by others as incompetent or “bad” mothers.

This study was designed to investigate the situation of homeless families in North Carolina with a focus on the policies of emergency shelters and their impact on family

structure and functioning. The overarching aims of this study were to examine existing shelter policies serving the homeless and promote best practices to preserve family integrity.

### **Background of the Problem**

Homelessness has been recognized as a serious social problem with government efforts to address the issue going back to the New Deal (Utt, 2008). However, U.S. government programs and services have historically been fragmented and uncoordinated, which not only interferes with their efficiency but also has the consequence of excluding people from securing needed assistance (GAO, 2010, 2012). Homelessness is a global problem; An unfortunate reality is that the U.S. has the largest homeless population among developed countries, in part due to a lack of cohesive efforts to prevent homelessness that have been adopted by countries in Western Europe (Toro et al., 2007). In countries where social policies are designed to prevent homelessness, it is far less common to see homeless families.

A persistent obstacle to addressing the problem of homelessness is the lack of a common vocabulary and definition of homelessness. Different countries have different definitions of homelessness and, further complicating the situation in the U.S., definitions of homelessness vary across states and locales and across agencies (Cackley, 2011; Culhane & Metraux, 2008; GAO, 2010, 2012; Makiwane, Tamasane, & Schneider, 2010; Minnery & Greenhalgh, 2007; Shinn, 2007; Toro et al., 2007). Advocates for the homeless argue that narrow definitions prevent people from accessing services and

actually add to the problem by excluding people in unstable living situations who are at high risk for becoming homeless.

The main issue in defining homelessness lies in whether homelessness is defined as “literal homelessness,” referring to individuals who live in shelters, on the street, in abandoned buildings, or other spaces not intended for habitation or, in terms of the broader “precariously housed,” which encompasses living arrangements such as doubling up with friends or relatives (Toro et al., 2007). The use of varying definitions of homelessness is one reason for discrepancies in estimates of homelessness presented by government officials, researchers, and advocates for the homeless. Politics also plays a prominent role in the discrepancies, especially in the way the different reports are interpreted. Conservatives claim that the lower figures are more accurate while advocates for the homeless argue that the higher estimates paint the more accurate picture. On a technical level, disparities in estimates also arise from the methodology; for example, the use of a Point-In Time snapshot versus a lifetime prevalence rate. There is also the reality that taking a census of an inherently transient population is a daunting challenge, hence the debate over how to interpret estimates is ongoing.

Congress first presented a general definition of homeless people in the 1987 Stewart B. McKinney Act, now known as the McKinney-Vento Act (Cackley, 2011). The definition of homelessness has been consistently expanded. In November 2011, the Department of Housing and Urban Development (HUD) finalized changes adding a new category of homelessness that includes unaccompanied youth and families with children and adolescents who are classified as homeless under other federal statutes (such as the

Head Start Act and the Runaway and Homeless Youth Act). The meaning of this expansion is that individuals who meet the broader definitions of homelessness in other federal statutes are eligible for HUD programs. Three federal agencies, HUD and the Departments of Health and Human Services (HHS) and Veterans Affairs (VA) have the responsibility for most of the programs and funds addressing homelessness (GAO, 2012). A definition of homelessness that is accepted across those three agencies and their programs is a first critical step in making homeless services more efficient and broadening the scope of individuals who can benefit from those services. The Interagency Council on Homelessness, which coordinates the federal programs, has undertaken strategic efforts to improve program coordination at the state and local levels, including the development of a common vocabulary for understanding homelessness and related issues.

To illustrate the scope of the problem, in 2009, less than half of all Head Start families that became homeless received housing (Cackley, 2011). Officials from HHS ascribed this to lack of affordable housing along with long waiting lists for housing assistance rather than to conflicting definitions. At the same time they admitted that there was no common definition of homelessness across Head Start program. As a result, some programs were inadvertently using inappropriate definitions that disqualified families that should have been eligible for housing assistance. The present changes are designed to ensure that problems of that nature are not repeated.

Another problem with how homelessness is defined that impacts families is the definition of *chronic homelessness*. Homeless women with children have historically

been excluded from classification as chronically homeless despite meeting the criteria established by the federal Department of Housing and Urban Development. Although many heads of families meet the defining criteria of having been homeless for 365 days and having a mental or physical health condition, they fail the stipulation that they be an “unaccompanied individual” (Zlotnick et al., 2010, p. 480). Many women with children have been homeless for a year or longer, but, as a result of the narrow definition, they have been unable to access federally funded services for chronically homeless adults. This problem reinforced the criticism of arbitrarily distinguishing between families and unaccompanied adults, which had a serious negative impact on homeless mothers and their children (Barrow & Laborde, 2008; Shinn, 2007). In July 2012, the federal government expanded the definition of chronically homeless to include youth and individuals with children making these groups eligible for CoC funds (National Alliance to End Homelessness, 2012).

Included in the current initiatives are efforts to expand and coordinate homeless services in rural areas (GAO, 2010). According to the North Carolina Coalition to End Homelessness (NCCEH), the state has about 585 facilities serving the homeless including emergency shelters, transitional facilities, and permanent supportive housing. As of January 2009 there were 3,925 emergency shelter beds, 4,480 transitional housing beds, and roughly 2,300 permanent housing beds in facilities located throughout the state. However, not all communities have access to these facilities. While 62 counties have at least one type of homeless facility (and in many cases, all three), 38 counties have no homeless facilities. Most without facilities are located in rural areas.

Obstacles to providing and accessing homeless services in rural regions include limited access to services, extensive service areas, geographically dispersed populations, and lack of transportation and affordable housing (GAO, 2010). There are very few programs that involve formal collaboration across agencies and the use of federal funds to connect housing with supportive services such as case management. A notable exception is a program whereby HUD provides housing vouchers to homeless veterans and the VA offers case management services. It is not coincidental that homelessness among veterans has declined substantially compared to other homeless groups (Witte, 2012). The provision of housing subsidies combined with intensive case management is advocated as an effective strategy for helping families recover from homelessness (Haber & Toro, 2004).

Improving collaboration between HHS and HUD has the capacity to expand and improve homeless services for rural areas (GAO, 2010). In their study of homelessness in rural communities, GAO included people living in overcrowded and substandard housing as well as those living in shelters or sleeping in public spaces. Shelters offered the most visible entry point for providing people with access to housing assistance and supportive services but they were inadequate in number. The shelters ranged from large comprehensive facilities with a full spectrum of onsite services such as substance abuse treatment, mental health services, case management and job training to ad hoc shelters set up in churches or other community organizations that offered space. Some shelters lacked the financial resources to pay for 24-hour staff and some areas where there were no formal shelters relied exclusively on volunteers for providing homeless services due to

limited funding or no funding at all. A number of shelters were described as “traditional,” which would likely imply that they had strict gender separation. Given the scarcity of rural shelters it seems likely that only the most comprehensive would be able to accommodate families with children. An exception might be some of the ad hoc service providers that provided homeless families with hotel vouchers (GAO, 2010). Severe overcrowding was a common problem in shelters, particularly those shelters related to domestic violence and child abuse, thus attesting to the fact that many homeless families have serious problems beyond housing instability. Families that are episodically homeless, that is those families that sporadically return to shelters, have the most intensive service needs (Culhane & Metraux, 2008). The fact that those families return shows that their needs for support have not been met by the existing services for homeless families.

The current initiatives to improve homeless services in the U.S. can be viewed as the culmination of the problem of homelessness that has been escalating since the 1980s. Quigley et al. (2001) implicate changes in income inequality that began during that era with the soaring rates of homelessness. Income inequality has become more pronounced over the last decade, and the economic problems that have accrued are highlighted by the fact that unemployment, lack of affordable housing, and poverty are the main causes of homelessness in families and single adults (U.S. Conference of Mayors, 2006, 2010, 2012). Some observers describe homelessness using the metaphor of “a game of musical chairs in which the players are poor people and the chairs are housing units they can afford,” or in a more elaborate version, the chairs represent housing that poor people can

buy or gain access by calling upon their social networks (Shinn, Baumohl, & Hopper, 2001, p. 102). Where the numbers of poor people exceed the availability of affordable housing and where personal social networks are strained or resource poor, some people will still remain homeless when the music stops playing. Individual characteristics such as level of education, availability of social capital, and health status serve as indicators of the risk and protective factors for becoming homeless (Caton et al., 2000, 2005, 2006; Haber & Toro, 2004). However, the ratio between the need for resources and the availability of those resources determine who remains homeless (Shinn et al., 2001). Without housing subsidies, the probability of being homeless again is high. In addition, troubled families have intensive needs for supportive services and are further compromised by shelter policies that disrupt their ability to stay together as a family.

### **Characteristics of Homeless Families**

#### **Service Needs**

Research conducted on patterns of service utilization by homeless families with children in four major locations (New York City, Philadelphia, Massachusetts, and Columbus, Ohio) disclosed three types of homeless families (Culhane & Metraux, 2008). The vast majority of homeless families experience fairly brief single episodes of shelter use. However, two small groups experience multiple episodes (episodic) or remain in shelters for long duration (long stayers). Although small, the proportion of long staying families is almost double the proportion of long staying single adults (20%-22% versus 11%). In terms of individual characteristics the families with long-term stays were more similar to families with short-term stays than to long staying individuals in that they had

less intensive social service needs and lower rates of mental health and substance use problems. Additionally, among all the groups they had the highest rates of employment and the lowest incidence of disabilities. One implication of this finding is that families who remain in shelters for a long time are members of the working poor. For these families, housing subsidies alone might be sufficient for preventing future homelessness.

As far as their impact on the system, even in small numbers and without intensive needs, long-term stayers are expensive to accommodate. They account for 50% of the shelter system resources, costing \$22,000 to \$55,000 per family per stay depending upon the area (Culhane & Metraux, 2008). The families with the most intensive needs were the episodic shelter residents who represent approximately 5% to 8% of the families. The services received by these families included inpatient psychiatric or substance abuse treatment and child welfare services. In general, families who have been homeless have unduly high rates of child welfare service involvement and foster care placement (Culhane et al., 2003). It seems probable that shelter policies imposing restrictions on homeless families play a role in foster care placement.

### **Parenting in Shelters**

Mothers who move into shelters with their children do so only as a last resort (Meadows-Oliver, 2003). Most shelters that house families have mandatory parenting classes or groups. However, the mandatory nature of the programs makes the women feel they are accused of being incompetent parents and magnifies their sense of disempowerment (Cosgrove & Flynn, 2005). In addition, the shelter rules and regulations interfere with the families' customary parenting practices. In some cases this may be

positive (for example, no corporal punishment), but mothers feel they are being constantly scrutinized and judged. Some mothers find the parenting groups useful while others say the information does not match their needs. A common opinion is that the parenting programs would be more acceptable if they were voluntary instead of requisite. A substantial proportion of homeless women with children are high school dropouts. An overarching desire is for educational programs that will enable them to acquire a good job and provide for their families.

Women living with their children in shelters are highly concerned with their children's psychosocial health and development (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003). They are acutely aware of the potentially detrimental effects of homelessness on their children, and in particular of the impact their own emotional state may have on their children. Feelings of stress and depression are pervasive. Clearly, many women in shelters who do not have the serious mental health needs associated with homelessness experience psychological distress that warrants counseling and treatment. The children may also have a need for emotional, behavioral, or academic support. School-based programs are among the many types of programs advocated by Haber and Toro (2004) to help homeless families.

### **Purpose of the Study**

The purposes of this study were to provide:

1. A synthesis of the literature on homelessness at a national level.

2. A comprehensive analysis of the policies enacted by homeless shelters in north central North Carolina, with a specific focus on policies that impact the integrity and cohesion of homeless families.
3. Recommendations for changes in shelter policies.

### **Specific Aims of the Study**

1. Provide an overview of the needs of homeless people in the United States.
2. Examine the family-related policies of homeless shelters in north central North Carolina.
3. Make recommendations to improve shelter policies that will promote family integrity.

### **Significance of the Study**

It has been more than 20 years since homeless women and families became a visible presence in cities across the U.S. Since then, a plethora of programs have been developed and implemented, many with questionable effectiveness (Shinn et al., 2001; Toro et al., 2007). There is abundant evidence that homeless shelters are not equipped to serve the needs of homeless families. The strongest case in favor of changing the nature of shelter policies is that more than half the families that arrive at emergency shelters for refuge are forced to split up (U.S. Conference of Mayors, 2006). Few shelters accommodate families or couples and most shelters have strict gender segregation. Not only does this mean that fathers and mothers cannot stay together but the most disturbing aspect of this practice is that adolescent boys cannot stay with their mothers and younger siblings. In many cases, boys as young as 11 are required to stay in facilities with single

men who are strangers. As a result, many homeless families send their adolescent sons to live with friends or relatives or make other accommodations (Macy-Hurley & Tull, 2009). Furthermore, most women who turn to shelters as unaccompanied women are actually mothers of minor children who desire to be reunited with their families (Barrow & Laborde, 2008).

There is a clear need for policy changes designed to preserve the cohesion of families that, by virtue of poverty and homelessness, face serious challenges. Fathers are almost absent from the scholarly literature on homelessness. This study seeks to illuminate the characteristics and needs of homeless families in North Carolina, which may increase the visibility of homeless fathers and provide useful information for providing services to both two parent and single parent families. The U.S. Conference of Mayors (2006) found only one shelter that could accommodate single fathers. Clearly, homeless families headed by single fathers have unique needs.

There is abundant research on families headed by single mothers and many shelters have programs designed to serve them. In the opinions of the mothers themselves, however, most programs fall far short of the mark. Programs fail to match the mothers' actual needs and may further stigmatize and disempower them (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003).

The findings from this study can be used to change shelter policies so they are family friendly and empowering to homeless families, and instead of further disrupting fragile families, provide services matched to their needs. While space and design are important in the type of accommodations shelters provide, the information from this

study may help to guide more efficient allocation of space for the comfort of homeless families. In addition, new shelters are being built; and many shelters are being redesigned or expanded. Changes in policy would compel them to provide space for homeless families, and in particular, keep adolescent boys with their mothers and younger siblings.

Cosgrove and Flynn (2005) argue that providing adequate shelter and resources for homeless families requires coordination and collaboration at all levels, including partnerships with universities that train healthcare personnel, social workers and other professionals who work with homeless families. Federal initiatives are underway to promote efficient coordination and collaboration across agencies (Government Accounting Office, 2012). The information gained from this study can be disseminated to a full range of public, nonprofit, and private organizations that are involved in helping homeless families. The American public recognizes that homelessness is a serious problem affecting local communities (Toro et al., 2007). This study seeks to address the inadequacies of the current system for providing assistance provided to homeless families and offer more effective alternatives for helping homeless families and reducing the probability that they will become homeless again.

### **Research Questions**

There are four main research questions driving this study:

1. *Research Question 1:* What are the characteristics and needs of homeless families in the United States?
2. *Research Question 2:* What are the standard policies of selected homeless shelters in north central North Carolina regarding families served?

3. *Research Question 3:* What are the ways in which existing selected shelter policies impact homeless family integrity?
4. *Research Question 4:* What changes to shelter policies are recommended that will promote the integrity of homeless families?

### **Conceptual Framework**

Dunn's (2008) approach to addressing policy issues serves as the conceptual framework for this study of homeless shelter policies. Dunn's model of policy analysis is distinctive in that the analysis is completed with a well-defined conclusion and a recommendation. The summative steps of this analysis model begin with investigating the background of the problem. A description and an overview of the problem are given along with some history of prior interventions. Next, the significance of the problem is determined by evaluating past policy performance, assessing problem scope and severity, and determining the need for an analysis. At this point, a clear statement of the problem is made. This step involves problem diagnosis, major stakeholder identification, and a determination of the goals and objectives. Following this, alternatives are described and analyzed, consequences forecast, spillovers and externalities described, and constraints and political feasibility assessed. In Dunn's final step, conclusions and recommendations are made. Criteria are selected along with an implementation strategy outline and a monitoring and evaluation plan. Policy limitations and unanticipated consequences complete the executive summary of the analysis (p. 467).

This study is framed within the scope of the problem of family homelessness that has been escalating since the 1980s. Policies enacted in some European nations, notably

Germany, are far superior to the haphazard approach to dealing with homelessness in the U.S. (Toro et al., 2007). Of the five countries in their international study (Germany, Belgium, Italy, the United Kingdom (UK), and the United States (U.S.)), Toro et al. found that the U.S. and the U.K. had both the highest prevalence of homelessness and the least compassionate attitudes toward the homeless. The researchers did not find the relationship coincidental and they raised the issue of the relationship between public attitudes and public policy. That is, if the American and British public could be persuaded to hold more compassionate attitudes toward the homeless, their opinions might drive changes in public policy. Alternately, if public policy was changed it might improve public opinion. It is possible that the current government initiatives to address homelessness might induce more sympathetic attitudes, particularly as many changes center on families and youth. Toro et al. conclude that, pragmatically, Americans recognize that homelessness is a serious problem, and if there is a sense of cynicism in the failings of traditional approaches to homelessness, the positive side is that people are looking for new solutions.

The U.S. spends far less money on families than European nations, a factor that has been implicated in the high rates of family homelessness (Shinn, 2007). The European countries that have enacted effective homelessness prevention programs have national social welfare policies (Toro et al., 2007). Needless to say, such policies are not popular in the U.S. Haber and Toro (2004) framed their argument for expanding public assistance to homeless families by acknowledging that their proposal goes against current public policy and opinion. Ronald Utt (2008) of the conservative Heritage Institute

argues that government efforts to address homelessness since the 1930s have been ineffective and calls for more private sector involvement. The most effective solution in the U.S. is likely to involve collaboration among the government, nonprofit, and private sectors. This type of collaboration is currently underway. Collaboration across government agencies and programs is essential for ensuring that homeless services are literally more “family friendly” both in terms of seeing that families are not excluded from services as they have been in the past and in changing shelter policies so that they accommodate families.

### **Definition of Terms**

The following terms are defined for the purpose of this study:

*Day only emergency shelter.* A facility offering temporary shelter and services for homeless persons during daytime hours only (North Carolina Division of Aging and Adult Services, 2011).

*Domestic violence center.* A facility offering temporary shelter and services to homeless domestic violence and/or sexual assault survivors (North Carolina Division of Aging and Adult Services, 2011).

*Doubling up.* A state of virtual homelessness. Living with friends, relatives, or others for economic reasons in the absence of having a permanent home (Witte, 2012).

*Family.* A term of self-designation that is used for a wide variety of groups throughout the human science literature. At any given time it may refer to several siblings sharing a household, same sex couples with and without children, a grandparent with

several grandchildren, an adult with an older relative, or an unmarried man and woman who live together without children.

*Homeless.* According to the McKinney-Vento Act of 1987, a homeless person is someone lacking a fixed, stable, night-time residence and whose main nighttime residence is a public or private shelter intended to provide temporary living accommodations, an institution that provides temporary residence, or a public or private place that is not intended for human habitation (Hersberger, 2005). The expansion of the McKinney-Vento definition of homelessness includes families and children as well as unaccompanied youth in order to make them eligible for HUD programs (GAO, 2012).

*Mission statement.* The rationale, purpose, and philosophy that guides the work of the shelter facility.

*Night only emergency shelter.* A facility offering temporary shelter and services for homeless persons during evening hours only (North Carolina Division of Aging and Adult Services, 2011).

*Rules and Regulations.* The parameters that govern the behavior and activities of residents on an everyday basis such as mealtimes; onsite chores; mandatory classes and activities; daily exit and entry times; consequences of rule infraction

*Safe haven.* A facility providing shelter and services to homeless individuals with severe mental illness who live on the streets and have been unable or reluctant to access needed support services (North Carolina Division of Aging and Adult Services, 2011).

*Social support.* Multifaceted interpersonal interactions that involve one or more of the three dimensions of assistance—emotional support, informational support, and practical support (Norbeck, Lindsey, & Carrieri, 1981).

*Transitional housing.* A facility offering shelter and services for homeless individuals and families for six months to two years in a safe and supportive environment designed to promote self-sufficiency (North Carolina Division of Aging and Adult Services, 2011).

*24-Hour emergency shelter.* A facility offering around-the-clock temporary shelter and services for homeless persons in general or for specific subgroups of homeless persons (North Carolina Division of Aging and Adult Services, 2011).

### **Operational Definitions**

*Family.* A man and a woman with at least one child under the age of 18 or one man or one woman with at least one child under the age of 18.

*Family integrity.* The ability of a family to stay together as a structural unit. Parental role function as family leader and primary authority figure is intact.

*Homeless.* People who have no permanent residence. They often live in places unfit for human habitation; in public places such as shelters, jails, and hospitals; in government or charity provided temporary housing such as motels and hotels; or in some shared space that is not under their tenure, control or ownership.

*Homeless families.* A parent, parents, or caregiver/s with children who remain together when they have no permanent home; ‘Homeless families’ most often refers to a mother with minor children but father headed and two parent households are also seen.

*Inclusion and Exclusion Criteria.* Specific criteria for admission to the shelter as well as the criteria for excluding certain individuals and applicants.

*Mission Statement.* The rationale, purpose, and philosophy that guides the work of the shelter facility.

*Rules and Regulations.* The parameters that govern the behavior and activities of residents on an everyday basis-such as mealtimes, onsite chores, mandatory classes, and daily exit and entry times; Consequences of rule infraction and the process of conflict resolution.

*Safe Haven.* Private or semi-private long-term housing for homeless people with severe mental illness. Limited to serving no more than 25 people within a facility.

*Sheltered Homeless Persons.* People who are staying in emergency shelters, transitional housing programs, or safe havens.

### **Limitations**

This study was limited to the analysis of policies in five homeless shelters located in a single Southeastern state which has a large, ethnically diverse population and a substantial number of rural counties. Additionally, each state had individual approaches to developing shelter policies and the policies of this state, North Carolina, may not be representative of other states. It is possible that the shelter directors/managers who agreed to participate differ from those who were not represented in the study.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Introduction**

This literature review provides an analysis of research about the characteristics and needs of homeless families and current policy issues associated with homeless shelter programs and practices. The William K. Dunn (2008) stepwise approach to policy analysis guides the selection of research literature chosen. Studies that provide a historical background for the current homelessness pandemic, homeless families and their experiences with homeless shelter policies, and features of homelessness are analyzed. Included in the reviews analyzed are: American and international public policy on homelessness, risk and protective factors against housing instability, service utilization by homeless families, and the impact of housing instability and homelessness on the structure and function of the homeless family.

The literature presented in this review is drawn from the following EBSCO databases: Academic Search Premier, MasterFILE Premier, Business Source Premier, PsycINFO, and PsycARTICLES. Keywords used either individually or in conjunction include: families, homeless, homelessness, mothers, fathers, parents, parenting, children, adults, shelters, housing, policy, programs, agencies, employment, education, risk factors, protective factors, services, and social support.

## **Background**

Homelessness in the United States has been aptly described as a “complex, often misunderstood social problem” (Hicks-Coolick et al., 2003, p. 197). Homelessness is enshrouded in negative stereotypes about what homeless people look like and what caused their homelessness to the detriment of homeless individuals and families (Meadows-Oliver, 2003; Cosgrove & Flynn, 2005; Hersberger, 2005). Homelessness has been recognized as a societal problem spurring government efforts to address the issue since the New Deal of the Great Depression (Utt, 2008). However, government programs and services are notoriously fragmented and redundant, severely undermining their effectiveness and efficiency (GAO, 2010, 2012). Internationally, as well as in the U.S., efforts to address homelessness are impeded by the lack of a common vocabulary and definition of homelessness (Cackley, 2011; Culhane & Metraux, 2008; GAO, 2010, 2012; Makiwane et al., 2010; Minnery & Greenhalgh, 2007; Peressini & Engeland, 2004; Shinn, 2007; Toro et al., 2007). A prevailing assertion is that the definition of homelessness should be expanded to encompass individuals and families in precarious living situations in order to prevent homelessness from occurring.

One aspect of homelessness on which there is general agreement is that families with children represent the fastest growing segment of the homeless population (Culhane et al., 2003; Macy-Hurley & Tull, 2009; Meadows-Oliver, 2003; National Coalition for the Homeless, 2009; Zugazaga, 2004). Unemployment tops the list of reasons for homelessness among families with children, followed by the unavailability of affordable housing, poverty, low wage jobs, and domestic violence (U.S. Conference of Mayors,

2006, 2010, 2011). Ironically, the lack of available housing has historically been downplayed as a cause of homelessness (Quigley et al., 2001). There is some justification for this approach given the documented prevalence of psychiatric illness, substance abuse disorders, and social isolation among homeless populations. Indeed, among unaccompanied adults, mental health and substance use disorders, combined with lack of access to services for those problems are among the main reasons for homelessness (U.S. Conference of Mayors, 2006, 2010, 2011). However, unemployment and lack of affordable housing are the dominant causes of homelessness for individuals as well as families.

Quigley et al. (2001) implicate changes in income inequality that began during the 1980s with the rising rates of homelessness in the U.S. The 1980s marked the start of a change in the face of homelessness as women and children became more prevalent in the ranks of homeless Americans (Bassuk et al., 1997; Culhane et al., 2003). The problem of homelessness also became far more visible as the need for emergency shelter exceeded the supply, paralleling the supply and demand for affordable housing. Some analysts have described the situation of homelessness using the metaphor of “a game of musical chairs in which the players are poor people and the chairs are housing units they can afford,” or in a more expansive version, the chairs represent housing poor people can buy or gain access by calling upon their social networks (Shinn et al., 2001, p. 102). Where the numbers of poor people exceed the affordable housing units and where personal social networks are strained or are themselves impoverished, some people will still remain homeless when the music ceases to play.

Individual characteristics such as level of education, history of childhood homelessness, and income stability serve as indicators of the risk and protective factors for becoming homeless (Caton et al., 2000, 2005, 2006). Ultimately, however, the ratio between the need for resources and the availability of those resources determine who *stays* homeless (Shinn et al., 2001). Housing subsidies have been found to be the critical factor in housing stability among families that had been homeless (Nemiroff et al., 2010; Shinn et al., 1998; Stojanovic et al., 1999). Without, subsidies, there is a high probability that families will become homeless again (Stojanovic et al., 1999). Among homeless mothers separated from their families, the lack of available housing presents one of the most formidable obstacles to being reunited (Barrow & Laborde, 2008). Nemiroff et al. (2010) found that formerly homeless women with dependent children were more successful in becoming reintegrated into their communities than unaccompanied women. For both groups of women, financial resources were essential for housing stability. Many homeless families have needs that extend beyond economic support but there is general agreement that housing stability is an essential condition for family stability.

### **Family Homelessness: Overview**

Among families with minor children, those who are episodically homeless have the most urgent and extensive needs for services (Culhane & Metraux, 2008; Culhane, Park, & Metraux, 2011). Long-term homelessness among families has tremendous financial and human costs. However, funding is scarce for addressing the plethora of needs of homeless families (Yousey et al., 2007). Homeless women with children have been historically excluded from being classified as chronically homeless. Despite their

meeting criteria for having been homeless for 365 days and having a mental or physical health condition, the federal definition of chronic homelessness stipulates that the person be an “unaccompanied individual” (Zlotnick et al., 2010, p. 480). Yet, many women with children have been homeless for a year or longer but as a result of the narrow definition are unable to access federally funded services for chronically homeless adults.

Yousey et al. (2007) describe homeless families as a group that is often forgotten. Barrow and Laborde (2008) use the term *invisible mothers* to denote homeless women who have minor children but are separated from them. According to Barrow and Laborde, homelessness among women in the U.S. manifests in two ways: women who enter homeless shelters with their children and in some cases with a husband or partner, and unaccompanied homeless women. However, the authors argue that the dichotomy between the two groups is actually false. In reality, most “lone” homeless women have minor children who reside elsewhere. Many women have mental health or substance use disorders yet efforts to establish programs to address their needs for psychiatric and substance abuse treatment services fail to recognize their needs for parenting programs and supports. In family shelters, parenting classes and programs are frequently mandatory but fail to address the needs of homeless parents while further adding to their sense of disempowerment by implying that poverty makes them incapable parents (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003). For women with children living in shelters the term “invisible mothers” is brutally ironic; most feel they are parenting under a microscope, constantly scrutinized and judged.

“Invisible fathers” might be a more appropriate term for describing how homeless families are portrayed in the scholarly literature. Virtually all studies of families living in shelters focus on mothers with children even though some have a spouse or domestic partner. Indeed, domestic violence often propels women to seek shelter with their children (Meadows-Oliver, 2003; Roll, Toro, & Ortola, 1999). The only insight into the experience of fathers caring for children despite unstable housing comes from an in-depth study of families living in an extended-stay hotel (Wingate-Lewinson et al., 2010). Many of the emotions experienced by the respondents are similar to those reported by homeless mothers and the study offers a unique opportunity to understand the perspectives of married parents raising children under conditions of financial and residential instability.

### **Homeless Shelter Policy: Men and Boys**

In European countries where there are effective social policies for reducing homelessness, homeless families are unusual (Toro et al., 2007). In the U.S., the nature of the shelter system may be a factor in the invisibility of fathers and intact families in the literature. In their survey of hunger and homelessness in 23 cities, the U.S. Conference of Mayors (2006) found few shelters that accommodate 2-parent families and only one that accommodates families headed by single men. Most shelters separate adult men from women and children. Some shelters go beyond that and stipulate that only younger boys can stay with their mothers; adolescent boys are forced to sleep at a shelter with single men. Some shelters set the age limit at 14 while others prevent boys as young as 11 from staying with female caregivers and younger siblings. Shelter space for families is typically scarce (Hicks-Coolick et al., 2003). Because no beds are available for them,

emergency shelters in two thirds of the survey cities must turn away homeless families with children while shelters in 70% of the cities must turn away unaccompanied individuals (U.S. Conference of Mayors, 2011).

In a section entitled “Family Break-Up a Requisite for Shelter,” the U.S. Conference of Mayors (2011) reported that families seeking refuge in emergency shelters could be forced to split up in 55% of the 23 cities. In Boston, Denver, and Phoenix, for example, mothers and children were accepted at family shelters while in most cases adult men had to sleep in shelters for single adults. A few shelters did accommodate 2-parent families. The Chicago Department of Human Services and its delegate agencies represented one of the few cities where shelter providers tried their best to keep families together and only separated them under extenuating circumstances. Cleveland had only one shelter that could accommodate 2-parent families. Ohio revised its shelter standards so that publicly funded shelters are now prohibited from separating adolescent boys from their mothers.

Some of the policies seemed to vary depending upon the service provider. Nonprofit or faith-based organizations may be more sensitive to the issue of allowing homeless families to stay together. For example, in Charleston, the Family Center at Crisis Ministries allowed mothers and fathers to stay together (U.S. Conference of Mayors, 2006). However, non-publicly operated shelters are often small in size (GAO, 2010). Additionally, many nonprofits do not have inclusive policies such as the Nashville Rescue Mission, which has no accommodations for families (U.S. Conference of Mayors,

2006). Women and their daughters and younger sons stay at the women's shelter while men and older boys stay at the men's facility.

Utah's largest shelter, the Road Home in Salt Lake City, stands out for accommodating families headed by single fathers as well as 2-parent families and families with older boys (U.S. Conference of Mayors, 2006). At the same time, all other Salt Lake City shelters impose the lowest maximum age for allowing male children to stay with their families, stating that boys over age 10 cannot stay with their mothers and younger siblings. Shelters in the Louisville metropolitan area set the maximum age limit for boys at 14, probably the ceiling for shelters that impose age restrictions on older boys. Adult men, however, have to stay in the men's shelter. Of four emergency shelters in Miami, two were equipped to accommodate homeless families. However, regardless of policy, the availability of emergency shelter space is highly inadequate for the burgeoning population of homeless families and single adults in Miami-Dade County (Rukmana, 2011).

The U.S. Conference of Mayors (2006) found varying policies in Los Angeles shelters. A comprehensive survey of family shelters in Los Angeles reported that more than one-third of the shelters (37.5%) do not allow boys over a certain age; the average maximum age is 11.4 years (Shelter Partnership, 2006). At the time of the report, there were 8,238 homeless families in Los Angeles County and scarcely one-quarter of the available programs were capable of accommodating homeless families. Close to 40% of the programs had tightened their entry criteria in the three years before the survey and 85% reported turning families away due to insufficient space. Two-parent families were

excluded from 41.7% of the shelter programs and as stated, many programs imposed restrictions on older boys. Eviction from their homes was the primary reason the families were homeless. About one-third had lived in unsubsidized hotels or motels before they turned to emergency shelters. Other families were referred to family shelters from other shelter programs. Mothers and fathers living with their children in hotels after losing their homes are extremely concerned for their futures and the impact of their precarious living situations on their children (Wingate-Lewinson et al., 2010).

Macy-Hurley and Tull (2009) cite the stringent admissions criteria of most homeless shelter programs as a major argument for alternatives to the traditional shelter system. They find the policies that prevent adolescent boys from staying with their families especially troubling. In response to this restriction, families often send their teenage sons to live with relatives or friends or attempt to find other accommodations. Mothers who enter shelters with their children are extremely protective of living under conditions where their children could be exposed to harm (Meadows-Oliver, 2003). Thus it is not surprising that mothers of older boys would send them to live with other relatives or friends. Mothers of teenage boys may be among the “invisible mothers” who enter shelters as unaccompanied individuals. One U.S. survey found that 60% of homeless adults are parents of minor children, including 41% of homeless men (Shinn, 2007). Only 7% of those men lived with their children compared with two-thirds of the women. For homeless women separated from their children, the absence of stable housing presents a major obstacle to being reunited with their children (Barrow & Laborde, 2008).

Other entry criteria specified by emergency shelters and transitional housing include the exclusion of parents with severe psychiatric disorders or addictions and even exclusion of pregnant women and mothers of infants (U.S. Conference of Mayors, 2006; Macy-Hurley & Tull, 2009; Shelter Partnership, 2006; Shinn, 2007). The Shelter Partnership (2006) called for the dramatic expansion of facilities that are capable of serving homeless families in Los Angeles. However, homeless families in California remain underserved (Macy-Hurley & Tull, 2009). Quigley et al. (2001) and the California Budget Project (2008) concluded that the main cause of homelessness in California was the lack of affordable housing. They view California as a microcosm of the situation of homelessness in the U.S.

There are numerous calls for radical changes to policies and programs for addressing homelessness in the U.S. A common complaint is that policymakers do not understand the needs of homeless families (Barrow & Laborde, 2008; Hicks-Coolick et al., 2003; Macy-Hurley & Tull, 2009; Shinn, 2007). Efforts are currently underway to improve program coordination and collaboration (Cackley, 2011; GAO, 2010, 2012). There is also the issue of whether those changes are sufficient when the emphasis should be on preventing homelessness. As a prelude to discussion of programs and policies, the following section provides a snapshot of homelessness in the U.S. at the present time.

### **Features of Homelessness in the United States**

The most recent and comprehensive data on homelessness comes from *The State of Homelessness in America 2012* (Witte, 2012). Every January communities throughout the U.S. conduct “point-in-time” (PIT) counts of homelessness, which includes a street

census of individuals sleeping on the street, in cars, in abandoned buildings, and in other venues not intended for living, as well as a census of individuals staying in shelters and transitional housing facilities. As of January 2011, an estimated 637,017 people were homeless on a given night, translating into 21 homeless people per 10,000 people in the general U.S. population. Most of the homeless people were individuals (63% or 399,836 people), of whom roughly 25% are chronically homeless. Homeless families with children comprise 37% of the homeless population, totaling 236,181 people in 77,186 families. Although the study does not include homeless youth, point-in-time data from HUD suggests that an estimated 8,153 unaccompanied youth were homeless on a given night and 14,678 youth accessed the shelter system during the last year. Most of the homeless people recorded by *The State of Homelessness* were living in shelters or transitional housing (392,316 individuals).

In spite of the economic recession, homelessness actually declined slightly (1%) between 2009 and 2011, which may be ascribed to federal resources allocated by the Homelessness Prevention and Rapid Re-Housing Program (HPRP), which is funded by the American Recovery and Reinvestment Act of 2009 (Witte, 2012). A total of \$1.5 billion in federal funds was invested in empirically proven, cost effective interventions that helped almost 700,000 people who were homeless or at risk for homelessness during the program's first year of operation in 2010. The positive side is that the federal investment succeeded in curtailing homelessness when economic conditions would have expected an increase. The downside is that homelessness is still a rampant social and economic problem and government funding sources are diminishing.

The most substantial decline in homelessness was among veterans (Witte, 2012). Although the number of individuals in homeless families declined by 1% at the national level, there were numerous differences among individual states as well as state-by-state differences in the numbers of homeless persons in general. Homeless family members increased by 20% or higher in 11 states and the overall homeless population increased in 24 states and the District of Columbia. Among the cities surveyed by the U.S. Conference of Mayors (2010, 2011) homelessness among families increased by an average of 9% from 2009 to 2010 and by 16% from 2010 to 2011 (Witte, 2012). The site of this study, North Carolina, was among the states with an increase in the number of homeless people in families. In 2009, there were 3,759 homeless people in families in the state, in 2011 there were 4,593, an increase of 22.19%, and in 2012, the National Coalition to End Homelessness reported 5065, a 34% increase.

The national report frames homelessness in economic terms, thus both income and the affordability of availability are pivotal factors (Witte, 2012). Between 2009 and 2010 there was a 6% increase in the number of poor households that spend more than half their incomes on rent, a condition HUD defines as “severely housing cost burdened” (p. 4). Three-quarters of all poor households living in rental properties fall into this category. Increases in unemployment and foreclosures added to the number of households at risk for homelessness. There was also an increase of 13% in the number of people who lived “doubled up,” meaning they reside with friends, relatives, or others for economic reasons. Living doubled up escalated tremendously during the 1990s, reaching levels that were unparalleled since the end of World War II (Shinn et al., 1998). In some

cases, doubling up can be a protective factor against homelessness (Zlotnick et al., 2010). Being able to double up implies that the person has some social support network.

At the same time, doubling up is a precarious living situation. In fact, for a person living doubled up, the odds of becoming homeless at some point during a year are 1 in 12 compared to 1 in 194 in the general American population (Witte, 2012). Young adults who have aged out of foster care and individuals released from prison have similarly high probability of becoming homeless as those who lived doubled up. Incarceration is a prominent factor in the histories of single homeless men, which distinguishes them from homeless single women and homeless women with children (Roll et al., 1999; Zugazaga, 2004).

Alexander-Eitzman (2006) is critical of an epidemiological approach to examining homelessness that focuses on individual characteristics such as mental illness and substance abuse. Economic conditions alone are insufficient for explaining homelessness, which is clearly more prevalent among individuals with histories of substance use and psychiatric illness regardless of economic conditions (Caton et al., 2005). In the final analysis, however, economic factors, specifically the availability of affordable and subsidized housing override individual characteristics in predicting housing stability (Shinn et al., 1998, 2001). In accordance with Bronfenbrenner's (1979) ecological model, if the problem of homelessness is to be addressed effectively it must be understood at all levels from the individual to the family, community, societal, and international levels.

## **Homelessness and Public Policy**

Dunn's (2008) approach to addressing policy issues serves as the conceptual framework for this study. It is important to understand the scope and degree of the problem as well as the factors that have contributed to the problem and the efforts that have been undertaken to resolve the problem. Toro et al. (2007) point out that despite extensive international research into the problem of homelessness, there is no cohesive database of the potential causes of homelessness nor is there an agreed upon definition of homelessness. Key findings to emerge from the international research are that the United States leads the developed world in the prevalence of homelessness but is certainly not alone in the problem, which is severe in many others countries including Canada, the United Kingdom, Australia, and France. A persistent obstacle to concerted efforts to resolve the problem of homelessness is the absence of a clear definition of what constitutes homelessness.

### **Defining Homelessness**

According to Toro et al. (2007), the use of varying definitions of homelessness accounts for discrepancies in estimates of homelessness presented by government officials, researchers, and advocates for the homeless. The main distinction lies in whether homelessness is defined as "literal homelessness," denoting individual who live in shelters, on the street, in abandoned buildings, or other spaces not intended for residence or in terms of the more expansive "precariously housed," which encompasses living arrangements such as doubling up with friends or relatives. Individuals and families who turn to hotels and motel as temporary residences due to economic

circumstances are not classified as homeless yet they see themselves as in a state of limbo and experience much of the same psychological distress as impoverished adults and families living in shelters (Wingate-Lewinson et al., 2010).

The McKinney-Vento Act of 1994 defines a person as homeless if he or she does not have a fixed, stable, night-time residence and whose main night-time residence is: (a) a public or private shelter intended to provide temporary living accommodations (b) an institution that provides temporary residence for individuals who are meant to be institutionalized, or (c) a public or private place that is not designed, or regularly used, for regular sleeping arrangements for human beings (Hersberger, 2005). In essence, McKinney defines literal homelessness. Minnery and Greenhalgh (2007) are highly critical of narrow definitions that result in the exclusion of people from programs that would provide them with needed services. A case in point is the exclusion of women with children from the definition of chronic homelessness (Zlotnick et al., 2010). In addition, Minnery and Greenhalgh (2007) argue that narrow definitions underestimate the extent of homelessness. While that is probably true, Toro et al. (2007) point out that even using the same definition (typically literal homelessness), estimate vary dramatically, depending upon technical issues such as the data sources and methodology as well as the political agenda of those conducting or interpreting the research.

There is the practical challenge of estimating the numbers of a population that by definition can be found in different places from one day to the next. In Canada, a collaborative effort by researchers and service providers drew upon homeless volunteers to assist them in conducting a pioneer needs assessment of the homeless street population

in Ottawa (Farrell, Reissing, Evans, & Taylor, 2004). The PIT approach proved to be the most useful technique for conducting a street survey as well as capturing the numbers of people in shelters and transitional housing (Witte, 2012). However, PIT data and lifetime prevalence data can also present disparate pictures of homelessness.

The U.S. Congress first presented a general definition of homeless individuals in the 1987 Stewart B. McKinney Act, now the McKinney-Vento Act (Cackley, 2011). The definition of homelessness has been consistently expanded for program purposes. In November 2011, the Department of Housing and Urban Development (HUD) finalized changes that add a new category of homelessness encompassing unaccompanied youth and families with children and adolescents who are classified as homeless under other federal rulings (such as the Head Start Act and the Runaway and Homeless Youth Act). What this expansion means is that individuals who meet the broader definitions of homelessness in other federal statutes are eligible for HUD programs. Three federal agencies, HUD, the Departments of Health and Human Services (HHS), and Veterans' Affairs (VA) are entrusted with the bulk of programs and funds addressing homelessness (GAO, 2012). A definition of homelessness accepted by those three agencies and their programs is a first essential step in making services more efficient as well as broadening the scope of individuals who can benefit from those services. The Interagency Council on Homelessness, which coordinates the federal programs, has undertaken strategic efforts to improve coordination at the state and local levels, which include the development of a common vocabulary for discussing issues related to homelessness.

In 1990, the General Accountability Office (GAO) reviewed the existing research on programs designed to prevent homelessness and concluded that there was insufficient evidence to determine their effectiveness (Shinn et al., 2001). A decade later, Shinn et al. argued that GAO's conclusion was still true. Twenty years later and after several revisions to the McKinney-Vento Act, GAO (2010, 2012) is gathering information on the coordination of programs and also calling for special attention to homelessness among families and youth and also to rural homelessness, which has been largely ignored as large urban centers experienced drastic increases in homelessness. The recent changes should expand the access by homeless individuals and families to services and programs as well as provide agencies with more cohesive information that will allow them to target their services more effectively and maximize the use of scarce resources. At the same time, the U.S. is experiencing unprecedented levels of poverty and homelessness and has made less impressive strides in dealing with homelessness European countries such as Germany (Toro et al., 2007).

### **International Perspectives**

In a survey including respondents from Germany, Belgium, Italy, the U.K., and the U.S., the U.S. and the U.K. were found to have the highest prevalence of homelessness and the least compassionate attitudes toward homeless people (Toro et al., 2007). In fact, the U.S. surpassed the U.K. on both measures. Americans were most inclined to attribute homelessness to personal failings and the American and British respondents were more likely to associate homeless people with criminal records and drug abuse and least inclined to discuss homelessness with friends and relatives. But even

the British respondents were more likely than the Americans to support federal funding to assist the homeless and to view homeless people as alcoholics. Given these findings it is not surprising that individual characteristics should figure prominently in research on homelessness in the U.S. and proposed solutions (Shinn, 2007; Shinn et al., 2001). Nor is it surprising that individuals and families living in shelters or hotels should feel stigmatized and ashamed of their situation (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003; Wingate-Lewinson et al., 2010).

Despite their judgmental attitudes, the U.S. respondents had a fairly accurate picture of homelessness; they were aware that many homeless people are parents, female, and have regular contact with their families (Toro et al., 2007). In addition, both the American and British respondents described homelessness as a serious problem in their area, which was probably a realistic appraisal. On a positive note, a sizable majority of respondents from all five countries including the U.S. said they were willing to pay more taxes to deal with the issue. Toro et al. raised the issue of the relationship between public attitudes and public policy. That is, if the American and British public could be persuaded toward more compassionate attitudes toward the homeless, their opinions might change public policy for the better. Alternately, if public policy was changed it might alter public opinion. It is possible that the current government initiatives to address homelessness might induce more sympathetic attitudes, especially as families and youth are a major focus. It is also possible that Americans have become cynical due to the failure of the existing programs to stem the escalating rates of homelessness since the 1980s.

Shinn (2007) points out that the U.S. spends far less money on families than European nations, a factor that has been implicated in the high rates of family homelessness. Among developed nations, only Japan has virtually no female or family homelessness despite a relative absence of social welfare programs. Shinn also argues that the arbitrary division of homeless persons poses an obstacle to providing services. Indeed, she decries the separation of fathers and in many cases, older boys, from their families as shelter policy. Hicks-Coolick et al. (2003) found lack of shelter space for children to be a pervasive problem among agencies providing homeless services. The U.S. Conference of Mayors (2006) confirmed that few shelters provide space for families. According to Shinn (2007) the higher proportions of homeless adults who are separated from their children in the U.S. compared to other countries, along with the greater number of homeless families, “are both likely consequences of American social policy” (p. 663).

Viewing the problem from multiple levels of analysis, Shinn (2007) attributes the high overall levels of homelessness to policy factors and the vulnerability of certain individuals and groups to policy (such as financial support for families), social exclusion, and individual risk factors. An ideal approach to addressing homelessness would synthesize the different levels of analysis for a comprehensive approach that recognizes the relative contributions of factors at different levels.

### **Ecological-developmental Perspective**

Haber and Toro (2004) proposed an ecological-developmental perspective for understanding homelessness that acknowledges the role of poverty and adversity in the

etiology of homelessness but also recognizes the resources and resilience of homeless individuals. The model is also predicated on the idea that homelessness has different meanings at different stages of development, which is especially important in view of the increasing presence of families with children and unaccompanied youth among the homeless population. A notable feature of their approach is that Haber and Toro recommend providing comprehensive service packages tailored to the unique needs of homeless adolescents and homeless families. Haber and Toro disagree with Shinn et al. (1998) who concluded that subsidized housing alone could resolve the problems of many homeless families. Shinn and her colleagues have since adopted a more expansive perspective on homelessness though subsidized housing is viewed as the pivotal factor (Shinn, 2007; Shinn et al., 2001).

Haber and Toro (2004) advocate housing subsidies combined with intensive case management for helping families recover from homelessness. This model is also consistent with the recommendations of Culhane et al. (2003, 2011). Haber and Toro (2004) envision a comprehensive, systematic approach to homelessness with programs and services aimed at all ecological levels, including family supports, community programs, school-based programs, social supports and networks, treatment and intervention programs, expansion of low-income housing, and changes at the policy level. Ideally, Toro et al. (2007) would like to see the U.S. move toward social policies that effectively prevent high rates of homelessness in European countries like Germany and Belgium. However, the U.S. may be better suited toward the strategies that have been

undertaken in Canada to unify and coordinate programs and services across provinces and local communities (Farrell et al., 2004; Peressini & Engleland, 2004).

### **Risk Factors for Homelessness and Unstable Housing**

The soaring rates of homelessness during the 1980s and in particular, the awareness that “women and children changed the face of homelessness in the United States,” generated an upsurge in research attention to the contributors to homelessness among women and families (Bassuk et al., 1997, p. 241). Bassuk et al. explored individual level risk and protective factors for family homelessness among poor women in Worcester, Massachusetts in a study comparing 220 homeless mothers recruited from Worcester’s emergency shelters, transitional housing programs, and welfare hotels, and 216 mothers who were receiving welfare benefits and had never been homeless. Weinreb, Buckner, Williams, and Nicholson (2006) also focused their research on homeless mothers who sought services from the Worcester shelters. Bassuk et al. (1997) consider Worcester a good site for such research because families that lose their homes almost invariably go directly to shelters rather than sleeping in a car, park, or abandoned building. The study was limited to mothers with children under age 17 who entered the shelter programs between August 1992 and July 1995. More than three-quarters of the families (76.4%) had never been homeless before and almost all of those families had spent less than 18 weeks in the shelter programs at the time of the study.

Rigorously trained female interviewers conducted the in-depth interviews, which extended over three or four 2-hour sessions (Bassuk et al., 1997). Both groups of impoverished women reported similarly high instances of family disruption, trauma, and

loss during childhood. There were two notable exceptions, however. The homeless women were more likely to have been placed in foster care and to have had female caregivers who used drugs. At the same time, these childhood experiences were not sufficient for explaining family homelessness in adulthood. The independent adult risk factors that emerged from the analysis included recent eviction, having recently moved to Worcester, interpersonal conflict resulting in fewer social ties, frequent reliance on alcohol or heroin, and being hospitalized for a mental health problem within the last two years. Being a member of an ethnic or racial minority was also a risk factor for homelessness.

On the other hand, factors that protected against being homeless included having a high school diploma, having a more extensive social network with better relationships, being a primary tenant, and receiving cash benefits of housing subsidies (Bassuk et al., 1997). The role of cash assistance and housing subsidies takes on greater importance in view of the fact that the study was conducted during the time that welfare reforms were being enacted. Homeless mothers in Worcester surveyed a decade later displayed poorer mental and physical health than their 1993 counterparts (Weinreb et al., 2006). Bassuk et al. (1997) noted that being a victim of violence did not increase the risk for homelessness but nonetheless violence was “omnipresent” in the lives of both groups of poor women (p. 246). Violent victimization does heighten the prospect for depression and posttraumatic stress, which are common among homeless women and can be compounded by the trauma of homelessness (Williams & Hall, 2009).

Caton and her colleagues have conducted extensive research on risk factors for homelessness on the premise that homelessness is a serious public health issue that

cannot be addressed without understanding the service needs of homeless populations (Caton et al., 2000, 2005). Their research was carried out in New York City's shelter system. According to Caton et al. (2000), research in this area has traditionally focused on the role of psychiatric illness in adult homelessness while ignoring the majority of homeless men and women who do not have severe psychiatric disorders. At the time of their study, two-thirds of the U.S. homeless population had never been hospitalized or diagnosed with a psychotic disorder. Using a matched case control design stratified by gender, Caton et al. examined 200 homeless adults and 200 adults who had never been homeless (100 men and women in each group) using the Structured Clinical Interview for DSM-IV (SCID) and the Positive and Negative Syndrome Scale (PANSS). With the Homeless History Form, the researchers discerned that about 77% had been homeless for three months or less and about 28% had been homeless for no more than one week.

There were some gender differences in the reasons for becoming homeless. Specifically, the men were far more likely to cite economic hardship or multiple reasons than interpersonal reasons for becoming homeless (Caton et al., 2000). Only a minority of women (21%) or men (32%) had spent time sleeping outside. A striking gender distinction was that while alcohol or drug abuse or dependence did not raise the risk of homelessness for the men, drug abuse or dependence emerged as a risk factor for homelessness among the women. Lifetime heroin and cocaine abuse were especially prevalent among the homeless women compared to the women who had never been homeless. Additionally, the homeless women had extensive histories of substance abuse treatment, thus implying that their substance dependence was severe and intractable. To

Caton et al., this factor represents a pivotal distinction between homeless women and women who have never been homeless.

For women and men, strong family support, especially financial support, proved to be an important protective factor against homelessness (Caton et al., 2000). Family financial support appeared to be even more important for men than for women. Consistent with other studies, lacking a high school diploma and having limited income from all sources including families heightened the vulnerability to homelessness (Bassuk et al., 1997; Zlotnick et al., 2010). The overall implication, according to Caton et al. (2000) is that impoverished adults who seek public assistance or shelter services require access to General Education Diploma (GED) programs and job skills training programs if they are to have housing security. Given the high rates of alcohol and drug abuse they also advocate the integration of substance abuse assessment and treatment into social service programs. Caton et al. also point out that individuals who are living in a doubled up situation are at even higher risk for becoming homeless if they are sharing living quarters with others who are heavy users of drugs or alcohol. Their main concern for policymakers and program administrators is that homeless adults have access to the tools that will help them gain stable employment and housing stability are primary tenants.

Using data from the 1997 Los Angeles County Health Survey, Cousineau (2001) compared the characteristics of adults in Los Angeles County who had experienced homelessness with those who had not. The survey captures data from the 26 health districts and eight planning districts in Los Angeles County and was based on telephone interviews with 8,004 adults age 18 or older. According to the results, an estimated

370,000 Los Angeles adults had been homeless within the last five years. Although this figure was 1.5 times higher than national estimates, Cousineau used a broad definition of homelessness that included individuals who stayed with a friend or relative. Those who doubled up accounted for 56% of the adults classified as homeless while those who were *literally homeless* represented 35% of the group. An additional 9% spent some nights with friends or relatives and other nights out on the street, in their cars, in shelters or in other venues.

Homelessness affected individuals of all racial and ethnic groups, though African American and Latino adults were more likely to have been homeless than White or Asian adults (Cousineau, 2001). African Americans were at especially high risk for homelessness. This can be explained by their higher prevalence among individuals in poor health and with low incomes, which were factors associated with homelessness in all racial and ethnic groups. Limited education was another risk factor for homelessness; 26% of the formerly homeless adults did not have a high school diploma versus 19% of those who had never been homeless. Formerly homeless individuals who acquired work were more likely to be working part-time or unemployed at the time of the survey. However, of those who were once homeless and had made significant strides in improving their education and income status, more than one-third were living above the federal poverty level; Close to 20% had earned a baccalaureate or postgraduate degree, and close to half were working in full-time jobs.

An unfortunate limitation of the study is that Cousineau (2001) did not explore what channels enabled those individuals to successfully turn their lives around. He

recommends a number of programs that could help achieve positive outcomes including job training and placement, rehabilitation services, access to health care, assistance with housing, and above all, an expansion of affordable housing, especially in areas where homelessness is most prevalent. The study illustrates that a significant proportion of formerly homeless individuals can successfully improve their lives though it is unlikely they can do so without assistance from government, nonprofit, and privately sponsored programs and services.

### **Long-term and Chronic Homelessness**

In subsequent research, Caton et al. (2005) investigated risk factors for long-term homelessness among men and women who had become homeless for the first time in 2001 and 2002. The researchers noted that there is minimal knowledge about individuals who turned to shelter services for a short time as compared to those who rely on such services for a long duration or return for repeated assistance. Phinney, Danziger, Pollack, and Seefeldt (2007) conducted their research on the housing stability of present and former welfare recipients from a similar perspective. As part of an ongoing study, Caton et al. (2005) presented the findings drawn from 377 single adult men and women who entered New York City shelters. Assessment was conducted with the Structured Clinical Interview for DSM-IV and the Positive And Negative Syndrome Score as in the earlier study (Caton et al., 2000), along with the Community Care Schedule, which encompasses demographic and background information (Caton et al., 2005). After the baseline interviews, data was collected at 6-month intervals for 18 months.

The overwhelming majority (80%) of the homeless men and women returned to conventional housing accommodations over the 18-month period, but that left a small but significant segment that were homeless for the full 18 months (Caton et al., 2005). In fact, those 20% who would be defined as *chronically homeless* represent twice the estimate projected from administrative data. To Caton et al., this suggests that long-term homelessness may be more prevalent than is commonly believed. There is also the fact that data from shelters excludes homeless people who live on the streets and do not seek help from service providers. As a result, estimates of the homeless populations of metropolitan areas can be vastly inaccurate (Farrell et al., 2004). While acknowledging that their findings are limited to the New York City shelters, Caton et al. (2005) suggest that underestimation of chronic homelessness is more likely.

Certain characteristics were linked with more favorable outcomes in terms of being homeless for a shorter duration (Caton et al., 2005). These attributes included being younger, having a present or recent job, earned income, family support, positive coping skills, and the absence of a history of arrest or substance abuse treatment. Older age and a history of arrest emerged as the overarching risk factors for chronic history. Incarceration plays a powerful role in homelessness among single men (Greenberg & Rosenheck, 2008; Roll et al., 1999; Zugazaga, 2004). Homeless women and in particular women with young children are more likely to be disadvantaged by a limited employment history.

Caton et al. (2005) recommend that shelters employ a type of triage system whereby individuals whose profiles make them more likely to be homeless for a short time are provided assistance in securing employment, along with temporary income and

other needed supports while those more vulnerable to long-term homelessness are provided more intensive supports to prepare them for a quicker transition to stable housing. Alexander-Eitzman (2006) took issue with Caton et al. (2005) for an approach he calls the “public healthification” of homelessness that treats a complex social problem as a disease where the causes and outcome reside within the individual (p. 764). He also criticized the authors for failing to go beyond the homeless individuals’ recent living accommodations to understand where they came from geographically as well as the features of their previous living arrangements and neighborhoods. Most important, Alexander-Eitzman emphasized the need to understand the dynamic interplay of personal, environment, and social forces in the trajectory of homelessness.

Caton et al. (2006) countered that an epidemiological perspective of homelessness is perfectly valid and is warranted if homeless individuals are to be provided with appropriate, individually tailored services. The authors view the identification of individual risk factors as a springboard for the development of innovative programs to effectively prevent homelessness and assist those who experience homelessness. Both authors agree that neighborhood factors are important both for understanding the etiology of homelessness and providing services in economically disadvantaged communities where residents are at increased risk for being homeless. Additionally, both authors concur on the need for research conducted at multiple levels of analysis, consistent with Bronfenbrenner’s (1979) ecological model and Dunn’s (2008) conceptual model. Rukmana (2011) investigated homelessness in Miami-Dade County from the geographic perspective advocated by Alexander-Eitzman (2006).

### **Single Women and Women with Families**

Zlotnick et al. (2010) conducted their research on long-term and chronic homelessness among individual women and women with children in response to the federal exclusion of families with children from the federal definition of chronic homelessness as well as the relative scarcity of homeless shelters for women compared to shelters for men and for families compared to single adults. For their dataset, Zlotnick et al. turned to the National Survey of Health Assistance Providers and Clients (NSHAPC), conducted in 1996 but remaining the sole nationally representative in-depth survey of homeless persons. The ambitious survey includes data from 11,983 homeless assistance programs from 6,307 service locations throughout the U.S. The NSHAPC sample includes 4,207 formerly or currently homeless clients, of whom 2,938 were currently homeless. Men comprised about two-thirds of that group. Very few currently homeless adults were couples (4.5%). Women alone or with children accounted for roughly 29% of the currently homeless clients. Among the 849 women, 405 lived with one or more minor children and 444 were unaccompanied adults. Consistent with the reality that many unaccompanied homeless women do have children (Barrow & Laborde, 2008), 183 of the currently homeless women had children living apart from them but were classified as unaccompanied (Zlotnick et al., 2010).

Most of the homeless women were under age 35, the overwhelming majority had never married, and nearly half had no high school degree (Zlotnick et al., 2010). Ethnically, roughly 12% of the women were Latino and the remaining women were primarily white or African American (44% and 40.3%, respectively). The histories of the

women confirmed the impact of childhood adversity and trauma on the probability of being homeless. One-third of the women had been physically and/or sexually abused in childhood (up to age 18), 22% had been homeless, 15% had been foster care, and 11.6% had resided in a group home. The only group difference was that a higher proportion of the women with children had been homeless at some point during their own childhood. Zlotnick et al. decry the lack of attention to the role of childhood trauma in adult homelessness despite consistent research documentation (Weinreb et al., 2006; Williams & Hall, 2009).

Older mothers with children were less likely to meet criteria for chronic homelessness, which Zlotnick et al. (2010) suggest might reflect having more resources and social supports than their younger counterparts or perhaps being more determined to secure stable housing so their children do not experience disruptions to school. It is also possible that the shelter restrictions on adolescent male children documented by the U.S. Conference of Mayors (2006) might motivate mothers of older boys to seek out housing assistance that allows the family to stay together. However, any reasons for the age difference in chronic homelessness among the mothers with children are purely speculative. None of the variables addressed by Zlotnick et al. (2010) could account for the age distinction in patterns of homelessness.

Among the unaccompanied women, African American ethnicity and childhood homelessness both increased the probability of experiencing chronic homelessness while having a high school diploma or equivalent and living in doubled up conditions protected against it (Zlotnick et al., 2010). Doubling up is an indicator of social ties and both

education and doubling up are manifestations of social capital. Ironically, having been in foster care was a protector against chronic homelessness, possibly, according to Zlotnick et al. (2010), because the foster care experience necessitated the development of survival skills or made the women more aware of the available services. Foster care experience is usually identified as a risk factor for adult homelessness (Bassuk et al., 1997). The current drive for a cohesive definition of homelessness and shared vocabulary among service providers may help to ensure that homeless women with children are not excluded from services for those who are chronically homeless (Cackley, 2011; GAO, 2010, 2012). The main focus of Zlotnick et al. (2010) is on preventing chronic homelessness, and they call on researchers and policymakers to invest in studies and programs with the capacity to prevent homelessness by illuminating and treating factors that contribute to homelessness.

### **Housing Instability**

According to Phinney et al. (2007), while the welfare-to-work initiatives of the 1990s successfully increased workforce participation by single mothers, with subsequent declines in child poverty, there have also been negative consequences among former welfare recipients including financial hardships, food insecurity, lack of health insurance coverage, and housing instability. In particular, low-income families with children are vulnerable to being evicted, doubling up with friends or relatives, moving frequently, or becoming homeless. Phinney et al. explored the issue of how well women fare in terms of housing stability after leaving welfare compared to women who receive cash welfare benefits. The data were drawn from the Women's Employment Survey (WES) a

longitudinal survey of single mothers who received public assistance in an urban Michigan county in February 1997. The study spanned the years 1997 to 2003 and the analysis focused on the incidence of eviction and homelessness, along with sociodemographic characteristics, mental and/or physical health problems, human capital (work experience and skills), hard drug use, criminal conviction, and domestic violence.

Roughly 20% of the women who had received welfare benefits had been evicted from their homes and roughly one-eighth had been homeless at some time during the study period (Phinney et al., 2007). Certain subgroups were at especially high risk for being evicted or homeless, specifically women who had experienced criminal convictions (50%), high school dropouts (38.8%), hard drug users (34.4%), and domestic violence victims (30.4%). Four personal problems assessed at the baseline interview were strongly linked with episodes of homelessness: physical health problems, mental health disorders, hard drug use, and domestic violence. Out of those four problems, use of hard drugs was the only one linked with being evicted in the future. In addition, almost 30% of the women who were poorly skilled or had limited work experience were evicted or homeless. Improving their education to provide financial support and stability for their children is a paramount concern among homeless mothers (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003; Rivera, 2003).

### **Geographic Mobility**

Alexander-Eitzman (2006) argues that comprehensive understanding of homelessness requires knowing where and how homeless people were living before their most recent housing arrangements. Rukmana (2011) investigated the residential origins

of homeless families and homeless individuals in Miami-Dade County, Florida, in a pioneer study comparing patterns of geographic distribution and mobility between the two groups. The study built on a 1996 research project by Culhane and colleagues, who used data drawn from the shelter systems of New York City and Philadelphia to identify the origins and characteristics of homeless families. The findings revealed that 67% of the New York City families and 61% of the Philadelphia families came from three dense geographic clusters marked by high rates of poverty, unemployment and non-participation in the labor force, overcrowding, abandoned buildings and vacancies, and higher ratios of rent-to-income. Demographically, the areas had more African American residents, more female-headed households with children under the age of six, and fewer adolescents, elderly people, and immigrants. According to Rukmana, spatial analysis of the previous addresses of homeless families and individuals offers useful information for helping cities and geographic regions target homelessness prevention and outreach efforts to maximal advantage.

As a theoretical framework, Rukmana (2011) turned to homeless mobility and institutional dependency, drift hypothesis, and service-dependent inner cities. Homeless mobility can alternately be beneficial or detrimental, leading on one hand to better employment opportunities or proximity to family support, or on the other to isolation and alienation from sources of social support and stability. For homeless individuals with mental health problems, institutional settings can either provide needed assistance or foster dependency. Deinstitutionalized individuals with mental illness, as well as homeless persons without mental health problems, also tend to gravitate to disadvantaged

urban areas where housing is more affordable and social service agencies are often concentrated. The data came from five outreach programs, five supportive service programs, 12 emergency shelter programs, and 28 transitional housing programs at a single point in time: January, 27, 2005. The array of programs produced a diverse cross-section of the homeless population of Miami-Dade County, yielding 1,201 completed surveys, 275 from homeless families and 926 from homeless individual adults.

There were significant differences in the geographic distribution of the previous addresses of the homeless individuals and families (Rukmana, 2011). The homeless individuals tended to come from areas characterized by extreme poverty and a concentration of social service programs and agency and to move amongst areas of the same type. In contrast, the families were more geographically dispersed in their prior residences, which were often in areas where affordable housing and social services were scarce. The pattern displayed by the homeless families was more consistent with drift theory, as they moved from their prior addresses to the urban centers where affordable accommodations and social services were available. The drift effect may account for the higher rates of homelessness Bassuk et al. (1997) observed among the families that had recently moved to Worcester. African American women who were unemployed had the highest risk for being homeless, as single adults and with their families (Rukmana, 2011). Rukmana (2011) and Alexander-Eitzman (2006) both emphasize the sheer heterogeneity of the homeless populations and share similar perspectives in understanding the geographic mobility of homeless adults.

### Seeking Assistance

O'Toole et al. (2007) explored the issue of where individuals turn for help when they first become homeless. According to the researchers, there has been scant attention to this question and to the extent that those settings are capable of addressing the plethora of needs of their homeless clients. Their survey of homeless adults was conducted in Pittsburgh and Philadelphia, Pennsylvania during the spring and summer of 1997. Their 230 respondents were overwhelmingly male, African American, single, unemployed, and had been homeless for less than one year. Less than one-third had no high school degree of GED and 19% had been arrested at some time during the previous year. Veterans comprised 22.6% of the sample. Chronic medical conditions (54.8%), mental disorders (51.3%), and substance abuse or dependence (75.7%) were prevalent. More than 14% of the respondents were parents of dependent children who had some caregiving responsibility within the last year.

Lack of employment (81%), lack of money (77%), and drug or alcohol problems (66%) were cited as the main reasons for being homeless (O'Toole et al., 2007). Smaller proportions of respondents attributed their homelessness to family crises or domestic conflicts (31%) or mental health problems (25%). Most respondents sought out services that were congruent with their immediate needs. However, as O'Toole et al. observed, they did not seek out services that would help them address the causes of their homelessness, which were often complex. Homeless mothers with children almost invariably express strong desires to advance their education and job prospects (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003). According to O'Toole et al. (2007), what is

needed is the expansion and integration of services at common “first stop” sites (e.g., soup kitchens, welfare and social service agencies, outreach programs, detoxification centers) to help newly homeless individuals acquire the package of services they need to help them make a more rapid transition from homelessness. The current state and federal efforts to streamline and integrate services for the homeless may produce a model more consistent with that vision (GAO, 2010, 2012). The fragmentation of services is a major obstacle to helping homeless individuals, families, and youth secure needed services to transition from homelessness.

Many homeless people turn to public libraries as a daytime refuge and source of information on the available resources and services. Hersberger (2005) believes public librarians can play an important role in helping homeless people and families acquire needed assistance. Her recommendations include interviewing individuals at the “first stop” sites identified by O’Toole et al. (2007) to find out their information needs. An additional recommendation is to extend outreach to shelters that serve families in order to help homeless children with psychological and educational support. Hersberger sees public libraries as something of a first stop site for homeless people and families, providing them with contact information on soup kitchens, shelters, and other service providers that match their needs. In Canada, the Homeless Individuals and Families Information System (HIFIS) was developed to provide a comprehensive, reliable database for informing and coordinating community-base homeless services throughout the country (Peressini & Engleland, 2004). Grown out of grassroots capacity building efforts, the HIFIS could be a valuable model for similar efforts in the U.S.

### Service Utilization

Research conducted by Culhane and colleagues on homeless families with children in four major locales (New York City, Philadelphia, Massachusetts, and Columbus, Ohio) initially showed similar patterns of shelter use between homeless families and individuals but closer analysis revealed some distinctions (Culhane & Metraux, 2008). The overwhelming majority of homeless families experience fairly brief single episodes of shelter use, while two small groups experience multiple episodes (episodic) or remain in shelters for a long time (long stayers). Although small, however, the proportion of long stayers among families is nearly twice the proportion among single adults (20%-22% versus 11%). The individual characteristics of families with long duration stays were more similar to *families* with short-term stays than they were to long-term stay *individuals*. They had less intensive social service needs, lower rates of mental health and substance use problems, and among all the groups, they had the highest rates of employment and the lowest incidence of disabilities. Even in small numbers and without intensive needs, long-term stayers are expensive to accommodate. They account for 50% of the shelter system resources, costing \$22,000 to \$55,000 per family per stay depending upon the locale.

The families with the most intensive needs were the episodic shelter residents, representing about 5% to 8% of the families (Culhane & Metraux, 2008). The services received by these families included inpatient psychiatric or substance abuse treatment and child welfare services. Examining 5-year prevalence rates of involvement with child welfare agencies and foster care placement in Philadelphia, Culhane et al. (2003)

observed that more than one-third of the mothers who had been homeless at some point were involved with child welfare services (37%), far exceeding the 9.2% for other low-income residents and 4% for all others (Culhane et al., 2003). In fact, half the children who became involved with child welfare services had mothers who had been homeless. Foster care placement was also extremely high for this group, approaching 62% for children of homeless families involved with child welfare services.

In research with homeless families in New York City, Park, Metraux, Brodbar, and Culhane (2004) identified a number of risk factors for child welfare system involvement. Domestic violence was a key factor in both homelessness and child welfare system involvement. Having more children heightened the risk for child welfare service involvement among homeless families in both the New York City and Philadelphia studies as well as the risk for foster care placement in the Philadelphia study (Culhane et al., 2003; Park et al., 2004). The child's older age at the time of the first homeless episode and recurrent entries to public shelters were also linked with child welfare service involvement (Park et al., 2004). The extent of overlap between utilization of the child welfare and homeless shelter systems led Park et al. call for greater coordination between the two systems for children of homeless families. They noted that the costs of homelessness reverberate at multiple levels of society, from sweeping negative effects on family cohesion to the economic costs to the public service systems.

More recently, Culhane et al. (2011) returned to Philadelphia for further research into the patterns and costs of service utilization by homeless families. The findings confirmed the intensive needs of families with episodic homelessness. Close to 30% of

the heads of those families had a history of inpatient mental health treatment compared to 13.4% of the families that were temporarily homeless and 7.4% of the long-term stayers. The episodic families also had rates of foster care placement that preceded residential instability and homelessness and continued. The patterns showed that the homeless families' needs for services were not alleviated by subsidized housing; in fact, these needs persisted and children were still at risk for foster care placement. These findings might seem to contradict the conclusion that subsidized housing is a decisive factor in preventing the recurrence of homelessness among families (Shinn et al., 1998; Stojanovic et al., 1999). However, the main implication is that subsidized housing is essential but not sufficient for families with serious needs.

Reinforcing the need for better coordination of services, Culhane et al. (2011) recommend that agencies serving homeless families should systematically screen homeless families and refer them to community service agencies on an ongoing basis. Australians Minnery and Greenhalgh (2007) interpret the U.S. federal legislation enacted over the last decade as evidence that the country is moving toward a “continuum of care” approach to dealing with homelessness and its causes (p. 650). The most recent federal initiatives affirm that this is the goal of federal policy (GAO, 2012). However, the coordination of services for homeless individuals and families is still a long way from being realized.

### **Hotel Accommodations**

Although the terms “transitional living” or “transitional housing” typically apply to housing provided by a service agency, the literal meaning of “transitional” can refer to

any intermediary living arrangement between stable housing and homelessness. Due to the scarcity of affordable housing, there are many families living in extended-stay hotels, typically members of the working poor or unemployed. Wingate-Lewinson et al. (2010) conducted an excellent qualitative exploration of 10 diverse respondents residing at an extended-stay hotel. Wingate-Lewis used the term *liminal living* to describe their living situation as “being in-between the thresholds of two entities,” namely “without the comfort of a stable and permanent home” by people who are seeking one (p. 14). Six of the seven women and three men were married and six were raising children (five women and one man).

The annual household incomes of the respondents ranged from \$11,200 to \$31,000 (Wingate-Lewinson et al., 2010). While those figures do not reflect the crushing poverty of women who turn to city shelters, families with those incomes are often priced out of the housing markets for homes and rental apartments. In fact, the lowest income was reported by a 51-year old widow who had gone back to school and was living in the hotel with her three grandchildren. All the respondents stayed at the hotel because they could not afford other housing. Although a few respondents had been at another extended-stay hotel, most had lost their previous homes due to foreclosure, eviction, or financial difficulties. One respondent had surreptitiously lived in an office. Two major themes arose from the analysis: “*Mentally it’s just too much*” and “*You have a hard time getting out*”.

All the respondents wanted their stay in the hotel to be as short as possible but felt they were in a situation where all they could do at that point was wait for something to

change (Wingate-Lewinson et al., 2010). Prayer and religious faith were important resources for several residents. One woman who expressed her faith in God reported that her son “begged his older sister to be patient” by telling her “at least we’re not on the streets, so mommy’s not gonna have us here too long...we have to wait” (p. 21). The reassurance that “at least we’re not on the streets” raises the issue of how parents deal with their children’s feelings when their only home is a shelter. There were persistent references to feeling “trapped,” “crowded,” “secluded,” “closed in” and confined (p. 21). These feelings are exacerbated in mothers living with their children in shelters where they have no privacy and must abide by the shelter rules (Meadows-Oliver, 2003). In fact, wanting a place with privacy and no restrictions, as well as desiring more space and a place of one’s own were common feelings among the hotel residents (Wingate-Lewinson et al., 2010).

Being unable to leave the hotel caused a substantial amount of emotional distress, with feelings of guilt, depression, and shame commonplace (Wingate-Lewinson et al., 2010). Once again, these feelings are intensified among homeless mothers in shelters (Meadows-Oliver, 2003). One woman commented that for a person living alone it might be tolerable to live in the hotel for an extended time but for a family with children “it would be totally unhealthy” (Wingate-Lewinson et al., 2010, p. 22). Some respondents were afraid that they might become complacent and “become too institutionalized” if they stayed at the hotel too long (p. 23). A 31-year old African American father with two children who had been laid-off from work and was evicted and plagued by poor credit was despondent, feeling that he failed to provide for his family like his father had. The

narratives of fathers are sorely absent from the literature on families that are homeless or living in unstable or temporary housing. This young father was burdened by a tremendous sense of guilt and shame at not being able to provide his family with a stable home. A White homemaker and mother observed the same feelings in her husband.

The father was also concerned for his daughter, who drew “pictures of a pretend bedroom and party sleepovers” that were beyond her grasp, and several parents expressed concern over children who were having difficulty adjusting to the cramped and unstable living arrangements (Wingate-Lewinson et al., 2010, p. 24). They were also worried about the psychological toll their living conditions had on their spouses, which further aggravated their own emotional distress. To Wingate-Lewinson et al., the experiences of the respondents highlight the “ease of falling into near homelessness” due to financial instability and the struggle of getting out (p. 26). Notably, a third issue she brings up is the need for generating solutions to unstable housing at the micro, mezzo, and macro levels by providing individuals and families with information and assistance in locating affordable housing, creating and promoting community support programs to help families with housing difficulties, and advocating for increasing funding for housing initiatives.

### **Health Status, Housing Instability, and Homelessness**

#### **Families and Children**

Using data from the New York City Department of Homeless Services (DHS) and the New York City Department of Health and Mental Hygiene (DHMH), Kerker et al. (2011) compared the health of families that had stayed in emergency shelters to the health of New York City residents in general and resident of low-income neighborhoods. The

data covered the years 2001 through 2003. The families served by the DHS family shelters included parents (predominantly single mothers) with children, pregnant women, and two or more related adults (spouses or domestic partners, parents with adult children, and adult siblings). Among the homeless adults, the rates of HIV/AIDS and tuberculosis were much higher than the overall rates for New York City (almost twice as high for HIV/AIDS and three times as high for tuberculosis) but were comparable to the rates recorded for other low-income residents. Only deaths resulting from substance use among the homeless adults stood out as exceeding the rates for low-income adults as well as the general city population.

A striking finding among the children was that the homeless children were less likely to have been tested for lead levels and had the highest prevalence of lead levels exceeding 10 micrograms per deciliter (Kerker et al., 2011). This occurrence highlights the substandard housing that homeless families are likely to have lived in before losing their homes. The overall findings were more of a confirmation of the adverse effects of poverty on the health of adults and children than of homelessness per se. Nonetheless, there were some indications that the health of homeless children may be compromised to a greater extent than the health of their low-income peers. Cutts et al. (2011) focused specifically on the health status of very young children in unstable housing situations, drawing from the ongoing Children's HealthWatch Study. Between 1998 and 2007, interviews were conducted with 22,069 family caregivers of children under age three seeking services at urban medical centers located in seven U.S. major cities (Boston, Baltimore, Los Angeles, Philadelphia, Little Rock, Minneapolis, and Washington, D.C.).

The surveys covered housing insecurity, food insecurity, and the child's health status, weight, and developmental risks.

Housing insecurity during the previous year was a problem for nearly half (46%) of the families surveyed (Cutts et al., 2011). Housing insecurity was linked with food insecurity and both had adverse effects on the children's growth and development. Having moved multiple times within the last year was more strongly linked with food insecurity than living in crowded quarters and was also more detrimental to the children's health. According to Cutts et al., crowding may be a strategy to prevent becoming homeless, whereas frequent mobility reflects an absence of social ties. Of the three groups examined (secure housing, crowded housing, and multiple moves), the children in families that had experienced multiple moves had the poorest health status, below average weight for their age, and heightened developmental risks. Crowding carried some risk factors for the children's health and development but not to the same degree as frequent mobility. The combination of food insecurity and housing insecurity placed the children in double jeopardy for poor health and development.

Cutts et al. (2011) point out that the development of children in unstable housing situations is compromised by the damaging effects to the parents' psychosocial health (such as depression) and parenting practices. Families forced to live in hotels (Wingate-Lewinson et al., 2010) and mothers living with their children in shelters (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003) are acutely aware of the negative effects their psychological distress and the limitations imposed by their living situation can have on

their children's well-being. Cutts et al. (2011) strongly advocate housing subsidies, energy subsidies, and other programs to prevent homelessness.

Coker et al. (2009) investigated the prevalence of homelessness and the health related effects of homelessness on fifth grade children in three American cities (Birmingham, Los Angeles, and Houston). The data were drawn from Healthy Passages, a multisite study of 5,147 fifth graders conducted from 2004 through 2006 via interviews with parent-child pairs. The results yielded a lifetime prevalence of homelessness of 7% among the fifth graders. This figure rose to 11% among African American children and children from the poorest families. Translated numerically, a school with 500 students would have 35 students who had been homeless at some time and a classroom of 28 students would have two students with a history of family homelessness.

Although the experience of homelessness did not make a difference in the children's physical health (after controlling for sociodemographic factors), homelessness took its toll on the children's emotional, behavioral, and developmental health (Coker et al., 2009). Parents who had experienced homelessness more often reported that their children had an emotional, behavioral, or developmental problem, and had received mental health, behavioral, or substance abuse services. Coker et al. emphasize that their findings should not be interpreted as showing a causal link between homelessness and children's psychosocial problems as the study was not designed to determine whether the children's emotional, developmental, or behavioral problems coincided with the time the family was homeless. However, living in unstable or substandard housing carries risks for such problems (Cutts et al., 2011).

Coker et al. (2009) recognize that being homeless or at risk for homelessness places stress on families that influence the children's development. Additionally, given that many homeless mothers have been victims of domestic violence, their children are likely to have witnessed family violence. Stress and depression can be unrelenting for families living in shelters or in temporary living quarters (Cosgrove and Flynn, 2005; Meadows-Oliver, 2005; Wingate-Lewinson et al., 2010). Coker et al. (2009) found it somewhat paradoxical that children who had been homeless were more likely to have received some type of mental health services but they surmised that these services were provided by the agencies that serve homeless families (or that these children had more severe problems than their peers who had never been homeless). They propose that expanding access to mental health services would help resolve some problems faced by families that are homeless or in precarious living situations. Nonetheless, Coker et al. state that the major solution for diminishing mental health disparities between children who have been homeless and those who have not lies in addressing the families' housing instability. Cutts et al. (2011) make similar recommendations.

### **Homeless Mothers**

Weinreb et al. (2006) compared the physical and mental health status of homeless mothers in Worcester, Massachusetts in 1993 and 2003. The time frame captures the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or welfare-to-work act, which imposed time limits on the cash benefits received by poor families and linked welfare with work (Phinney et al., 2007). Many families suffered financial and housing instability as a result. The data sources were the Worcester

Family Research Project and the Worcester Homeless Families Program Study, for 1993 and 2003, respectively (Weinreb et al., 2006). Both studies employed similar inclusion criteria, and in both a substantial proportion of the women were Latinas, reflecting the high levels of Latin heritage families in Worcester living below the poverty level (30% in 1993 and 38% in 2003). There was one distinction, however. For the 2003 study, eligibility was restricted to women who had a drug, alcohol, or mental health disorder the previous year while the earlier study was epidemiological and included all homeless mothers who sought to participate.

In 2003, the respondents were slightly older (on average roughly 2.5 years), and their children were slightly older as well (Weinreb et al., 2006). On other sociodemographic measures, specifically ethnicity, marital status, and mean number of children, the two groups of women were similar. However, although the incomes did not differ between the two groups of families, the effects of inflation and spending power left the 2003 families substantially poorer. While more women in the later study had a high school education, their high school diploma did not work to their advantage financially. Indeed, whatever positive impact education might have had was eclipsed by the poorer physical and mental health of the women in the 2003 study, who had high rates of major depression, physical limitations, and PTSD. Weinreb et al. stressed that the differences in inclusion criteria for the two studies could not be responsible for the magnitude of the differences in health and mental health status between the two groups. In particular, the women in the 2003 study had four times the prevalence of major depression than their counterparts a decade earlier even despite a narrow assessment period.

Weinreb et al. (2006) noted that most of the Latina respondents were Puerto Rican, and Puerto Rican mothers have a high probability of heading families that live below the poverty level. In addition to the need for shelters that are sensitive to cultural or linguistic challenges faced by homeless mothers, Weinreb et al. propose that homeless shelters are currently dealing with families with more serious health and mental health needs than shelters in the 1990s. According to the researchers, other studies have disclosed that homeless mothers who suffer depression often do not access mental health services, yet depression can have a devastating impact on parenting. Even mothers who may not have clinical levels of depression have expressed concerns over their children's witnessing their crying and other signs of emotional distress over having to live in a shelter (Meadows-Oliver, 2003).

### **Parenting**

Meadows-Oliver (2003) conducted a meta-synthesis of qualitative research studies exploring the experiences of women living in homeless shelters with their children. The meta-synthesis encompassed a total of 18 studies spanning the 1990s from 1992 to 1999, with participants that varied in age, ethnicity, and family size. Six major themes emerged from the analysis: *on becoming homeless*, *protective mothering*, *loss*, *stressed and depressed*, *survival strategies*, and *strategies for resolution*. The reasons for becoming homeless are amply documented in the literature including eviction and lack of affordable housing, unlivable or condemned housing, domestic violence, drug dependence, and divorce or separation. For all of the women, moving into a shelter with their children was a last resort when they had nowhere else to turn. In most cases, moving

into the shelter was part of a continuum of homelessness that began with losing their home, continued with living sporadically with relatives or friends, and finally culminated in entering a homeless shelter.

Guarding their children against danger in the shelter was an essential and unrelenting activity that in many cases was shared by the mothers living at the shelters (Meadows-Oliver, 2003). Beyond protecting their children against physical harm, many of the mothers also worried about the emotional impact of being homeless. According to shelter rules, the children had to be with their mothers at all times, which kept them physically safe but which also exposed them to the intense emotions (such as uncontrollable crying) that the mothers were unable to hide. Several mothers observed signs of emotional trauma such as aggression or withdrawal in their children. As a result, some of the mothers chose to have their child or children live with relatives until they found stable housing. Shelter regulations that limit space for families or do not allow adolescent boys to stay with women and younger children are another reason mothers may send their children elsewhere (Macy-Hurley & Tull, 2009; Shelter Partnership, 2006; U.S. Conference of Mayors, 2006).

The profound sense of loss the women experienced extended beyond the loss of their home (Meadows-Oliver, 2003). Loss of privacy and loss of freedom were very real and important concerns for women living with their children in a communal space with formal and often rigid rules. The women were forced to adhere to formal schedules and protocols that diverged from their natural family life. Their parental authority was further undermined by the shelter staff and the women felt a loss of respect as well as authority.

Feelings of stress and depression were commonplace and several women admitted to having suicidal thoughts. There was a pervasive sense of helplessness. Prayer and social support were the predominant survival strategies. Prayer was also a common strategy among the hotel residents (Wingate-Lewinson et al., 2010). For homeless individuals, hope is frequently crystallized in the ideal of “having a place of their own” (Partis, 2003, p. 16). Partis described how the residents of a London shelter appeared to be in a constant struggle between retaining hope and feeling worn down by the harsh realities of their lives.

While the shelters provided formal supports including individual counseling, parenting classes, support group meetings, and information about community agencies, financial and housing assistance, other mothers were important sources of informal support (Meadows-Oliver, 2003). The mothers also found support in their children. Participants in a study of homeless adults in South Africa described how they formed “families” with other homeless people, often after losing contact with their own families (Makiwane et al., 2010). Many women stayed in contact with their families and also formed bonds with other homeless women. As in the U.S., joblessness and poverty were the main causes of homelessness, and like their U.S. counterparts many of the South African homeless women had been victims of childhood abuse and domestic violence.

Despite their distress, the women framed their experience of being homeless as a time of “growth and development” (Meadows-Oliver, 2003, p. 135). Their overriding aim was to acquire resources that would not only lift them out of homelessness but would prevent them from becoming homeless again, namely a job, education, and permanent

affordable housing. Acquiring a good education was a dominant theme. The Los Angeles County study demonstrates that a significant proportion of adults who have been homeless do achieve these goals (Cousineau, 2001). While education and employment are essential for raising homeless women from poverty, obstacles related to poverty can prevent many women from taking advantage of them (Rivera, 2003). Rivera taught a popular education class based on the empowerment philosophy of Paolo Freire to women who were currently or formerly homeless. The women were highly motivated and reported higher self-esteem, self-confidence, and a sense of community, as well as needed increases in basic education skills. With their own educational progress, many women became advocates for their children's education. Yet, despite these gains, 36% of the women were forced to drop out of the shelter class before they earned their academic credential due to welfare-to-work requirements which did no more than prepare them for low-paying jobs. In addition, several women dropped out as a result of health problems, learning disabilities, lack of transportation and child care, substance abuse, and domestic violence. Many families have intensive needs beyond stable housing (Culhane et al., 2003, 2011).

Cosgrove and Flynn (2005) conducted a phenomenological, participatory research exploration of the parenting experiences of 17 women (including two pilot interviews) living in what the authors described as "strength-based" shelters located in the Northeast (p. 130). Designed to accommodate eight families, all the residents live in the same building, share three bathrooms, and have access to a common television/playroom, a kitchen, and a meeting room. The women ranged in age from 20 to 32 years and their

children ranged from three months to 12 years. Family size ranged from one to four children. The sample included six Latinas, four African Americans, three White participants, and two multiethnic participants. Only three of the 15 women had been married. Most of the women had a high school diploma or GED or had some college including one who had an associate degree. Only three women lacked a high school degree. Although the sample was small the level of education exceeded the level of most homeless women. Yet despite their education, most had been in low-paying jobs, which exposed them to greater risk for homelessness.

Sense of stigma in being a homeless mother and conflict due to disparities between shelter rules and the participants' previous parenting practices emerged as two powerful and interrelated themes (Cosgrove & Flynn, 2005). The women felt they were under constant scrutiny and were perceived by people including (or perhaps especially) service providers as an "aberrant Other" (p. 133). Feelings of being "humiliated" and "disrespected" were pervasive. It is noteworthy that the parents and single adults living in the extended-stay hotel expressed shame and embarrassment though they were not under the same scrutiny and constraints as the mothers living in shelters (Wingate-Lewinson et al., 2010). Cosgrove and Flynn (2005) emphasized that the women did not feel stigmatized by shelter staff and in fact, expressed very favorable perceptions of the staff members, whom they described as respectful and supportive. Nonetheless, they felt they were constantly judged because they diverged from the ideal of the "good mother" (p. 134).

The shelters provided a parenting group that was designed to be flexible and allow the participants to select the topics, but at the same time it was mandatory, which provoked some negative feelings (Cosgrove & Flynn, 2005). The homeless mothers in the studies reviewed by Meadows-Oliver (2003) were similarly ambivalent about the parenting groups. A majority of the women complained that the parenting group either did not meet their needs or raised questions about their competence as parents (Cosgrove & Flynn, 2005). In fact, Cosgrove and Flynn acknowledged that the mandatory group contradicted the empowerment philosophy of the shelter program. The women felt further disempowered by the shelter rules as did the mothers in the earlier studies (Meadows-Oliver, 2003). In general, the mothers living in shelters recognized that there had to be formal rules in the shelter environment but the rules and restrictions were psychologically detrimental and disempowering.

To Cosgrove and Flynn (2005), a particularly noteworthy feature was that all the women had a repertoire of coping strategies and strengths. While they did not attempt to downplay their personal difficulties, “themes of self-efficacy, perseverance, resilience, and resistance” were woven throughout their narratives as they portrayed themselves as being “strong” or “strong minded” (p. 135). Analogous to homeless mothers in earlier studies (Meadows-Oliver, 2003), the women expressed short-term and long-range goals centered on education and employment (Cosgrove & Flynn, 2005). A universal theme was that policymakers lack understanding of the needs and experiences of homeless people. Above all they wanted to dispel negative stereotypes about homeless mothers and

inform the public about the realities of being part of the working poor and living precariously due to the lack of available affordable housing.

Cosgrove and Flynn (2005) outlined a number of recommendations for improving policies for the homeless at all levels, from seeking input from shelter residents on altering shelter policies and programs to best suit their needs to developing state and federal policies based on a social analysis of homelessness and increasing the supply of low-cost housing, raising the minimum wage, and subsidizing child care at the state and federal levels. In other words, they recommend addressing the problem of homelessness at multiple levels (Shinn, 2007; Shinn et al., 2001).

### **Stress and Trauma Histories**

Weinreb et al. (2006) found high levels of PTSD among the homeless mothers in the Worcester shelters. Williams and Hall (2009) point out that while losing one's home in itself is traumatic, for many homeless mothers, losing their home "may have been the most recent in an accumulation of tragic events that these mothers may have experienced" (p. 199). According to the researchers, knowledge of the prevalence of traumatic stress among homeless mothers and of the impact of a history of traumatic events may have on current traumatic stress provides a useful springboard for targeting psychosocial assistance to homeless mothers who suffer traumatic stress. Williams and Hall cited the Worcester study (Weinreb et al., 2006) as one of the few studies that examined PTSD in homeless mothers.

For their own research, Williams and Hall (2009) recruited mothers who had applied for shelter at a nonsectarian nonprofit social service agency in Davenport, Iowa,

that sponsors a supportive transitional and permanent housing program for homeless single-parent families. A total of 75 mothers with a mean age of 30 responded to the survey which was conducted in 2006. The sample was ethnically diverse, with the respondents identifying as white (54%), multiracial (31%), African American (21%), Latina (9%), and Native American (3%). The education level and work experience of the group was higher than in many studies of homeless adults and families. The overwhelming majority of respondents had a high school diploma or GED (80%) and three-quarters (76%) had either worked or attended school within three months of the study. Most of the women lived with their children (89%) and those who did not intended to regain custody of their children after they obtained stable housing, a prevalent but elusive goal among homeless women separated from their children (Barrow & Laborde, 2008).

Social workers conducted interviews with the women using a series of standardized assessments including the Global Appraisal of Individual Needs-Quick (GAIN-Q), Williams' Life History Calendar (LHC), the Davidson Trauma Scale (DTS), and the Traumatic Stress Index (TSI). A notable and troubling finding was that close to two-thirds of the women had PTSD and most had experienced multiple traumas prior to losing their homes (Williams & Hall, 2009). For 52% of the women the most traumatic event in their lives took place before they become homeless, thus highlighting the powerful impact of past trauma on the lives of homeless mothers. Especially troubling was the fact that on average, the women experienced 12 traumatic or distressing events in their lives: more than double the number of events reported by women in general

community research. Furthermore, more than two-thirds of those experiences could be classified as traumatic events. While those events classified as distressing did not exert a significant impact on the mothers' current levels of traumatic stress, past *traumatic* experiences exerted a significant impact in elevating current traumatic stress.

According to Williams and Hall (2009), budget constraints often compel the administrators of social service agencies to focus mainly on issues related to housing and employment. At the same time, high levels of traumatic stress can seriously impede a person's ability to maintain stable housing and employment. As Weinreb et al. (2006) observed, homeless shelter programs today are likely to be dealing with clients whose psychological needs exceed those of the past. Zlotnick et al. (2010) find it sadly ironic that studies consistently document high rates of childhood trauma in homeless adults yet the link between childhood trauma and problems such as substance abuse and homelessness in adulthood is rarely addressed in research and intervention.

Roll et al. (1999) and Zugazaga (2004) both explored the experience of stressful life events among homeless single men, single women, and women with children. Roll et al. (1999) conducted their research with 228 adults who were referred by 29 social service agencies located in the Buffalo, New York, metropolitan area. They utilized several different surveys including the Housing, Income, and Services Timeline (HIST), created for assessing the life histories of poor and homeless adults in the areas of housing, homelessness, employment, income, and social service use; the Diagnostic Interview Schedule (DIS); the Modified Life Events Interview (MLEI); the Social Network

Interview (SNI); the Interpersonal Support Evaluation List (ISEL); and the extensively used symptom checklist (SCLI-90-R).

A notable finding was that women with children were the most vulnerable to physical assault, possibly implying that domestic violence played an important role in their homelessness (Roll et al., 1999). Roll et al. noted that the study only examined assault over the last six months and surmised that a longer time frame might have revealed assault histories in the lives of the single women. As it was, the experience of assault was almost 10% more common among the women with children compared to the single women. The homeless men had more lifetime income than either of the two groups of women despite the fact that the three groups had equivalent levels of education. The women with children received the most lifetime support from public assistance even despite the fact that the study was conducted before welfare reforms curtailed the financial assistance available for single adults. Roll et al. suggested that many of the mothers might have turned to the welfare system due to a lack of affordable child care.

Both groups of women suffered higher levels of depression, anxiety, and other manifestations of psychological distress compared to the men (Roll et al., 1999). To at least some extent the psychological problems might have been a reflection of the women's abuse histories (Weinreb et al., 2006; Zlotnick et al., 2010). Enduring poverty is another potential contributor to their distress (Roll et al., 1999). The homeless women with children were least likely to have experienced stresses commonly linked with homelessness such as being exposed to the cold or lacking enough to eat. It is possible that like the homeless Worcester families, the women with children sought shelter

immediately (Bassuk et al., 1997). Additionally, some shelters that serve families try to ensure that children have proper nutrition (Yousey et al., 2007).

The single men were most likely to have substance use disorders (68%) as well as inpatient treatment for substance dependence, and criminal histories (Roll et al., 1999). Nonetheless, substance use disorders were also common among the single women (45%) as was recent assault victimization (25%). In addition, the single women had less income from working than the single men and less income from public assistance compared to the women with children. There were both similarities and differences among the three groups of homeless adults, with the unique profiles of each group clearly showing how services and assistance could be targeted to the advantage of each group. The efforts currently undertaken to make homeless services more cohesive and efficient should allow services and assistance to be matched more appropriately with client needs (GAO, 2010, 2012).

Zugazaga (2004) focused on homeless single men, single women, and women with children who were served by shelters located in Central Florida. The sample of 162 participants was evenly divided among the three groups. The instrument used to assess traumatic events was a modified version of the List of Threatening Experiences Questionnaire (LTE-Q). Sociodemographically, about 60% of the participants were members of racial or ethnic minorities, 45% were single, 20% were married at the time of the study, 70% had finished high school, and less than one-third (32%) of the participants were employed. Although the mean age of 39 was slightly higher than is often reported in studies of homeless adults, the mothers with children were significantly younger than the

single women or single men. The mean age of the single adults was 40 or older compared to 30 for the women with children. In addition to being younger the women with children differed from the single adults in that were likely to be minorities and to be married and have less education.

Of the three groups, the single men had experienced the longest duration of homelessness (Zugazaga, 2004). There were no differences in the length of homelessness between the two groups of women. Stressful life events were most prevalent in the histories of the single women though all three groups had unusually high prevalence of stressful life experiences compared to the general population. Childhood physical and sexual abuse marred the childhoods of the two groups of women, with 46% of the women having experienced physical abuse and 39% having been sexually abused. Foster care placement was also unduly common among the women (33% of the women with children and 30% of the single women). The findings for both childhood abuse and foster care placement correspond to the findings of Bassuk et al. (1997). Domestic violence was also prevalent among both groups of women although it was more common in the lives of the single women who also had higher incidences of sexual victimization in adulthood and psychiatric hospitalization (Zugazaga, 2004). Domestic violence or hospitalization might have played a more prominent role in the homelessness of the single women, while the women with children were most likely to have been evicted.

Among the men, the overwhelming majority had been in prison (almost 82%) and a majority had problems with drug or alcohol abuse, which were far less common among the women (Zugazaga, 2004). The pattern for the men was consistent with the profile of

homeless single men reported by Roll et al., 1999). In addition, both studies confirmed the prevalence of victimization among homeless women though Roll et al. (1999) did not delve into the childhood experiences of the respondents. The findings of Zugazaga reinforce the assertion of Zlotnick et al. (2010) that the role of childhood trauma in adult homelessness warrants greater research and policy attention.

### **Conclusion**

Homelessness in the U.S. has been escalating since the 1980s, with increasing visibility not only of the homeless population but of the presence of women and children amongst that population (Culhane et al., 2003; Macy-Hurley & Tull, 2009; Meadows-Oliver, 2003; Zugazaga, 2004). The economic recession has led to unprecedented levels of poverty and homelessness, including increases in the numbers of homeless families (U.S. Conference of Mayors, 2010, 2011; Witte, 2012). However, shelters are poorly equipped to serve families. There are few shelters where families can stay together. More often, men are separated from women and children, and boys as young as 11 may not be allowed to stay with female caregivers and younger siblings (Shelter Partnership, 2006; U.S. Conference of Mayors, 2006). The term “homeless family” is ironic when families are forced to split up to find shelter.

Domestic violence is often a precursor to homelessness among women with children (Meadows-Oliver, 2003; Roll et al., 1999; U.S. Conference of Mayors, 2008). However, even women with a spouse or partner usually seek shelter with only their children, or in many cases on their own. Indeed, the dichotomy between homeless women with children and unaccompanied homeless women is misleading and presents an

impediment to the provision of services because most women who enter shelters unaccompanied actually do have children (Barrow & Laborde, 2008; Shinn et al., 2001). Among women who move into shelters with their children, parenting is a challenge constrained by strict rules, lack of privacy, constant scrutiny, and their own psychological distress (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003).

Ironically, researchers have made tremendous strides in understanding the risk factors for homelessness but not in linking them to prevention and intervention programs (Zlotnick et al., 2010). From an alternative perspective, the emphasis on individual risk factors has clouded understanding of the fact that unemployment, poverty, and the lack of affordable housing are the main causes of poverty (U.S. Conference of Mayors, 2010, 2011). Consequently, the availability of low-income and subsidized housing is pivotal to preventing homelessness from occurring or recurring. A comprehensive approach is needed that tackles the problem of homelessness at multiple levels; from targeting services to address individual risk factors, to changing social and public policy to make affordable housing a reality for all individuals at risk for becoming homeless.

### **CHAPTER III**

### **METHODOLOGY**

This analysis was guided by Dunn's (2008) framework for evaluating policy. His framework includes reviewing documents, visiting sites, and determining how five criteria are met for the homeless shelters.

#### **Sample and Setting**

The total population of the following shelters and transitional housing projects in north central North Carolina was used for data collection. Shelters were identified from agency listings, websites and community information lists for an approximately 75 mile radius. Eight shelters were identified and managers recruited. The facilities provided emergency, short-term, and transitional housing for individuals and families who had lost their living accommodations for any number of reasons: refuge from domestic violence, eviction because of lack of rent or mortgage payment, crowded doubled up situations, release from a hospital or other institution, and referrals from another shelter.

Of the eight shelters contacted, all managers volunteered to participate. Three persons managed more than one shelter run by an organization; two managers had oversight of one shelter. The shelters were Code named Alpha 1 and 2, Beta 1 and 2, Gamma 1 and 2, Delta, and Epsilon. Most managers were females, blacks and whites were included. Age range was between 40–60 years of age.

### **Data Collection**

Data for shelter policy analysis was obtained from a number of sources including telephone, electronic media, and an author-developed questionnaire. The investigator visited each site by appointment. Managers were asked to complete a survey for each shelter, including both closed end and open end questions. Responses to the 25 item open and closed end questions were data. The questionnaire was developed the literature review and state and federal homeless shelter requirements and stipulations (U.S. Department of Housing and Urban Development, HUD.gov). The directors or managers were asked to complete this instrument which took between 10 and 15 minutes to complete. The author utilized the same instrument with each facility to maximize consistency in data collection quality and instrument control. The questionnaire data collection tool is in Appendix A.

The second type of data collection included shelter mission statements, resident rulebooks, lease agreements, and data mined from archived sources. Directors and managers of eight of the homeless shelters and transitional housing complexes in north central North Carolina were asked to provide, or otherwise make available, policy information about their respective facilities. Also, data was mined from documents prepared by and for a variety of local, state, and national agencies and entities involved in alleviating homelessness. Sources such as the United States Department of Housing and Urban Development, the United States Conference of Mayors, the National Coalition for the Homeless, the North Carolina Coalition to End Homelessness, and Healthy Carolinians were utilized.

Specific data reviewed included:

1. The mission statement of each shelter or transitional housing project with any associated information
2. Aggregated and nonaggregated data reports to funding and oversight agencies, committees, and organizations containing details of services offered and shelter population characteristics
3. Facility policies, rules and regulations governing the daily routines of the service population
4. Written and verbal criteria for admission and denial of service at each facility
5. Shelter capacities with characteristics and numbers of persons and families admitted and those turned away
6. Rationales associated with family nonadmittance

The final data sources were field notes taken during the manager discussion and tour of the shelter. Each manager interview, site visit, and shelter tour lasted approximately 2-4 hours.

### **Data Analysis**

This research study included subjective and objective qualitative and quantitative elements. The data derived from the written and interpretive rationales guiding the operation and policies of 8 homeless shelters and transitional housing units. These shelter policies have not been studied previously, thus exploratory and inductive qualitative approaches proved useful (Hage, 2006). Primarily descriptive compilation and basic content analyses were used. Research question one was answered using a synthesis of the

literature and reported in text format. Research question two was answered using data points for specific shelter policy and was reported using tabular and text format. Research question three was answered using literature and interpretation of data points from the 8 shelters. The data identified key issues relevant to familial integrity through the answers to proxy questions that investigated parental role function and family ability to remain together while seeking and receiving shelter from the 8 sheltering facilities.

### **Protection of Human Subjects**

The names and addresses of the shelters and housing projects as well as their directors and managers will be kept anonymous. Responses and information gathered will be presented in an aggregated fashion. The University of North Carolina at Greensboro's Institutional Review Board was consulted regarding status for the study and granted an exemption.

## CHAPTER IV

### RESULTS

This chapter presents the findings for the first two research questions asked in Chapter I. Data includes an overview of the characteristics and needs of homeless families in the United States and proceeds to a description of each sheltering facility sampled in this study. Last, results from the survey questionnaire completed by the total sample of shelter director/managers, information from each of the five resident handbooks, the stipulations included in the transitional housing lease agreements, the Mission statement for each facility, and archived data accessed about the facilities is presented.

#### Research Question 1

*What are the characteristics and needs of homeless families across the USA?*

Although one general description of the homeless family proves inadequate to capture many of the variations reported between groups across the country, homeless families do share a number of socio demographic features. All across the United States, the average homeless family typically emerges from the poorest and most disenfranchised group in that particular geographical area. In 2011, approximately half of all homeless people are members of families while approximately 52 percent of beds for homeless people (emergency shelter and transitional housing) were used by people in

families, and 48 percent of shelter beds were used by single homeless individuals (US Conference of Mayors, 2011).

### **Characteristics of Homeless Mothers**

The majority of homeless families in urban areas are comprised of a single young woman in her late 20s who is not with a husband or partner but has managed to hold onto her children. The women parent two to three children with nearly half of the children being under age six. Rural areas evidence slightly higher rates of two parent homeless households. Approximately half of all mothers who become homeless have a high school diploma and nearly one-third are employed with sporadic work histories. Most have no medical or dental insurance and often utilize hospital emergency departments for health care (National Center on Family Homelessness, 2010).

### **Health Issues**

Homeless mothers with children experience higher rates of upper respiratory illnesses, hypertension, and clinical depression. Over 90% of homeless mothers report having experienced physical and/or sexual assault during their lifetimes and two-thirds of these assaults were grievous and perpetrated by a husband, a boyfriend, or a family member (Bureau of Justice Statistics, 2006). In terms of racial designations, there is an over representation of families of color in the homeless population, nationwide and locally. Of all homeless families, approximately 43% are Black, 38% are White non-Hispanic, 15% are Hispanic, and 3% are Native American; fewer than 2% are Asian/Pacific Islanders. Assessing the homeless population in only the rural areas, however, entirely different numbers are seen. White females make up the largest

percentage of the rural homeless, where homeless single mothers outnumber homeless single men (National Coalition to End Homelessness, 2010). Nearly all parents report a history of unstable housing situations with multiple moves before entering a shelter. Most have lived with family, friends, and sometimes strangers. Holding steadfast to their children, they slept on couches and floors trying to stay indoors and housed. Many homeless parents have had childhood experiences of being homeless or having been in the foster care system, themselves.

### **Characteristics of Homeless Children**

Children experiencing homelessness are also beset with psychosocial and physical challenges that can be directly related to their tenuous, uncertain lifestyles and a lack of basic necessities. Studies indicate that they are ill at three to four times the rate of housed children (Hicks-Coolick et al., 2003). A history of having irregular mealtimes with high caloric, poor quality food often results in them becoming overweight, yet, they are hungry two times more frequently than children in stable housing. Their poor nutritional status also leads to their having two to four times the rates of ear and respiratory infections, five times more stomach and gastric problems, asthma, obesity, and breathing problems (Buckner, 2008).

### **Psychosocial Characteristics**

Homeless children have emotional and behavioral problems at three times the rate of housed children and double the rates of developmental delays and learning disabilities. In school and social settings the children often exhibit more hostile and aggressive

behavior than other children and nearly half of homeless children are observed to be anxious, depressed, and withdrawn (Buckner, 2008).

### **Needs of Homeless Families**

While families who become homeless do not fit one general description, there are certain basic needs that they do share. These include access to affordable and appropriate: housing, health care, health insurance, treatment for mental, emotional, or drug problems, protection from violence, childcare, education, job and skills training, healthy food sources, transportation, and recreational resources for parents and children. Finally, undergirding all of the needs associated with maintaining a lifestyle free from homeless episodes, is access to employment opportunities that pay a livable wage or, if unable to work, a stable adequate income from some source (National Coalition for the Homeless, 2009; Rog & Buckner, 2007).

### **Research Question 2**

*What are the standard policies of homeless shelters in north central North Carolina regarding families served?* Each shelter is described below.

#### **Alpha 1 and 2**

These two shelters were faith based facilities that provide housing services to the entire spectrum of homeless people and service need.

**Mission and goals.** The overall mission of the facility is to preach the gospel of Jesus Christ and to meet human needs in his name without discrimination. The goal is to provide emergency shelter and supportive services to homeless individuals and families

by identifying each reason for homelessness, target the problem, then stabilize the situation so that participants in the program can work towards self-sufficiency

**Physical description.** The shelters can house 76 single women & men, and have 64 beds for 20 families. Single men and women live dormitory style in rooms with 4 beds each. Families are housed in 2 room family suites. Meals are served in a community dining room. The laundry room, lounges, computer room, resource center, bathrooms, and television room are available for use by residents.

**Services provided.** Two hot meals and a bag lunch each day, Personal hygiene products, Life-skills training, Substance abuse education and counseling, Transportation assistance, Case Management, Self-help and therapeutic groups, Educational supportive services, Computer and Internet training, Access to computers for e-mail and job searches, immediate referrals for crisis intervention, Clothing vouchers and, Access to a telephone to make and receive calls.

**Service population.** Individuals and families. No unaccompanied persons under age 18 are served.

**Admission/Exclusion policies.** In order to be eligible for admission, applicants must have proof that they meet the Department of Housing and Urban Development's definition of homelessness. They must also have proper and valid identification; provide a personally written statement verifying their homeless status; be referred from a shelter or another agency; prove lack of funds and shelter after discharge from a hospital or a health related agency; show proof of eviction with the original eviction papers; if institutionalized for longer than 30 days and destitute, must bring proof of discharge. At

the intake interview, the applicant must have a current valid picture ID or a driver's license, a Social Security card for each household member, pay stubs and any proof of income such as child support or disability payments, and an eviction notice where applicable.

**Rules of residency.** All adults must be employed or seeking employment during weekdays with proof given to case manager at weekly meeting. Residents must be out of the facility between 9 am and 3 pm weekdays unless given official permission to do otherwise. All meetings deemed mandatory by case manager or director must be attended. No borrowing or lending of money or material items from staff or other residents is allowed.

Clothing worn by residents must meet staff approval or be changed. Private living areas must be kept clean at all times and no changes made to bed or furniture placement. Residents must pass daily room inspections. No food, drink, candy, or gum can be taken to residents' rooms or outside of the dining room. All medications not related to asthma must be kept locked in the Security office and no child can access their own medicines.

The Radio and television programs played in common areas must be suitable for children under age 13 and appropriate for family settings, as determined by the shelter director. Children must be supervised by parents at all times. Parents must know where their children are and what they are doing at all times.

All residents must be in the shelter by 10 pm each night unless employment is proven. Room curfew for children under age 14 is 8:30 pm, Sunday-Thursday, and 10 pm on Friday and Saturday; children over age 13 must be in their rooms by 10 pm, Sunday-

Thursday, and by 11 pm on Friday and Saturday. Adults are expected to be in their beds with cell phones, radios, television and lights off by 11 pm, Sunday-Thursday, and by midnight on Friday and Saturday. Residents must sign in and sign out when leaving the facility, provide their destination, and give an expected return time. Staff may ask for verification. Parents must be at the shelter to meet children after school. Any childcare arrangement made between residents must be accompanied by a child release form approved by the shelter director or face dismissal.

No personal relationships between staff and residents are allowed. No sexual contact is allowed between residents or between residents and staff. No overnight visitors are allowed (E. g., Noncustodial children, friends, siblings, etc.) No pets are allowed on the premises.

**Mandatory activities.** All residents must submit to a drug test upon program entry and randomly thereafter at any time a staff member requests. Parenting class, anger management, stress management, job readiness training, family enrichment, men's/women's support group, a weekly case management meeting, and resident's meeting are all required. Residents may not talk to or communicate with a resident that has been discharged.

**Length of stay.** Emergency shelter for individuals and families is followed by housing with intensive social support for up to 12 months. At the 90 day end of probation time, and residents have been deemed properly 'shelterized' by their case managers, that is, able to maintain themselves and their children with greater independence, cost supplemented transitional housing with intensive social support is available to them for

up to two years. Permanent housing with supportive case management is available for the disabled. The facility also provides contracted support services to parolees of the federal prison system as well as to U.S. veterans and their families.

### **Beta 1 and 2**

These shelters are operated by a large nonprofit organization that provides a wide variety of social services to a large population in north central North Carolina. Women with children and single women are housed.

**Mission.** Empower individuals and families to restore hope, restore stability and thrive through quality support services, advocacy, and education. The mission is realized by providing accessible, affordable, high quality counseling to families and individuals, victim services, prevention services, and community education.

**Physical description.** Home-like settings that can house up to 27 women and children each. Each house has 5 to 6 family living spaces. Each family has a private room; the kitchen, bathrooms, living room, and laundry room are shared. There are playgrounds and activity areas for all.

**Services provided.** Both shelters provide an initial box of emergency food, and personal supplies to each individual household. Clothing, diapers, and other necessities are also available. Therapy groups, case management, children's play therapy groups, parenting classes, social service referrals, legal advice, court representation, job search and job readiness classes. Finally, assistance with applications for food stamps, housing, and childcare.

**Service population.** Single women and women with children who are escaping domestic violence. Single male victims are counseled and placed in hotels or boarding. Former residents can return to the shelter as many times as needed or for family or group counseling.

**Admission/Exclusion policies.** Persons are admitted by calling the telephone crisis line and being placed on a waiting list. Single women and women with children are admitted. Male children up through age 17 are housed; Female children of any age can accompany parent. Male victims of domestic violence are assisted to a motel or boarding house accommodation, paid for by this facility.

**Rules of residency.** Each woman is required to meet weekly with their case manager/therapist and set goals for meeting her needs and improving her situation. Each parent is responsible for feeding her own family. All single women must be in the facility by 9 pm, and all mothers with children must be in the facility by 8 pm. Children must be supervised by their mothers at all times. All shelter residents must participate in cleaning workdays. No pets are allowed on the premises.

**Length of stay.** Since the year 2011, the average stay has increased from 3 months to 6 or 7 months.

### **Gamma 1 and 2**

This nonprofit facility was founded by a community organization and serves Homeless families in which one applicant adult is employed at least 20 hours per week.

**Mission.** To help working low-income and chronically homeless individuals and families who are ready to help themselves achieve their full potential for functional,

social, and economic self-reliance through the design and application of cost-effective individualized “Client Success Plans”.

**Physical description.** Altogether the two sites have 17 two and three bedroom apartments. Each unit has a refrigerator, a stove, an air conditioner, and a heating unit. A recreational area for children is attached.

**Services provided.** Financial and credit counseling; Education, employment and training referrals, Case management.

**Service population.** Homeless families with low income and at least one parent working 20 hours a week and in need of emergency or transitional housing.

**Admission/Exclusion policies.** A parent must meet the level of income set by the federal government for program entry. Family must reside in the county where service is received. Applicant must be able to provide photo identification, a Social Security card, a paystub or some other proof of income. Be willing to participate in a structured program with case management. Agree to follow an established budget and case plan.

**Rules of residency.** Residents must meet twice a month with their case manager/counselor. Maintain employment of at least 20 hours per week. Pay rent when due. Have no more than five persons per household. Housing and employment must be sought on a daily basis. Alcohol, weapons, and nonprescribed drugs are not allowed. No visitor can be left alone in an apartment at any time. An adult must be present in the apartment at all times when children are under the age of twelve. Parents are held responsible for their children’s behavior. Children may not run in the apartments or play

on staircases at any time. Parents must be with children under the age of five in the play areas. No pets are allowed on the property.

Residents may be assigned household chores. Apartment temperature may not be adjusted by residents. Daily apartment inspections are conducted. All residents have an 11 pm curfew. Any absence of over 3 days from the facility by a resident must have prior arrangement with the case manager or the shelter director. Residents may not increase the security of their apartments in any way. Door locks or keys cannot be added, changed, or removed on apartment doors. All visitors must leave by 11 pm. No overnight visitors are allowed. No business can be conducted in the apartments.

**Length of stay.** Residents can remain in emergency housing for up to 90 days and in transitional housing for up to two years.

### **Delta**

This facility was developed by a faith based collaborative to serve the needs of homeless families.

**Mission.** To express the love of God to people in need through practical action in the area by offering emergency financial assistance, food assistance, emergency and transitional shelter, and rapid re-housing.

**Physical description.** The facility is a large one story brick building with front parking and a rear play area for children. Sixteen families can be accommodated in the program. Each family has an individual, efficiency apartment –type room with private bathroom, kitchenette, and a dining table. This room can hold a maximum of two bunk bed structures, a crib, and a double bed. Maximum family size allowed is 7 people if one

child is in a crib. The facility has a congregate dining room and kitchen where residents are allowed to eat and prepare meals. Meals are often brought in and served to all residents by a community or church group.

**Services provided.** Case management. Residents are assisted to find more permanent housing, education and training programs, employment opportunities, and childcare. Sporadic skills training, academic tutoring, and parenting workshops are offered on site. Access to a telephone and a computer with internet. Personal items such as: cooking and eating utensils, bed and bath linens, toothbrush, toothpaste, baby bottles, diapers, deodorant, school supplies, toilet and toileting items, shampoo, lotion, food items, kitchen and laundry detergent are among the provisions given to residents free of charge.

**Service population.** Homeless parents/guardians with children. Referrals from shelters, maternity hospital postpartum discharges onto the street, and Walk-ins are put onto the waiting list.

**Admission/Exclusion policies.** Applications are taken from the waiting list. The applicant must be a resident of the county geographic area and have custody of the child/ren they bring to the facility. The parent must have some source of income such as child support, alimony, or employment. No marriage certificate is required for parenting couples to be housed as a family. No unaccompanied teens are accepted.

**Rules of residency.** Residents must meet with a case manager biweekly. There is no fee for staying at the facility. Visits from nonresidents are allowed between 2 pm and 5 pm, only. Visitation is allowed outside the building or in the waiting area at the

entrance to the building. Any visitor under age 18 must be accompanied by an adult. No visitor is allowed in the building or the building's parking lot after 5 pm. Residents and children are not allowed in other residents' rooms. Children must be supervised by their parent at all times. Residents are not allowed to watch another resident's child unless a formal babysitting agreement has been approved by the shelter director. Only another residents is allowed to babysit on-site during weekdays between the hours of 8 am and 5 pm, and then, only for the children of one other resident. Children cannot run or ride toys in the building. Children cannot operate the washers and dryers and must be accompanied by parents when in the laundry room. Physical punishment is not allowed at the facility. Children who are at home during school hours must stay in their room during those hours and the office notified.

Loans of money or personal items are not allowed between residents. Rooms are inspected daily. Pets are not allowed on the premises. All residents must be in their rooms by 10 pm. Curfew exceptions are arranged in advance with the director for jobs and emergencies. Otherwise, no one is allowed entry to the building between 10 pm and 7 am. All children, including infants and toddlers, must be in their rooms by 9 pm. Only staff can admit nonresidents into the facility.

**Length of stay.** Residents are allowed to stay for 90 days or until more permanent housing is found. In some exceptional situations, a number of additional months have been given.

**Epsilon**

This facility was developed by a coalition of faith based organizations to serve homeless individuals and families unable to afford market rate housing.

**Mission.** To provide transitional housing to individuals while giving them an opportunity to work towards self-sufficiency. The ultimate goal is for the individual to be independent and to qualify for conventional housing.

**Physical description.** A community complex of two story apartment buildings and a one story administration building that contains a classroom and rooms for computer use, tutoring, and general activities. Separate buildings contain 32 studio apartments for single people; 12 two bedroom units, and 24 three bedroom units for families.

**Services provided.** Case management. Free tutoring service for adults and children. Access to computers. Workshops and job training classes. An organized athletic program for children and teens that operates throughout the year.

**Service population.** Homeless persons seeking to become independent and qualify for conventional housing. In the family units, an adult child housed with a parent, must also fill out a screening background application.

**Admission/Exclusion policies.** Applicant parents must be adults age 18 and above and have custody of all children accompanying them into shelter. Agree to a background check, rental history, and a criminal history. Every applicant must have a resume on file before being housed. A parent must be employed and have income sufficient to pay rent and utilities for the apartment; that income must not exceed current Tax Credit Income Limits. Applicants must have a negative drug test and be willing to

sign a six month lease. Each applicant must be eligible for the HUD Homeless Program. Each individual must maintain gainful employment or be involved in training or education that will lead to a higher income.

**Rules of residency.** Each month residents must meet with their case manager and bring their bank statement and check stub. Residents must consent to unannounced, random drug and alcohol screening. No smoking is allowed in the apartments and no alcohol is allowed within the apartment community. Residents must attend mandatory monthly life skills training. Monthly apartment inspections are conducted. Each resident must contribute monthly to a personal savings account with an amount predetermined by the resident and their case manager.

**Length of stay.** Residents can stay for at least two years. There is the possibility of long extensions if no permanent housing has been found and the families are deemed to be good tenants and pay their rents on time.

### **All Shelters**

Table 1 provides details across the shelters in terms of numbers of beds (26–260), number of families allowable (11–36), length of stay allowable (one month to 12 months), rent charge (free or not), maximum age of children allowed with parents (17) and services provided. All facilities had eligibility requirements of living within the area surrounding the service delivery site, official identification papers for each adult and members of a family to be considered for admission review, and proof of homelessness. Employment or stable income was a requirement at three of eight facilities.

Table 1

Shelter Characteristics and Policies

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Capacity of the facility: a. Total b. Families with Children	a. 180 b. 20	a. 26 b. 11	a. 80 b. 16	a. 125 b. 16	a. 260 b. 36
How does this facility define <i>family</i> ?	At least 1 individual over age 18 with a child. The adult must have official custody. If a 2 parent household, a marriage license is required.	At least 1 individual over age 18 with a child. The adult must have official custody. If a 2 parent household, no marriage license is required.	A family is at least 1 adult with a child. The adult must have official custody. If a 2 parent household, no marriage license is required.	A family is at least 1 adult with a child. The adult must have official custody. If a 2 parent household, no marriage license is required.	At least 1 individual over age 18 with a child. The adult must have official custody. If a 2 parent household, no marriage license is required.
Current # Families	88	8	7	13	34
# families denied/week	@10	1-5	3-4	6-10	@10
How long can residents stay in this shelter?	From 1 – 12 months	For 6 months, then up to 2 years	For 60 days, then up to 2 years	For 90 days, then extensions can be granted until long term home is found.	Start with a 6 month lease. Renewals for up to 2 years. Indefinitely as a renter.

Table 1. (Cont.)

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Is there a cost or fee charged to use this facility?	No for 90 days. Then, Yes when an income has been started	No	Yes. Rent is charged.	No	Yes. Rent is charged.
# individuals denied stay this month	Unsure	Unsure	Unsure	Unsure	Unsure
Change in denials from last month	An increase Guesstimate	No change. Guesstimate	No change Guesstimate	Unsure	No change Guesstimate
# Families applying to stay this month	@10/week	1-5/week	3-4/week	@10/week	@10/week
# Families on waiting list	120	2	@100	46	10
Primary reason for denial of family:	Insufficient space in the facility. Not enough beds	Insufficient space in the facility.	Family deemed unsuitable for this facility.	Insufficient space in the facility.	Insufficient space in the facility.
Shelter is available to:	Individual male & female adults. 1 & 2 parent adult families. Emancipated & homeless teens are not served	Individual adult females & female-headed families with sons under age 18 & daughters of all ages	1 & 2 parent families with any age or gender of children.	1 & 2 parent families with any age or gender of children.	Individual adult males and females. 1 & two- parent families with any age or gender of children.

Table 1. (Cont.)

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Shelter provides:	Two hot and one cold meal/day. Some personal items. Case Management, Social service & employment referrals, Training & educ. workshops, Religious studies, Parenting classes, Laundry room, cleaning supplies	Limited supply of emergency food and personal items. Resident prepares own meals for family. Case management, Therapeutic Support, Social service referrals, Training & educ. workshops, Laundry room & supplies	Small amount of emergency food and personal items. Case management, Social service referrals, Training & education workshops, Money management classes	Uncooked food and personal items. Case management, Social service referrals, Training & education workshops, Computer use, Children's library, Laundry room & supplies	Case management, Social service referrals, Training & education workshops, Children centered activities, Tutoring, Computer room, Laundry room
Mandatory activities List all:	Case management mtgs. Must attend all Educational Training, Employment & informational programs to which referred by staff and Case manager. Narc anon if history of addiction.	Case management meetings. Therapeutic support mtgs.	Case management meetings. One parent must be employed 20hrs/week	Case management meetings.	Case management meetings. Life skills workshops. Narcotics Anon meetings if history of drug use
Maximum age for boys with parent/s	17	17	None	17. No max if son is a student	None

Table 1. (Cont.)

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Maximum age for girls with parent/s	17	None	None	None	None
# of members in a single family allowed	6	Dependent on age & sex of children	Five per apartment	Seven usually.	7 in 3bdrm apt 5 in 2bdrm apt If with 1 adult.
# of <i>children</i> allowed per family	4-5	5-6 if using a crib. Dependent on age and sex of children.	4	6 (5 plus infant in a crib)	6 in 3 bedroom apartment 4 in 2 bedroom apartment If with 1 adult.
Is there a lights out/ bedtime for adults?	Yes	No	No	No	No
Is there a lights out /bedtime for children?	Yes	Yes	No	Yes. Flexible	No
Is there a mandatory time for residents to be in their personal space?	Yes	No	No.	Yes. 10pm for adults/ 9pm for children	No for adults/ 8pm for teens on weekdays/ 10pm for teens on weekends

Table 1. (Cont.)

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Is there a night time curfew for residents to be in the shelter?	Yes	Yes. 8pm mothers 9pm single women	Yes 11pm if in Emergency housing. No, if in transitional Housing	Yes. 10pm A later time can be requested for job or crisis.	No
For children?	Yes	Yes	Yes	Yes	No
Do residents have a mandatory exit time each day?	Yes. Mon-Fri. residents must be out of the shelter from 9am until 3pm	No	No	No	No
Are residents allowed to visit with family or friends on-site?	No	No usually. Exceptions given	Yes. Limited	Limited times & only in waiting room or outside building	Yes. Limited
Are residents allowed to have <i>nonresidents</i> in their rooms or apartments?	No	No	Yes	No	Yes
May fellow residents visit in one another's rooms apartments?	No	No	Yes	No. Yes, if a fellow resident has contracted to babysit during weekdays only	Yes

Table 1. (Cont.)

Characteristics and Policies	Alpha 1 and 2	Beta 1 and 2	Gamma 1 and 2	Delta	Epsilon
Can shelter staff discipline resident children without consulting a parent?	Verbal redirection only				
Are there rules governing parental discipline of children?	Yes. No corporal punishment is allowed				
Are pets allowed?	No	No	No	No	No
Residents participate in determining rules, regulations, and consequences?	No	No	No	No	No

One surprising finding was that most of the facilities did not allow rearrangement of furniture, even if children or families would be better served. In addition, residents cannot participate in rule establishment and policy making at any facility. Some facilities may have a resident or homeless person on state or regional committees or on local homeless coalitions. All facilities have a process for resident grievance resolution. All residents are asked to obey staff instructions with little or no questioning at six out of eight facilities. No shelter manager tracks admission requests that are denied and none had a system or requirement to track denied phone or in person requests.

These findings reflect federal, state and local guidelines. Federal regulations provide definitions of homeless for specific groups, and recordkeeping requirements for services provided, persons served and financial expenditures. In addition, verification of veteran or disability status is mandated. The shelter itself must provide protection against domestic violence. State and local stipulations determine guest and visiting hours, sleep time, eating time, identification required to reenter the facility each day, and local health department and fire codes. In addition, safe water, heating, food facilities, the number and type of restroom facilities are often locally mandated.

### **Research Question 3**

*What are the ways in which existing shelter policies impact homeless family integrity?*

Living arrangements were specified by the facilities. One facility with two sites required a marriage certificate be shown for any parenting couple wishing to reside together. All other facilities, except those for domestic violence, allowed couples entry

and cohabitation without formal proof of marriage. Resident to staff, or resident to resident personal relationships with physical contact was not permitted at any sites.

Mandatory requirements by all facilities included a) parents work with a case manager with whom they developed plans for education, employment, lifestyle enhancements, and permanent housing, b) performance of daily, weekly, or monthly inspections of rooms and apartments for cleanliness and overall care, and c) parents to be in progress towards the goals developed with their case manager. Drug and alcohol testing was required prior to entry as well as unscheduled random tests throughout residency, except for the domestic violence shelters. Six of eight sites required resident participation in periodic clean up days.

Curfews were common among the shelters. All facilities have a designated time for residents to return to the housing site. Two facilities, covering three sites, have bedtime curfews for children, two sites have a lights out bedtime curfew for parents, as well. No visitors are allowed after a designated time in all facilities. One facility requires residents in both their shelters to leave during certain hours of the day.

Parenting Rules were implemented across the shelters with both specific and general guides. All facilities require resident to have official custody of all children they have in residence. Parents must have supervised children at all times in all facilities. No physical punishment of children was allowed at any shelter. Resident could not have an outside relative babysit their child (children) inside seven of eight facilities. Residents must have a written contract with another resident for babysitting if it is conducted on site

at 3 of 8 shelters. If care is provided on site, the contract must be approved by the shelter manager.

Visitors and Guests have an exit time at each facility. Guests must remain outside resident living space in 7 of 8 facilities. Exceptions do not apply to children, parents, and other relatives of the resident. No pets are allowed in any of the sheltering facilities.

## **CHAPTER V**

### **RECOMMENDATIONS**

The study utilized Dunn's applied policy analysis model. Eight shelters managed by five managers composed the sample. Interviews, questionnaires and written reports were used for data sources. The recommendations for policy changes utilized Dunn's criteria for evaluating policy performance and are discussed below. Lastly, recommendations for policy changes are discussed.

#### **Research Question 4**

*What changes to homeless shelter policies are recommended that will promote the integrity of homeless families?*

Family integrity is defined in this study as the ability of a family to remain together as a unit. While this physical definition holds external structure as the primary concept undergirding family integrity, a functional dimension of family integrity emerges from the research as well. The ability of the parent to maintain a position of competent family leader in the eyes of their children relates to the internal integrity of the family. Several issues reflect the challenges to homeless family integrity found in the answers to previous research questions. For each challenge, policy recommendations are discussed and identified as pertaining to Dunn's criteria of effectiveness, efficiency, adequacy, equity, responsiveness or appropriateness.

### **Challenge of Identification**

The required presentation of official documents by homeless families to validate their identities and make them eligible to receive services often act as barriers to needed shelter. Important documents such as original social security cards, child custody papers, birth certificates, and driver's licenses are often lost and stolen due to the frequent household moves for which female headed homeless families are noted. In addition, frantic escapes from violent partners, the confiscation and destruction of property by unpaid apartment managers and storage companies, or losses caused by the police destruction of homeless encampments can cause many months of effort to regain these important items.

The policy recommendations pertain to the Dunn's equity and efficiency criteria. Shelter headquarters should develop a relationship with the major agencies that provide important identification data such as the Social Security office, Department of Motor Vehicles, and the Department of Health and Human Services. Intake staff at the local shelters can have access codes to contact an established agency contact who can verify or validate information given by the applicant. Another option is to teach intake staff to make use of the Homeless Management Information System (HMIS) to retrieve and input information that is definitive enough to allow applicants to be nearly paperless. This would allow time for the shelter applicant to get new documents while being sheltered.

Each adult in two parent households as well as children over age eighteen with parents in transitional housing are screened separately for credit, housing, and criminal histories. A negative report on either parent or an adult child can cause the family to be

denied housing. Allowing the head of household to be the primary credit reporter may decrease denial of family admissions to shelters.

Homeless families should not be held to a higher standard than those who are housed. On a case by case basis, one responsible parent in a homeless family could be assessed for their likelihood of moving the family along a trajectory leading to a permanently housed position. Rather than deny shelter to the family without further consideration, the negative history of the family member should be viewed for its current potential for danger. If none is seen to exist, the applicant should be assessed and given the opportunity to be singly screened as family representative and support services focused on helping the family move towards greater viability.

Recognizing the difficult financial position of the middle class at this time in history should warrant another look at providing assistance to the very low income parent. With an unemployment rate in double digits, and an incarceration rate the highest in the world, applicants with an intimate family member having a criminal record and very little money is almost the norm in many very low income communities.

### **Challenge of Family Definition and Membership**

A family that includes an extended family member who is a minor, and for whom the applicant adult does not have custodial papers, cannot be housed together as part of the family at any of the facilities. Marriage definitions and traditional family constellations are not the same as when most of the federal and state guidelines for shelters were developed, thus may not reflect today's environment and societal preferences.

Sample recommendations reflect Dunn's equitable and responsive criteria. If shelter intake staff can determine the history of the dependent's relationship with the applicant, an emergency guardian ad litem status could be sought for the resident acting as parent. A cultural norm in Black and Mexican cultures is the informal adoption or close association of individuals as though blood kin. The *play sister*, *play daughter*, *play* . . . appellations are typically informal in the legal sense but no less real in the social and functional sense. Often, no distinctions are made between these relatives and actual blood or marriage-related family. Policies that address cultural appropriateness and equity would allow ethnic, racial, geographic location and lifestyle considerations when determining family constellation, ties and supportive functions at a local or state level rather than only national levels and guidelines.

### **Challenges to Parental Role Function**

The requirement that residents be out of the facility during the day unless given special permission to do otherwise is policy in two shelters but some 20 families are impacted. The rationale that all residents must get out and seek employment every day is problematic in this time of few jobs. How does a mother negotiate looking for a job with one or two children in tow? Parents who are seeking employment may not have suitable or responsible trustworthy adult to supervise their children when out of the shelter, as required by noted policies across shelters.

In most facilities, parents are not allowed to change children's bedtimes or other shelter determined rules for children. If a special event or occasion prompts a child to request a later bedtime, it would be against shelter rules for the parent to grant the

request. In addition, children must be supervised by their parents at all times. In a number of shelters, all meetings deemed mandatory by the case manager or director must be attended. Most of the workshops and classes are prescheduled on the shelter's calendar and not according to family function or parental need for child homework, sickness or school activities, as found by Gengler (2011).

The recommendations pertain to Dunn's responsiveness and appropriateness criteria. Stop the policy of having the residents leave the shelter every day. Allow a 3-5 day residence period. Develop an onsite job search center that takes full advantage of the internet and drop in employers. Maintain an updated list of skills attained by all residents. Skills that can be used short term or long term can be catalogued with the center and residents with those skills are easily accessed if there are requests made for that skill. Elder companions, childcare assistants, and painter's assistant are examples of skills that can be earned in a short amount of time.

Allow parents flexibility in the decisions that affect their children's lives. It would require extreme resolve to maintain the position as head of the family and caretaker with so little power over one's child or one's own circumstance (Gengler, 2011). Establish a range of time periods to allow meals, bedtimes and visiting hours to provide more family like atmosphere and more autonomous decision making. Mandatory workshops and meetings should be made with consideration for the residents' schedules first, rather than primary a shelter schedule. Make use of technology, so viewing videotapes or online computer programs can be used in lieu of onsite attendance. As 30% of homeless mothers are employed at minimum wage jobs, a stressful choice is forced between risk of job loss

for asking to attend meetings and loss of housing or child rearing because of meeting nonattendance.

Visiting hours that are conducive to positive role models for children, support of parents, especially single mothers, and work or school engagements would be important to establish. Inclusiveness of local homeless, school principals, employment agencies and church groups. Shelters may recruit church groups or service learning students from local colleges to provide shelter staffing to avoid financial strain for shelters.

These changes may necessitate legislative revision to the McKinney-Vento Homeless Assistance Act, such as those provided by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (Public Law 111-22). Current political climate may lessen the opportunities to revise McKinney-Vento and economic difficulties may lessen the possibility of increase for allocations. Also, state and local revisions and flexibility are needed.

### **Summary**

The nursing profession has long recognized the value of contextual detail when assessing and planning for the wellness needs of individuals, families, and communities. In this study, the policies used by shelters for help seeking homeless families provided that socioeconomic contextual detail. Homeless shelters provide an unequalled and valid service to individuals and families bereft of most things material while at the same time beset by challenges that are physical, emotional, and spiritual. The ways in which shelter policies impact homeless families were found to have at least two dimensions. The protective intent of some policies, such as those that limit contact with nonresidents by

disallowing or narrowly proscribing visitors to prevent undue incursions on the resident's privacy, often fail to outweigh the negative impact of these same policies. In this case, diminishing resident contact with family and friends often causes a decrease in available social and emotional support. This can leave residents feeling isolated, depressed, and ultravulnerable.

The conceptual framework, anchored by a Dunn-constructed technique, provided criteria for formulating recommendations and policies which are posited as a crucial first step in planning solutions. Sample policies were recommended to improve or attain adequacy, appropriateness, effectiveness, efficiency, equitableness, and responsiveness to the needs and circumstances of homeless families.

A number of recommended policy changes, especially those related to the flexibility of eligibility requirements for program enrollment, are politically sensitive at this juncture in current national and North Carolina politics. The issue of undocumented immigrants being able to receive social services and other support is likely to provoke the placing of constraints on sheltering facilities that receive state and federal dollars to prevent such gestures. The economic climate has decreased funding at all levels for homeless shelters and families, both material and financial. Collaborations with community social, civic and church groups may provide an important resource for equity, appropriateness, efficiency and responsiveness of shelters to homeless family needs. Regulation, allocation and policy changes provide for those criteria as well as adequacy and effectiveness that shelters may provide a healthy and supportive short term solution for homeless families.

Future research is needed to determine the acceptability of policies at federal and state levels. One area of research is investigation into the quality of the mandated case management services being received by all residents in all shelters. In addition, where a proper system is not in place, it will be important to determine appropriate and acceptable benchmarks and goals for individual residents to reach that indicate successful movement towards permanent housing. Importantly, it is incumbent upon cities and states to evaluate if adequate number and type of housing is available or not for homeless persons. With increased economic problems, increased business layoffs and bankruptcies, many areas have housing shortages. As previously stated, the state of North Carolina has experienced a 37% increase in homeless families in the past 5 years. It is unclear if adequate and available housing is available for those homeless persons.

Last, a better collaboration of assets across the health and human service network can decrease redundancy and waste of meager resources while demonstrating to charitable donors and to the community-at-large the advantage of fiscally sensitive cooperative ventures.

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**APPENDIX A**  
**DATA COLLECTION INSTRUMENT**

**Survey Questionnaire**

Capacity of facility:\_\_\_\_\_ #Adults\_\_\_\_\_ #Children\_\_\_\_\_ #Families\_\_\_\_\_

Current # of Residents:\_\_\_\_\_ #Adults\_\_\_\_\_ #Children\_\_\_\_\_ #Families\_\_\_\_\_

Length of stay permitted at this facility\_\_\_\_\_

01. Have any applicants been denied service this year? Yes\_\_ No\_\_

02. Was this an increase since last year? Yes\_\_\_ No\_\_\_

03. Approximately how many individuals were turned away? per week\_\_per month\_\_\_\_\_

04. Were any families turned away? Yes\_\_ No\_\_

05. What is the usual or typical reason that a family gets turned away?

- a) Not enough space\_\_\_\_\_
- b) Not enough available beds\_\_\_\_\_
- c) No beds\_\_\_\_\_
- d) Gender of applicants \_\_\_\_\_
- e) Age of one of the family members\_\_\_\_\_
- f) The behavior of the parent/s \_\_\_\_\_ of the children\_\_\_\_
- g) Parental problem/Diagnosis\_\_\_\_\_
- h) Not enough time since last shelter entry\_\_\_\_\_
- i) No valid identification\_\_\_\_\_
- j) Not enough staff to supervise\_\_\_\_\_

06. Is shelter available to:

- a) Single adult men
- b) Single adult females
- c) Mother and child/ren
- d) Father and child/ren
- e) Teen: Boys\_\_\_ Teen: Girls\_\_\_

- f) Father and Mother with child/ren
- g) Other\_\_\_\_\_

07. This shelter provides:

- a) Meals\_\_\_\_\_ Food\_\_\_\_\_
- b) Social services such as case management
- c) Referrals for housing, employment and other services
- d) Education and training programs
- e) Parenting classes
- f) Other \_\_\_\_\_

08. Is participation in **any** of the above activities mandatory? Yes\_\_\_ No\_\_\_

09. Which of the above activities are mandatory? \_\_\_\_\_

10. Which of the above activities **are not** mandatory?\_\_\_\_\_

11. Do you provide shelter services to unaccompanied children or teens? Yes\_\_\_ No\_\_\_

12. Do you provide shelter services to single men? Yes\_\_\_ No\_\_\_  
 Do you provide shelter services to single women? Yes\_\_\_ No\_\_\_

13. Do you provide shelter services to homeless families? Yes\_\_\_ No\_\_\_

14. How many people in a single family can you accommodate? \_\_\_\_\_

15. Is there a limit to the number of children that you can accept into the shelter with each family? Yes\_\_\_ No\_\_\_

16. What is the maximum number of children that can be accepted per family? \_\_\_\_\_  
 Girls\_\_\_ Boys\_\_\_

17. Do you have an **age limit** for male children in families? Yes\_\_\_ No\_\_\_  
 Is there an **age limit** for female children in families? Yes\_\_\_ No\_\_\_

18. What is the maximum age for children accompanying their parent/s?  
 a) Girls\_\_\_\_\_ b) Boys\_\_\_\_\_

19. Does this shelter accept dependents of all types? Yes\_\_\_ No\_\_\_

20. Do your residents have a nighttime curfew? Yes\_\_ No\_\_

21. Do your residents have a time to exit the shelter each day?

Monday through Friday Yes\_\_ No\_\_

Weekends Yes\_\_ No\_\_

22. Do children have a specified bedtime or lights-out time? Yes\_\_ No\_\_

Do Adults? Yes\_\_ No\_\_

23. Can the facility staff chastise or punish a child without **first** consulting with the parent? Yes\_\_ No\_\_

24. Do residents have a vote (or a voice) in deciding the rules, regulations, and consequences at this facility? Yes\_\_ No\_\_

25. Is there a cost for staying at this shelter? Yes\_\_ No\_\_ How much?\_\_\_\_\_

When does it have to be paid?\_\_\_\_\_ Briefly describe who pays & how do they pay?\_\_\_\_\_.

Additional Comments: