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A Policy Agenda for Addressing Homelessness

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Homelessness in the United States after World War II was primarily a problem of adult men, and initial attempts to address the problem were generally aimed at getting these men treatment for alcohol abuse and mental illness (Bahr, 1973). In the modern era of homelessness, however, the housing-displaced population also includes sober men and single women, families with children, and unaccompanied youth, necessitating distinct policies and programs to meet the needs of each group (National Center on Family Homelessness [NCFH], 2009). Before making policy decisions, however, it is imperative that we develop a better understanding of homelessness and what we know about how to address it. This article provides a foundation for researchers, policymakers, and educators by reviewing existing literature regarding policy strategies commonly enacted to address individual and family homelessness. It also identifies those practices believed to be most effective in helping people get and stay housed. After providing some introductory definitional and demographic information, we describe the methodology that guided our review. We then describe the main tenets of homeless policy in the United States as it applies to homeless individuals, and also to homeless families. These solutions tend to fall into one of three categories: attacking poverty, increasing the stock of housing, and providing social services.

The law provides guidance in establishing what it means to be homeless. Until very recently, the U.S. Department of Housing and Urban Development (HUD) defined as homeless “an individual who lacks a fixed, regular, and adequate nighttime residence” who resides in “supervised publicly or privately operated shelter designed to provide temporary living accommodations” (HUD, 2010) or “a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings” (HUD, 2010). The Department of Education’s definition, as expressed in the McKinney-Vento Homeless Assistance Act, is broader, including HUD’s definition plus “children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason... abandoned in hospitals; or awaiting foster care placement” (U.S. Department of Education, 2004, p. 2). The primary distinction between the two is its consideration of those who have no home but live with friends or other family members, called “doubled up” – they have always been homeless according to the Department of Education, but were not by the previous HUD definition. In May 2009, President Obama signed into law a bill known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, which includes individuals and families who are doubled-up in the HUD definition (NAEH, 2009). However, this broadening of the legal definition is not yet reflected in most published research on the numbers of homeless people.

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Those formerly differing definitions make arriving at accurate counts of the homeless challenging; estimates of how many people are homeless have differed both for departments of the government and advocacy agencies. At the turn of the 21st century, the U.S. Census Bureau reported that there were in the neighborhood of 230,000 homeless: 178,638 sheltered individuals and another 50,000 persons on the street (Rollinson & Pardeck, 2006, p. 9). But citing an earlier study by the U.S. Census bureau, Burt (2001) found that there were four times that number: “on any given day, at least 800,000 people are homeless in the United States, including about 200,000 children in homeless families” (p. 1). In 2004, the National Law Center on Homelessness and Poverty (NLCHP) found that about 840,000 persons were “literally homeless—on the street or in temporary housing—on any given day across the United States” (2004, p. i). On a single night in January 2008, HUD (2009), counted 664,414 sheltered and street homeless persons (p. 8).

In addition to the magnitude of the homeless population, we need to understand its demographics. Based on a survey sponsored by the federal government, NLCHP (2004) suggests that single men now comprise 41 percent of the homeless population, families with children 40 percent, single women 14 percent, and unaccompanied minors 5 percent (p. 8). Analysts find that homeless persons in shelters and on the streets are younger than they were in the past (Shlay & Rossi, 1992; Shane, 1996), with 65 percent of the homeless in their late 20s to mid 30s (Ropers, 1988, p. 38). And while there have always been persons of color in shelters and on the streets, today they represent a much more significant segment of the homeless population (Roth, Toomey, & First, 1992; Toro, 1998). African Americans, in particular, are overrepresented—comprising 40 percent of the homeless population while making up only 11 percent of the general population (Rollinson & Pardeck, 2006, p. 11).

Counter to prevailing stereotypes, researchers document that some of the homeless population have regular jobs, earnings, and education. Data from the turn of the 21st century show that lawfully employed persons comprised a quarter or more of the homeless population (Scolaro & Esbach, 2002). Newer reports suggest that employment among the homeless may be around 45 percent (Gargiulo, 2006, p. 358). However, the majority of the homeless are unemployed, many chronically so, and most of the individuals who do have jobs are underemployed or work on the bottom rungs of the labor market ladder. Studies that investigate the education backgrounds of the homeless conclude that more than half of the population has a high school degree (Gargiulo, 2006; Roth et al., 1992). Up to a third more have some education beyond high school (Ropers, 1988).

Methods

We employed the following strategy for collecting material (Goetz & LeCompte, 1984). We ran searches using ERIC FirstSearch, ProQuest, and Google Scholar. We began by bracketing “homeless education” and branched out to include “homeless policy,” “history of homelessness,” and “unaccompanied youth.” We uncovered books and articles in the form of literature reviews, empirical work, theoretical work, and advocacy pieces. As we read, we added cited pieces of interest not already in our database, accumulating nearly everything of substance written about homeless children and their educational experiences, as well as a wide sampling of articles on homelessness writ large.

We followed a multi-step process to unpack and make sense of the literature.

1. After an initial period of reading, we developed a comprehensive model of homelessness, one that incorporates all the central elements and ideas in the homelessness literature, beginning with the causes and continuing through impacts and efforts to ameliorate and/or prevent homelessness. This model became our framework for cataloging and coding data (Patton, 2002.)
2. We labeled each element of our model.
3. We read each piece in our database in the same manner one would read a transcribed interview (Patton, 2002; Silverman, 1998). We coded each data point of text based on the labels on our comprehensive model (Merriam, 1998). We coded to the smallest unit possible, generally a sentence but occasionally a phrase. The paragraph was almost always the largest unit coded. Many pages of text had multiple codes.
4. We re-copied every now-coded article and book in the database.
5. We lifted each coded piece of text and placed it on a separate sheet, with accompanying information about its origin. At this point, we had about 10,000 individual slices of text, now decoupled from the articles and books.
6. We then grouped all the information by codes.
7. Then we reread all of the codes, generally multiple times, to form conceptually coherent elements (Glaser, 1978; Strauss, 1987). For example, through this work we uncovered the three differing types of approaches to homelessness: addressing poverty (1D1), increasing housing (1D2), and providing social services (1D3). We now had “1D1” – “addressing poverty to ameliorate homelessness” with conceptual categories 1D1a and 1D1b -- “public assistance” and “employment opportunities.” Data (text information) was then regrouped to the smallest unit possible in an interactive fashion.
8. Across all our work, we memoed ourselves about insights and questions that formed as we progressed (Lincoln & Guba, 1985). As with the analytic work described above, each memo had a unique home and single code. In general, we used codes from the model.
9. Next, building back up from the smallest units, we captured what the literature told us, i.e., we wrote the overcoming homelessness story, framed for policymakers.

Addressing Homelessness: The General Problem

We have seen that homelessness is no longer a problem of single men. And though substance abuse and mental illness are still believed to contribute to homelessness, our understanding has been widened to include structural explanations such as poverty and lack of available housing (Burt, 2001). So too have policy solution strategies become much broader and more varied. They generally fall into one of three categories, with some overlap: addressing poverty, increasing access to low-income housing, and providing social services.

Addressing Poverty

In 2008, 13.2% of Americans, about 39.1 million people, lived in poverty (United States Census Bureau, 2009). According to Medcalf (2008), over one third of all people living in poverty had incomes less than half the poverty level. Researchers who view homelessness as a structural

problem rather than an individual one believe that homelessness is caused by poverty and that addressing poverty is its logical solution. “The issue of poverty itself, which demoralizes and destroys people, must be dealt with” (Shane, 1996, p. 215). The two most popular policy strategies researchers and advocates feature to address the poverty that leads to homelessness are increasing public assistance and expanding employment opportunities.

Public Assistance

Proponents of increasing public assistance to help address homelessness work from a fairly straightforward assumption that with more assistance to pay for food and health care, individuals and families will be able to afford to pay more for housing. Public assistance, also called welfare or direct income support, takes form through programs like Temporary Aid to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP, also referred to as “food stamps”), or other cash benefit programs. Unfortunately, the levels of assistance offered by these programs have failed to keep up with inflation, meaning that support levels have declined dramatically in real dollars since the 1970s (McChesney, 1992). Additionally, eligibility for federal assistance has become laden with requirements that often exclude the neediest people from getting help (Greenberg & Baumohl, 1996). Income support programs could help alleviate the stresses of poverty if they were expanded or their rules were relaxed to make more people eligible to receive assistance (Mihaly, 1991; McChesney, 1992; Shlay & Rossi, 1992). Burt, Aron, Lee, and Valente (2001) also point out that some people are homeless only once or twice and for relatively short periods; in these instances, it is possible that “only a simple form of emergency [income] assistance that tides them through whatever crisis triggered their fall into literal homelessness” (p. 182) would suffice.

Employment Opportunities

Some scholars believe the solution to homelessness will come from policy that decreases individual and family poverty through employment: job training, more job opportunities, and a higher minimum wage that keeps pace with inflation. Job training programs for the homeless are a very popular strategy. Snow, Anderson, Quist, and Cress (1996) point out that homeless people tend to be willing and able to do odd jobs and often go to great lengths just to get by, concluding that “most homeless people are active agents in pursuit of subsistence” (p. 96). Toro (1998) also points out that “many young homeless men have some employable skills and many women homeless with their children have good parenting abilities” (p. 130) that could be capitalized upon by job training programs. The McKinney Vento Law has provided funding for demonstration job training programs (Foscarinis, 1996), and some states have had success using federal funds to help people overcome barriers to employment (Burt, et al., 2001).

Hardin (1996) and Rotheram-Borus (1991) argue that existing job training programs have been unsuccessful in ameliorating homelessness not because of inherent problems with the programs or their participants, but because of the lack of availability of well-paying jobs. Shinn and Weitzman (1996) would like to see job training programs with guaranteed job placement. Some communities have experimented with offering financial incentives to encourage businesses to move into low-income areas (Flynn, 1985), but creating well-paying jobs has proven difficult (Oakley & Dennis, 1996). Increasing the earning power of jobs is another crucial element to

lessening poverty. Rafferty (1995) cites “increasing the minimum wage” specifically as a strategy to combat homelessness (p. 56).

Increasing the Stock of Housing

Some researchers believe that the most obvious policy solution to homelessness is the provision of housing. As Johnson (1988) succinctly points out, “all homeless persons share the need for housing, despite the fact that many of them are homeless for different reasons” (p. 134). However, *housing* is a broad term encompassing many forms: temporary shelter, welfare hotels, transitional housing, supportive housing, and permanent housing. An examination of the different types of housing is crucial to understanding the potential policy avenues to alleviate the impacts of and prevent the emergence of homelessness.

Emergency Shelters

Temporary housing, most often in the form of emergency shelters, is emphasized in the McKinney-Vento Act and is the “primary mechanism for providing direct services to homeless families and children” (Solarz, 1992, p. 282) and single homeless adults (McChesney, 1990). Emergency shelters are usually run by community organizations or faith-based groups and provide “a clean environment to sleep, humane care, some meals, and referrals to other agencies” (Medcalf, 2008, p. 104). But not all emergency shelters are the same (Dworsky, 2008). In their 1995 report, Rog, Holupka, and McCombs-Thornton (1995) show that “emergency shelters are a heterogeneous lot, ranging greatly in capacity, staffing patterns, types of service provided, and resident restrictions...there are no clear categories or types of shelters” (p. 502). In addition, shelters often vary in physical structure. Many emergency shelters for individuals are simply large halls filled with beds (Ropers, 1988). Others, particularly those designed for families, consist of separate rooms or apartments. Homeless people are also sometimes placed in Single Room Occupancy (SRO) hotels, often referred to as welfare hotels (Ropers, 1998; Williams, 2003).

Unfortunately, emergency shelters are believed by many analysts to be insufficient to meet the needs of individuals and families experiencing homelessness (Kiesler, 1991). One problem with shelters is that they are often crowded, chaotic and stress-producing, particularly for families with children (Nunez, 1994b). Personal safety is a concern for many residents (Anooshian, 2005; Karabanow, 2004; Shlay & Rossi, 1992). Many emergency shelters only allow residents to spend the night, requiring them to leave early in the morning, taking all of their possessions with them, and return in the evening for re-admission. When residents are permitted to stay more than one night, there are usually limits on the number of nights they can stay (Shinn & Weitzman, 1996).

Another problem is lack of emergency shelter capacity. Despite increases in funding through the Emergency Shelter Grant Program (part of the McKinney-Vento Act) and a 200% increase in shelter capacity between 1988 and 1996 (Burt, et al., 2001; Foscarinis, 1996), funding remains “woefully inadequate” (National League of Cities, 2004, p. 197) and many shelters have to turn people away. Burt and colleagues reported in 2001 that the average rate of availability of shelter housing was 178 units per 10,000 people in poverty nationwide (p. 276). A 2001 study of U.S.

cities found that 37% of all requests for emergency shelter, and 52% of requests from families, went unmet because of lack of resources (Medcalf, 2008, p. 10).

Even if there were enough beds in emergency shelters, many scholars remind us that they are not the whole solution to the problem of homelessness. Some feel that emergency shelters comprise “a stopgap, band-aid response to a tragic problem” (Bassuk, 1992, p. 264; Ropers, 1988), “the implicit rationale behind [which] is that homelessness is due to temporary displacement” (McChesney, 1990). Although “emergency shelters provide a natural intervention point for disrupting the severity of homelessness” (Johnson, 1988, p. 154), placing homeless people into emergency shelters is “nothing more than warehousing poverty” (Swick, 2005, p. 198) and “putting a temporary dressing on what has become a large, festering wound in the social body” (Bassuk, 1984, p. 45), particularly when insufficient permanent housing exists: “indeed, a massive emergency shelter system has mushroomed and threatens to persist despite the fact that, for many individuals and families, the ‘emergency’ has solidified into a chronic condition” (Weinreb & Buckner, 1993, p. 401). These calls have not gone unheeded: nationwide, between 1988 and 1996, more growth occurred in transitional housing facilities than in emergency shelter capacity (Burt, et al., 2001).

Transitional Housing

Transitional housing refers to those facilities intended to fill the gap between emergency shelters and independent permanent housing, usually allowing longer stays than shelters and providing more intensive services designed to prepare people for independent living (NCFH, 2009; Rog, et al., 1995). “Transitional programs, designed to help families move from shelter to permanent housing, provide homeless families with six months to two years of residence and support services” (Weinreb & Buckner, 1993, p. 401). These sites may “focus on particular barriers to stable housing and provide services and supports to address issues [such as] fleeing domestic violence or struggling with addictions” (NCFH, 2009, p. 35), provide more general counseling (Ropers, 1988), or offer training in such “living skills” as “budgeting, shopping, and home management” (McChesney, 1990, p. 197). However, some researchers would prefer service-linked permanent housing in lieu of transitional facilities (Rog, et al., 1995), contending that transitional facilities have been misused “to cope with the scarcity of affordable permanent housing, lack of community services, and limitations of the emergency shelter system” (Weinreb & Buckner, 1993, p. 401).

Permanent Housing

Many argue that housing efforts should focus on increasing the stock of available affordable permanent housing (Biggar, 2001; Burt, et al., 2001; Ely, 1987; Gore, 1990; Leavitt, 1992; McChesney, 1990, 1992; Medcalf, 2008; Shlay & Rossi, 1992; Solarz, 1992; Stronge, 1992; Williams, 2003). “To end homelessness, society must invest in affordable housing” (Williams, 2003, p. 27). Both changing voucher programs to be more accessible and physically creating new homes – by building new structures or renovating older ones – form part of this approach. As McChesney (1990) points out, by focusing on emergency shelter, cities have for decades squandered precious resources on expensive temporary accommodations instead of using those resources to build permanent low-income housing.

One type of low-income housing is public housing, that which is owned and run directly by government. It was created during the Great Depression and presently houses approximately 1.2 million individuals and families nationwide (NCFH, 2009). However, the Quality Housing and Work Responsibility Act of 1998 allows public housing authorities to set admissions criteria that favor higher-income eligible people, keeping out over two thirds of the 13 million lowest-income families (Crowley, 2003). In the 1960s, federal initiatives shifted from building public housing developments to offering subsidies to private developers who agree to allow a certain percentage of low-income households to rent their units (Carliner, 1987). Currently, most housing subsidies, such as Section 8 vouchers, are given directly to tenants to help them rent private units, but the current levels need to be expanded and adjusted (Better Homes Fund, 1999; Jencks, 1994; Roy, Maynard, & Weiss, 2008; Williams, 2003) so that “no low-income family is forced to spend more than 30% of its income to live in decent and stable housing” (Mihaly, 1991, p. 22). Likewise, because budgets have been dramatically reduced in the last several decades (Burt, et al., 2001; Carliner, 1987), many low-income housing programs have long wait lists, some so long that the lists are closed: “over 40% of Section 8 and 15% of public housing waiting lists are closed to new applicants” (NCFH, 2009, p. 36). Another challenge of Section 8 vouchers is that families who receive them still have to negotiate with landlords on their own, and in tight markets, landlords generally choose non-subsidy tenants; similarly, Section 8 does not provide funding for the security deposits that most landlords require (NCFH, 2009).

“Studies have shown that families exiting homelessness with a housing subsidy...are 21 times more likely to remain stably housed than comparable families exiting a shelter without a subsidy” (National Alliance to End Homelessness [NAEH], 2007, p. 2) but these subsidy programs cannot correct the fact that many cities have a severe shortage of low-income housing available. Many researchers (e.g., Better Homes Fund, 1999; Biggar, 2001; Duffield & Lovell, 2008; McChesney, 1990; Medcalf, 2008; Mihaly, 1991; Shane, 1996) advocate construction of new housing units, rehabilitation of existing structures, and prevention of gentrification and abandonment in both rural and urban areas. This approach is popular among those who believe that homelessness is caused by lack of available housing rather than personal characteristics. “There is no reason to believe [people]’s personal characteristics – their ability to manage money or to look for new housing, for example – have changed in the last 20 years. What has changed is the low-income housing market” (McChesney, 1990, p. 198).

Ziesemer and Marcoux (1992) push for policy initiatives at local, state, and federal levels to aid in the creation of more low-income housing. Some promising approaches to creating quality, affordable low-income housing have emerged in recent years (Roy, et al., 2008). Shlay and Rossi (1992) and Johnson (1988) suggest such housing solutions as non-conventional housing forms (like shared housing), alterations to zoning codes to allow for more low-income housing construction, increasing housing credit availability, and community land trusts. Similarly, housing trust funds have increased in popularity. Originally proposed in 1994 by the National Low Income Housing Coalition (Dolbeare, 1996), a National Housing Trust Fund was established by the Housing and Economic Recovery Act of 2008 – the first new production program since the Section 8 program specifically targeted high-poverty households in the 1970s (NCFH, 2009). Many states, counties, and cities have developed these trust funds, which draw revenue from public sources and are used to create housing for extremely low-income families

(Better Homes Fund, 1999). “State housing trust funds create long-term capacity and have significant economic impact” (NCFH, 2009, p. 38). Some more radical proposals, such as adopting the developing world’s practice of allowing unemployed homeless residents to construct their own homes or allowing the homeless to squat in vacant housing, have been suggested as well (Shlay and Rossi, 1992).

Housing First/Rapid Re-Housing

Some programs, usually directed at dual-diagnosed single adults – those with serious mental and physical issues – are known as “housing first” because they aim to get homeless people into permanent housing immediately (Burt, et al., 2004; U.S. Conference of Mayors, 2008). They can be controversial because some, known as “harm reduction” or “low demand,” do not require residents to maintain total sobriety or to participate in any services (Burt, et al., 2004; Oakley & Dennis, 1996). However, these programs have been shown to be successful in achieving stable housing and employment for dual-diagnosed individuals (Burt, et al., 2001). They operate from the assumption that the primary need of any homeless individual is housing – “adequate permanent housing is, of course, the most important intervention in cases of homelessness” (D’Ercole & Struening, 1990, p. 149) – and that “the factors that have contributed to a household’s homelessness can best be remedied once the household is housed” (NAEH, 2003, p.9). The housing first model includes a component of choice over the location and type of housing and no time limit on the length of stay (NAEH, 2003). Oakley and Dennis (1996) explain that this approach is supported by research showing that individuals are more likely to accept treatment once their basic needs have been met, not when “they are fearful and ostracized” (p. 184).

Following the housing first example, many cities have developed rapid re-housing programs for homeless families. Research shows that not every family needs transitional housing before entering permanent housing (Rog, et al., 1995). Rapid re-housing programs are “aimed at reducing the time it takes for families to move out of shelters and into permanent housing” (U.S. Conference of Mayors, 2008, p. 21), often by providing short-term rental assistance, help searching for housing, and case management to help the family prepare for the move (NAEH, 2007). The National Center on Family Homelessness points out that “it is less expensive to pay a family’s rent than to pay for their stay in a motel” (NCFH, 2009, iii).

Most researchers agree that rapid re-housing programs are most likely to be successful if they also include follow-up services for residents. The Edna McConnell Clark Foundation (1990) recommends supportive services for resettling families because “simply providing new apartments neither guarantees a family’s stability nor prevents future homelessness” (p. 43). Rog and colleagues (1995) studied six programs providing rapid re-housing and supportive services and found that they were largely successful. Likewise, McChesney (1990) argues that permanent housing with services “enables families to put down roots – develop their own support networks and community ties – in a community where they expect to remain, as opposed to spending six months...developing friendships and ties that will end when they leave transitional housing” (p. 198).

Providing Social Services

Although some researchers and advocates believe that policy to decrease poverty or increase housing could be enough to address the problem of homelessness, most analysts assert that ensuring access to housing is not the only answer (e.g., Baron, 2003; Hartman, 1986; Jahiel, 1992c; Jencks, 1994; Leavitt, 1992; Nunez, 1994b; Toro, 1998). These researchers maintain that the homeless “also need help with job skills, alcohol, drugs, depression, schizophrenia, and a host of other ills” (Jencks, 1994, p. 121). Accordingly, the largest body of research and theory on policies to address homelessness deals with the provision of social services, in conjunction with or separate from housing. The availability of services for the homeless has increased in recent decades (Burt, et al., 2001), reflecting a widely-held belief that “a continuum of services is required to meet the multidimensional needs of homeless people” (Johnson, 1988, p. 145).

Services provided to the homeless vary widely, and, like housing, are provided by private and publicly-funded organizations (Dworsky, 2008). They happen on-site at shelters or off-site in tandem with transitional housing, permanent housing, or no housing at all. NAEH (2003) reports that the majority of surveyed homeless individuals identified their most crucial needs as help finding a job and help finding housing. They also noted a need for transportation, case management, and physical health care, including vision and dental (NAEH, 2003). The three main bundles of services commonly available to those experiencing homelessness are case management and wraparound services, mental health and substance abuse treatment, and physical health care. A range of other interventions, including attempts to prevent homelessness from occurring in the first place, may be offered to supplement these services.

Case Management and Wraparound Services

Case management is a crucial element of service provision for people experiencing homelessness. “Case managers...provide critical intervention services. Quick and appropriate response to crisis can make the difference between residential stability and homelessness” (Oakley & Dennis, 1996, p. 182). A case manager is a person who takes on the responsibility of helping individuals or families determine what services they need, what types of assistance they qualify for, and how to access them. A case manager might make referrals to treatment programs, secure passes for public transportation, help make appointments, and provide other logistical support. Case management services have proven helpful for “a variety of homeless populations,” including single adults, families, unaccompanied youth (Toro, 1998, p. 129). Jackson (2000) found that the density of case management meetings was the most critical variable related to decreasing the length of homelessness.

Wrap-around services, those that stem from one treatment plan involving multiple providers, rather than each provider having its own plan for a client, have proven promising. Successful treatment is also more common when cities have databases, multi-agency teams, and co-located programs to help this population. Data sharing allows staff members from one agency to see other treatments a client is receiving elsewhere and plan its services accordingly, avoiding duplication (Burt, et al., 2004).

Mental Health and Substance Abuse Treatment

Because substance abuse and mental illness commonly co-occur in the homeless population (Oakley & Dennis, 1996), it is difficult to separate the two types of treatment, and this group of services is often referred to collectively as alcohol, drug, and mental illness or ADM. Despite public perceptions of the homeless, which tend to paint these individuals as intractably mentally ill, Oakley and Dennis (1996) assert that “only between 5% and 7% of the single adult population needs acute inpatient psychiatric care” (p. 185). Burt (2001) finds that people with mental illness and substance abuse histories, even head-of-household single mothers, can live stable lives if they are supplied with both treatment and housing. She offers evidence that in the long run, such programs are cost-neutral; that is, the cost to provide them offsets the costs that would be required to treat people in crisis. Oakley and Dennis (1996) found that most people with ADM disorders want and are able to live independently in the community once they receive appropriate treatment.

Increased ADM treatment is prescribed by many professionals who work with or study homeless populations. “A wide expansion of substance abuse treatment programs is needed, with improved access for those who need them” (Shane, 1996, p. 220), particularly with an emphasis on “maximiz[ing] dignity, self-respect, and potentiality” (p. 220). Because many homeless people have had negative experiences with treatment programs or facilities, “the manner of approach in working with this population should communicate equality, respect, and dignity” (Flynn, 1985, p. 198). Flaming and Tepper (2006) point out the profound marginalization and exclusion from society suffered by homeless persons, particularly those with ADM disorders. Johnson (1988) calls for empowerment of clients because “the process of empowerment reduces the impact of social problems on both client and society” (p. 167). One empowering approach requires that clients contribute to program costs once they find employment (Burt, et al, 2004). Oakley and Dennis (1996) recommend involving clients in the assessment of their needs and creation of their treatment plans, relying on peer support as well as guidance from recovered formerly homeless ADM sufferers.

Many programs aimed at people with ADM issues use an outreach approach where teams of trained workers go onto the streets to make contact with individuals and try to get them into treatment (Flynn, 1985). Research shows that most chronically homeless people “are unlikely to connect even with the best housing programs unless these first contacts are effective” (Burt, et al., 2004, p. 20) and that there is stigma associated with using the homeless service system (Backer & Howard, 2007). For these reasons, Oakley and Dennis (1996) recommend that contacts be made repeatedly in a patient and nonthreatening manner and that homeless individuals be offered an array of services from which to choose. Other cities have taken a more coercive approach, attempting to curtail chronic inebriate street homelessness by creating programs modeled after drug court – once arrested for public inebriation, individuals are able to opt for treatment plus transitional housing instead of jail time (Burt, et al., 2004). Still other cities, like Philadelphia, combine these two approaches by sending outreach teams consisting of a police officer, a social worker, and a local benefits technician to try to get shelter-resistant people into housing and treatment (Burt, et al., 2004).

Physical Health Care

Recognizing that physical health is a serious need of people without shelter, Title VI, Subtitle A of the McKinney-Vento Act established a grant program for the provision of physical health services to the homeless (Foscarinis, 1996). “Without state-of-the-art medicine...we do no more than guarantee chronicity and deterioration even in a sheltered environment” (Greenblatt, 1992, p. 51). Jahiel (1992a) stresses the need for comprehensive intake services that include physicians, nurses, and social workers; prevention services including vaccinations for homeless children; and hospital coverage that provides a sheltered place to recover from illness and surgery so homeless individuals are not discharged back to the streets only to get sick again. He also advocates for the extension of medical coverage to homeless persons either through an expansion of Medicaid or the creation of new programs (1992a).

Other Services

Other services for the homeless sometimes include training in money management, parenting, home maintenance, and landlord-tenant relationships (Johnson, 1988). Some programs offer legal assistance and HIV/AIDS prevention and treatment services (Burt, et al., 2001). In recent years, some programs have begun to offer access to and training in how to use the Internet (Finley, 2003). Several researchers promote programs that offer clients help building and maintaining relationships with family, friends, and neighbors, since “these connections need to be made on a pragmatic day-to-day level if the larger structural issues in the society that go beyond housing are to be addressed” (Leavitt, 1992, pp. 32-33). Additionally, “demonstration programs have repeatedly found that meaningful daytime activity to combat isolation is crucial to housing stability,” so some programs offer housing support groups, tenant associations, and so-called community livingrooms (Oakley & Dennis, 1996, p. 184). One such approach presented by Pearce (1995) aims to combat isolation and promote physical health by meeting the recreational needs of the homeless with sports leagues, field trips, and summer day camps.

Homelessness Prevention Services

Many researchers point to the crucial role that homelessness prevention policies and programs can play in keeping individuals and families from losing their homes in the first place, though there is little funding for such efforts (Aron & Fitchen, 1996). As one advocate noted, “once somebody becomes homeless, it’s that much harder to rehouse” him or her (Egan, 2002, p. 59). Hartman (1986) points out, “one clear question for public policy is whether evicting someone from his or her home for failure to pay \$89-a-month rent to a public agency makes sense” (p. 81) both morally and from a cost-analysis perspective – “the costs to the public of providing the same person with adequate overnight shelter are several times that” (p. 81). The U.S. Conference of Mayors (2008) survey revealed that while 13 of the 25 participating cities had adopted policies aimed at preventing homelessness, many of these were aimed generally at households in foreclosure, not specifically those in at highest risk of becoming homeless.

Advocates argue for expansion of promising programs that target very low-income households and offer services such as legal assistance with eviction proceedings, rental supports, and one-time emergency cash assistance (Hartman, 1986; Lindblom, 1996). Legal programs have been

shown to help keep many people in their apartments, at least in part because so many low-income families are informally evicted by landlord threat. When these households make landlords go through formal eviction proceedings, they get a chance to assert their legal rights and often emerge victorious (Lindblom, 1996). Mihaly (1991) details successful rental support programs like ECHO Housing in California, which operates a rental deposit guarantee program to help landlords and tenants agree to a schedule for making payments on owed rent. The program encourages landlords to rent to low-income tenants by guaranteeing to make up any shortfall if a tenant defaults (Mihaly, 1991). Recently, through HUD's Neighborhood Stabilization Program, some cities have started providing services to protect the rights of tenants living in foreclosed properties, instituting mandated notification times for tenants as well as rental assistance for displaced tenants (U.S. Conference of Mayors, 2008). When President Obama signed the HEARTH bill reauthorizing HUD's McKinney-Vento Homeless Assistance programs in 2009, it included immediate protections for renters living in properties going into foreclosure (NAEH, 2009).

Policy changes could help households avoid homelessness. Current public assistance policies discourage home sharing by reducing benefits to people who reside in the same household and prohibiting subsidized residents from having non-family members live with them (Lindblom, 1996). "Some homelessness experts have even suggested a new Aid to Families with Dependent Adults program to reduce the burden on low-income parents and others who house adult at-risk persons" (Lindblom, 1996). Changes in the rent-to-income ratio have also been suggested, as 30% of income may be too much to expect low-income families to pay (Hartman, 1986). Indeed, "most homeless persons cannot afford to pay any rent at all" (Shlay & Rossi, 1992, p. 150).

Special Issues for Families

According to almost everyone who studies homelessness, families with children represent the fastest growing category of the homeless (Anooshian, 2005; Merves, 1992; NCFH, 2008, 2009; Popp, 2004; Rubin, et al., 1996; Van Ry, 1992): "If asked to describe a 'typical' homeless person, few people would think of a child living with a parent in a shelter for the homeless. Yet perhaps the most alarming change in the homeless population has been the dramatic rise in the number of homeless families with children" (Solarz, 1992, p. 275). Families with children comprised about 25 percent of the total homeless population by the 1980s, about 33 percent in the 1990s, and about 40 percent in the 2000s – perhaps as much as 50 percent in the nation's major urban centers (see Burt et al., 2001; Better Homes Fund, 1999; Hicks-Coolick, Burnside-Eaton, & Peters, 2003; NAEH, 2007; Williams, 2003).

At the end of the 1980s, Nunez (1994a) estimated that there were "600,000 homeless families with roughly 1 million children" (p. 29), with point-in-time estimates between 61,500 and 500,000 (Shane, 1996, p. 15). A decade later, Burt (2001) confirmed that "during a typical year between 900,000 and 1.4 million children are homeless with their families" (p. 1). The dominant form of family homelessness is a single adult with one or more children (Polakow, 2003; Sullivan & Damrosch, 1987). 80 percent or more of homeless families are headed by women (Bassuk, 1992; Better Homes Fund, 1999; Lumsden & Coffey, 2001; Shinn & Weitzman, 1996), "many of whom were homeless themselves as children" (Hart-Shegos & Associates, 1994, p. 2).

In general, the women (and men) heading homeless families are young and becoming younger each year (Bassuk, 1992; Mihaly, 1991; Shinn & Weitzman, 1996). Studies show that the average homeless woman with children is in her 20s (Anooshian, 2005; Nunez, 1994a), with an increasing number of children (teens) heading homeless families (Institute for Children and Poverty, 2003). In a 2009 report, HUD reported that 54 percent of adults in homeless families were between age 18 and 30 (p. 32). Homeless families also come disproportionately from minority groups (Shinn & Weitzman, 1996; Sullivan & Damrosch, 1987). According to recent data assembled by NCFH (2008), 62 percent of homeless families are “families of color,” 43 percent African American, 15 percent Hispanic, and 3 percent Native American (p. 3). The young single women who head families also tend to be undereducated (Jozefowicz-Simbeni & Israel, 2006; Masten, et al., 1997). According to Nunez and Collingnon (1997), the average single-parent homeless mother “reads at or below the 6th grade level and [leaves] school by the 10th grade” (p. 57). Shinn and Weitzman (1996) also document that homeless women have weak job histories. Nunez (1994b) found, for instance, that only “40 percent of all family heads had even six months of employment” (p. 31).

Given the young age of homeless mothers, we should not be surprised to learn that homeless children are very young (Kling, Dunn, & Oakley, 1996; Mihaly, 1991; HUD, 2009). According to the NCFH (2008), “42 percent of children in homeless families are under age six” (p. 3; see also Burt et al., 2001). Infants and toddlers are the norm (Toro, 1998). A recent HUD (2009) report provides the following age breakdown for familial homeless children in shelters and transitional housing: 51 percent under age 6, 34 percent ages 6 to 12, and 15 percent age 13-17 (p. 32). Boys and girls are represented equally among homeless children (Burt, 2001; Hombs, 2001).

The passage of the McKinney-Vento Act in 1987 was the first active step the federal government took to protect homeless families and children; before that time “services for homeless children and families [were] grossly inadequate” (Jahiel, 1987, p. 112). Perhaps because they are viewed more sympathetically than adults (Jahiel, 1992b), homeless children and their families are the subject of a great deal of policy research and advocacy attention (see, for example, Anooshian, 2000; Biggar, 2001; Kiesler, 1991; NCFH, 2009; Swick, 1997). Kiesler (1991) argues that homeless children should have policy priority because only by helping them can we stop the intergenerational cycle of homelessness. Rafferty (1995) points out that “reduction or elimination” of poverty and homelessness “would, in the long term, cost our society less than the persistence of current levels of poverty and its consequences” (p. 56): “the suffering and damage inflicted on these children through illness and lapsed education and trauma...not only reflects badly on all of us, but it is actually bad *for* us...we, as a society, are worse off because of it” (Egan, 2002, p 59).

Although not all homeless families are alike (McChesney, 1992), they are distinct from individuals experiencing homelessness in several important ways. Accordingly, distinct policy and programmatic responses have arisen or are advocated for homeless families. Different income support programs, different housing priorities and structures, and different services are all needed to address the issues facing homeless families. As in the previous section, so too do policies aimed at addressing family homelessness fall into the three main categories of addressing poverty, increasing access to housing, and providing social services.

Poverty

One of the most crucial policy interventions for homeless families is increasing their income to decrease the effects of poverty. This can be accomplished through direct income supports, tax credits, and increasing the minimum wage. Additionally, supporting employment with related services, such as transportation subsidies, removes barriers to employment. Unlike individuals, homeless families also need quality, affordable, accessible child care in order for adults to go to work.

Income Supports

Families who are homeless can be eligible for a wide range of income supports such as TANF, Section 8 or public housing, SNAP, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid, and others (Taylor & Brown, 1996). Unfortunately, many of these programs are underfunded (Better Homes Fund, 1999; Rafferty, 1995). Indeed, “AFDC [Aid to Families with Dependent Children] was not indexed [for inflation]...the real value (constant dollars) of the median states’ maximum monthly AFDC benefit for a four-person family fell from \$599 in 1970 to \$379 in 1985, a 37% decrease” (McChesney, 1992, p. 255) that puts housing costs out of reach. In the welfare reform of 1996, AFDC was replaced by TANF, which suffers the same problems. “TANF benefits are the primary source of income for families who are homeless [but] families receiving the maximum monthly TANF benefit would have to spend 210% of their monthly income to afford a two-bedroom apartment at FMR [Fair Market Rent]” (NCFH, 2008, p. 39). Nonetheless, enrolling families in income support programs has been shown to be important: “despite...grants at well below the poverty level, [our] data suggest that welfare remains a protective factor against family homelessness” (Bassuk, et al., 1996, p. 645).

Additionally, these programs are often underutilized, failing to reach all who qualify for them because families do not know about the programs or how access them (Kiesler, 1991). As Medcalf (2008) observes, “TANF...reaches only a small fraction of children in households with poverty-level incomes” (p. 9). For example, in the San Antonio area of Texas, 23% of children live in poverty but only 5% get TANF; “results of surveys...reveal that homeless young families are often experiencing difficulty both in accessing the TANF program and in meeting its ongoing eligibility and participation requirements” (Reeg, Grisham, & Shepard, 2002, p. 2). WIC and food stamps are plagued by similarly low levels of enrollment by eligible families. Advocates push for restoring federal food stamp funds to pre-welfare reform levels and increasing access by holding outreach activities for residents of shelters (Better Homes Fund, 1999). States have the discretion to give priority to certain populations, and advocates believe they should use this power to assist homeless children. They also hold that the federal government should provide more information to shelters about its Child and Adult Care Food Program, which provides reimbursement for meals served to homeless children, so that more shelters will be able to provide more meals (Better Homes Fund, 1999).

Another crucial income support championed by many researchers and advocates is the Earned Income Tax Credit (EITC), a powerful tool for combating poverty. The EITC is a “tax reduction and wage supplement for low and moderate-income working families” (NCFH, 2009, p. 40) with

the potential to help families avoid homelessness (Bassuk et al., 1996; Better Homes Fund, 1999; Jencks, 1994; Mihaly, 1991; Shinn & Weitzman, 1996). The National Center for Children in Poverty calculates that if every state instituted a state-level refundable EITC set “even at 50% of the federal credit, it would lift an additional 1.1 million children out of poverty.” (as cited in NCFH, 2009, p. 41). Shinn and Weitzman (1996) argue that increasing the minimum wage would be of particular benefit to homeless families headed by women, who tend to be employed at or below minimum wage, in low-paying, part-time, service sector jobs without benefits (Better Homes Fund, 1999).

Job Training, Transportation, and Child Care

Employment services, like income supports, can help homeless families afford housing if they lead to “a major increase in income” (McChesney, 1990, p. 197). Many family shelters and transitional housing programs have job training and education services for parents (Rog, et al., 1995), but since “the typical homeless head-of-household has a tenth grade education and reads at a sixth grade level...often has a substance abuse history...[and] has virtually no work experience” (Nunez, 1994b, p. 111), these individuals require much more basic and intensive education and skill development than most programs are prepared to provide.

Another crucial employment-related service is transportation assistance, since individuals cannot get to work without transportation (Medcalf, 2008). This assistance can take the form of subsidies for public transportation, free bus and subway passes, or transportation to work sites provided by housing facilities. Child care services are also considered one type of employment support, since parents cannot work if they do not have places to send their children (Biggar, 2001; Kiesler, 1991; McChesney, 1992; Mihaly, 1991; NAEH, 2007; Shane, 1996): “child care is a significant expense for all working families and may become a barrier to work for families who are homeless” (NCFH, 2009, p. 41). Moore (2005) reports that some counties provide free child care for up to 15 months after families leave a shelter. Shinn and Weitzman (1996) argue that access to high-quality affordable daycare is key to increasing women’s participation in the labor force, though this creates a particular dilemma. That is, according to Jencks (1994),

single mothers now care for their children. If we make them take jobs, someone else will have to care for their children while they are at work. We will have to pay the people who watch these children more than we now pay their mothers to do the same job. (p. 110)

This issue does not frequently appear in the literature, much of which seems based on a belief that poor mothers should work outside the home. Currently, states are given federal funding through the Child Care and Development Block Grant (CCDBG) to provide child care vouchers, and can also transfer up to 30% of their TANF funding to child care expenses (NCFH, 2009). They can prioritize who gets CCDBG vouchers, but only one state, Massachusetts, gives priority to homeless children (NCFH, 2009).

Housing

The basic structure of housing available to homeless families differs little from that available to individuals, and it is poorly suited for families' needs. "Independently of other issues, priorities in housing policies should be different for homeless families than for individual homeless adults" (Kiesler, 1991, p. 1247). Mihaly (1991) recommends that "families always should be sheltered in facilities that provide separate sleeping spaces that meet local health and safety codes... provide 24-hour shelter, and allow them to leave their possessions safely during the day" (p.22). Rafferty and Shinn (1991) assert that family shelters need to provide privacy to shield children from communicable diseases, "control over light and noise so that children can sleep and do homework, and enough space so that young children can explore their environments, [and] nutritious meals, or...refrigeration and cooking facilities so that families can prepare nutritious meals" (p. 1176). But these types of facilities are hard to come by. In more than 70% of the cities in one survey, homeless families were reported to be the largest group for whom emergency shelter and other needed services were most seriously lacking (Solarz, 1992, p. 276). According to the NCFH (2009), there were 29,949 units of emergency shelter, 35,799 units of transitional housing, and 25,141 units of permanent supportive housing for families available, totaling 90,998 units, while Nunez (1994a) estimates roughly 600,000 homeless families.

Policies and requirements at shelters often affect families differently than homeless individuals. Emergency shelters and transitional facilities often have length-of-stay limits that result in repeated forced moves, "needlessly increas[ing] the suffering of homeless families, especially the children in them" (Shinn & Weitzman, 1996, p. 121). Children's social connections and schooling are often disrupted by these moves (Rafferty & Shinn, 1991). In one attempt to address this problem, "New York City mandated shelter stays for up to one year in order to help families reduce residential (hence school) mobility" (Williams, 2003, p.28). Likewise, many families are forced to split up upon entering a shelter because family shelters commonly accept only women with young or female children (Rafferty & Shinn, 1991). And the neediest families are often excluded from shelter facilities precisely because of their needs: in one study, 84% of programs excluded women with substance abuse problems, 63% excluded women with mental illness, 42% excluded families with a seriously ill member, 40% of facilities excluded families with adolescent male children, and 17% percent would not provide services to victims of domestic violence (Weinreb & Buckner, 1993, p. 405). Thus, parents are often forced to "seek alternative, precarious arrangements in order to keep their children with them" (Duffield & Lovell, 2008, p. 15).

The call for policy that enacts permanent housing solutions to replace emergency shelters is even stronger with regard to homeless families than with regard to homeless adults. Some researchers believe that many of the traumas facing homeless families would be solved by permanent housing. For example, according to Kiesler (1991), "many problems of mental and physical health will decrease or be eliminated through stable housing alone" (pp. 1248-1249). Duffield and Lovell (2008) call for the HUD definition of "homeless" to be broadened to mirror the Department of Education's definition, so that more families would be eligible for housing assistance. Unfortunately, though McChesney (1990) reminds us that "delivery of social services in the absence of permanent housing is an ameliorative rather than a curative approach to

homelessness” (p. 197), we will see in the next section how services separated from housing are still a major focus of efforts to ameliorate homelessness.

Services

The greatest volume of research and advocacy work exists in the area of providing social services (Hart-Shegos, 1999; Shlay & Rossi, 1992). Indeed, “there is mounting support for the widespread implementation of comprehensive models...that educate and train families, that offer counseling, [and] that provide diverse forms of family support, from child care to health care” (Nunez, 1994b, p. 47). These services might take place within transitional housing facilities or off-site at community agencies. Many emergency shelters are also starting to conduct assessments and provide needed services (Rog, et al., 1995).

Unfortunately, the provision of services is expensive and often difficult given the widely varying and multiple challenges confronting homeless families. Many facilities and programs are run by non-profits and volunteers, who tend to be “long on love and short on cash” (McChesney, 1990, p. 199). And designing services can be difficult since not all families have the same needs. Ziesemer, Marcoux, and Marwell (1994) remind us that many stressors are common to families living in poverty even before they become homeless. Some families have serious health problems, substance addictions, mental health disorders, illiteracy, children in foster care, or may never have lived independently (Edna McConnell Clark Foundation 1990). Some have suffered abuse without support. “It is not unusual for shelter staff to be the first ones to hear of a mother’s long history of physical abuse” (Weinreb & Buckner, 1993, p. 402). Given “the enormous caseloads of high-risk, multiproblem families...[and the] diverse problems presented by clients, caregivers must design a broad range of program models” (Hausman & Hammen, 1993, p. 366). The five main categories of services typically offered to homeless families: case management; addiction and mental health support; enhancement of social connections and empowerment; parenting support and family reunification; and physical health care.

Case Management

Case management services are one of the most popular strategies for helping families escape homelessness (Rog, Holupka, McCombs-Thornton, Brito, & Hambrick, 1997; Stahler, et al., 1997). Operating on the assumption that services for families exist in the community but are inaccessible (Rog, et al., 1997), case management introduces a “benefits and entitlements specialist, expert at negotiating service bureaucracies” (Hausman & Hammen, 1993, p. 366) who can link mothers and children with services and programs. Case workers also provide training in basic household skills like budgeting and problem-solving (Rog, et al., 1995), connect families with religious institutions and recreational activities (Edna McConnell Clark Foundation, 1990), and accompany families while they visit agencies, make court appearances, take their children to medical appointments, and even go to routine places like the grocery store (Nunez, 1994b).

Unfortunately, caseworkers in Rog and colleagues’ 1997 study reported spending three quarters of their time completing paperwork, making phone calls, going to meetings, conferring with colleagues, and traveling to visit families, dramatically reducing the amount of time they were able to spend with families. The ability of a case manager to develop trusting relationships with

her clients is crucial to successful interventions (Nunez, 1994a; 1994b), and is more probable when caseloads are lower. Intensive case management models involve dramatically reducing caseloads so that frequent meetings and high levels of support can be given to the highest-risk families – for example, those who “have severe health problems, are headed by teenage mothers, have children in foster care, or those who have never lived on their own” (Edna McConnell Clark Foundation, 1990, p. 35) – until they are stabilized. Jackson (2000) finds that intensive case management may make a significant difference in decreasing the duration of families’ homelessness and preventing repeated episodes of homelessness. But intensive case management is also expensive, and therefore not available to many families. And whether intensive case management is really necessary for most families is debated. “No clear pattern has yet emerged” (Rog, et al., 1997, p. 80) between family needs, the intensity of case management, and outcomes. Shinn and Weitzman (1996) discovered that “once families had subsidized housing and income support from welfare, case management services made only a small additional difference” (p. 115).

Mental Illness, Substance Abuse, and Counseling

ADM problems, as well as sub-clinical mental health issues, are well-documented in homeless families, though not at rates higher than in other low-income families (Goodman, 1991). Rog and colleagues (1995) found that 67% of homeless families in their study received mental health or substance abuse services (p. 509). Indeed, many programs require participation in ADM programs. At the same time, many homeless mothers who are preoccupied with basic survival find required participation in treatment so stressful or threatening that they decline to participate (Weinreb & Buckner, 1993), even if it means sacrificing shelter. Because substance abuse can often lead to having one’s children placed in foster care, some programs attempt to address addiction and family reunification issues together, making sobriety for the sake of getting one’s children back the goal (Nunez, 1994b). Research has also shown that the effects of a combination of stressors is much greater than the sum of each separate stressor (Neiman, 1988), and Goodman (1991) points out that the combination of family substance abuse and homelessness produces extreme trauma that is likely to have long-term effects on families even after they return to housing.

Although, as McChesney (1990) points out, “delivering mental health services will not decrease the total number of homeless families” (p. 197), and the Urban Institute (2000) reports that helping families deal with emotional problems is much easier once families are permanently housed, counseling is nonetheless a popular service delivered to this population. The experience of being homeless creates significant trauma, particularly for children, and counseling can help victims deal with its effects (Goodman, 1991). Even for those homeless individuals who do not suffer from chronic mental illness, mental health treatment is often needed for “temporary personal crises such as divorce or separation, domestic violence, or death in the family” (Ropers, 1988, p. 179). Individual members of a family may need counseling and the family unit may need group counseling to improve communication and cohesion (Daniels, D’Andrea, Omizo, & Pier, 1999; Weinreb & Buckner, 1993). Some argue for the teaching of coping strategies like social problem-solving, relaxation training, and behavioral self-control to help children (Menke, 2000) and adults (Daniels, et al., 1999) handle the stresses of being homeless.

In particular, trauma caused by violent victimization is common in homeless families (Better Homes Fund, 1999). Women escaping partner violence are not the only victims. Tyler and Melander (2009) found high rates of partner violence experienced by both men and women in their study, prompting them to recommend extreme sensitivity on the part of service providers to the potential mental health outcomes of violence, such as Post-Traumatic Stress Disorder. Victims of partner violence who are homeless are also at high risk of revictimization, so Tyler and Melander (2009) advocate training for shelter personnel and changes in laws to allow greater protections, as well as additional research into ways to break the cycle of violence. D'Ercole and Struening (1990) point to the high likelihood of homeless women having experienced physical or sexual abuse at some point in their past as a reason for caregivers to be particularly sensitive to the effects of trauma these women might be experiencing. Bassuk and colleagues (1996) call for health care providers to incorporate screenings for indicators of abuse and assault into routine exams with homeless women, both alone and with children.

Social Connections and Empowerment

Oakley and Dennis (1996) demonstrate the need for persons experiencing homelessness to engage in meaningful activity to combat isolation and forge social connectedness. Formal and informal social connections are believed to be crucial for homeless families (Rabideau & Toro, 1997). Without them, “it is extremely difficult for families to exit homelessness, and almost impossible for them to remain housed” (Jackson, 2000, pp. 18-19). The director of one New York City program, disagreeing with well-established research, asserts that most homeless women do indeed have at least one person on whom they can rely; what is often lacking is appropriate guidance in identifying and reaching out for that support, and a “strategy of finding alternative supports may be pivotal to family stabilization” (Hausman & Hammen, 1993, p. 367). This is particularly critical for the mother of an infant, because having a safe place where her child can live for even a few days can protect her from having that child placed in foster care. Toro and Wall (1991) emphasize the need for services to help families “repair relationships and maintain productive roles in the community” (p. 484). Stahler and colleagues (1997) also emphasize the need for aftercare, less intensive supports that help families maintain the social connections they forged while in treatment.

Empowering homeless families is also crucial. Too many programs “actually do more harm than good” because they are “based on a deficit model of human services” (Swick, 2005, pp. 198-199). In contrast, though few in number, family-centered programs “recognize inherent strengths within all families and value the priorities that each family establishes” (Taylor & Brown, 1996, p. 21). These programs operate from the assumptions that the caregivers in the family are competent, family preservation is essential, families are capable of making decisions about their own treatment, and “families have rights and beliefs that need to be recognized and respected” (Taylor & Brown, 1996, p. 21). Cultural sensitivity can also empower the family by validating clients’ cultural and ethnic identities (Stahler, et al., 1997; Taylor & Brown, 1996).

Fraenkel, Hameline, and Shannon (2009) detail a study using group narrative therapy to promote both family empowerment and social connections with other families. This technique, which was well-received by study participants, involves having families tell narratives of how they came to be homeless and envision preferred futures. By encouraging positive expectancy – a sense of

hope about the future (Stahler, et al., 1997) – and focusing on externalization – encouraging families to identify themselves as separate from the circumstance of being homeless – this therapy seems “uniquely suited to address the impact of stigmatizing language and images of ‘the homeless’ and to help families recover and enlarge other ways of viewing themselves” (Fraenkel, et al., 2009, p. 329).

Parenting Support and Family Reunification

Homeless families are at increased risk for child abuse and neglect charges (Nunez, 1994a; 1994b), so the provision of services specifically targeting the needs of parents is crucial to this population (Shane, 1996). Some shelters require participation in formal parenting classes, while others consider this too much stress for a woman in crisis and focus instead on strengthening self-esteem until the woman is ready to volunteer to participate (Hausman & Hammen, 1993). Daniels and colleagues (1999) call for interventions “intentionally designed to affirm and enhance homeless mothers’ parenting skills as a fundamental empowerment strategy” (p. 169) leading to improved parenting. Rabideau and Toro (1997) report that the amount and quality of social support mothers receive is an important predicting factor in their children’s self-perceptions, concluding that, “maternal social support may serve as a protective factor that facilitates resiliency in homeless children” (p. 13). Supporting mothers may also help reduce instances of child abuse and neglect (Better Homes Fund, 1999).

Physical Health Care

Physical health care is frequently cited as an urgent need of homeless families, especially children (Menke & Wagner, 1997). Shane (1996) cites research from Philadelphia suggesting that the first six months of homelessness are the most dangerous, and calls for preventive services, early detection and care of illness, and treatment for existing medical conditions to improve health outcomes for homeless adults and children. The American Academy of Pediatrics (2005) calls for pediatricians to be aware of the special mental and physical health problems faced by homeless children, and to use “appropriate screening to identify family, environmental, and social circumstances, as well as biological factors” in pediatric assessments (p. 1097). Particularly for families, such services as pre- and post-natal care (Shane, 1996), childhood immunizations, health education for parents (Nunez, 1994b), regular physicals, and lead poisoning screenings (Mihaly, 1991) are especially important. In addition to treating acute illness, other researchers acknowledge the need for appropriate recreational activities and facilities to support children’s healthy physical development (Neiman, 1988).

Although “Medicaid is the primary way that children who are homeless receive health insurance” (NCFH, 2009, p. 43), two thirds of eligible children are un-enrolled. For this reason, many advocates call for expansion and outreach designed to increase enrollment in Medicaid and State Children’s Health Insurance Programs (SCHIP). They also call for expansion of presumptive eligibility – whereby, in certain low-income areas, programs are able to enroll a child to start receiving coverage immediately based on the family’s reported income, and have a month to verify that income – would also help enroll homeless children. Fourteen states have presumptive eligibility for Medicaid and nine for SCHIP (NCFH, 2009). Likewise, expansion of the Medicaid reciprocity model, which allows recipients in one state to receive Medicaid in

another state without re-establishing eligibility, would make health benefits more accessible to homeless families (American Academy of Pediatrics, 2005). NCFH (2009) points out that enrolling families in Medicaid is more cost-effective to society than paying for expensive visits to the emergency room.

Food insecurity, also shared by many housed families living in poverty, is believed to be especially problematic for homeless children. The NCFH (2009) notes that although “SNAP has been called ‘the single most effective program in lifting children out of extreme poverty,’” (p. 17), it and other programs, such as WIC and the Summer Food Service Program, fail to reach enough homeless families and children. Additional outreach and enrollment efforts are needed (NCFH, 2009), as well as modifications to existing food packages that “meet the needs of families with no access to refrigeration or storage” (Mihaly, 1991, p. 24). Some cities require higher nutritional standards for meals provided to homeless families than to individuals (Nunez, 1994b) under the assumption that childhood nutrition lays a foundation for academic and socio-emotional success, as well as physical health in adulthood. Additionally, Shlay and Rossi (1992) cite evidence that the availability of food subsidies may actually prevent homelessness by allowing “precariously housed persons to put most of their income into housing” (p. 151).

Conclusions

The face of homelessness has changed dramatically in the last several decades, turning what was once a problem of single men with substance abuse issues to one that affects sober men, women, young children, and adolescents. In this article, we have examined the policy framework for alleviating and preventing homelessness, with special concern for the problems of displaced families. We reviewed actions in three policy domains of attacking poverty, increasing the stock of housing, and providing social services.

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