Family Homelessness In America

More Families Are Homeless

The number of families experiencing homelessness is greatest in America compared to all other industrialized nations (National Center on Family Homelessness, 2011) and has now reached historic proportions (Bassuk, DeCandia, Beach, & Berman, 2014). Family homelessness is a growing social problem affecting families in every state. More than 2.5 million children, many below the age of six, are homeless each year (Bassuk, DeCandia, Beach, & Berman, 2014). Despite these staggering figures, comprehensive strategies to end family homelessness have not been implemented, and the nature and mix of housing options coupled with services and supports continues to be debated.

With the exception of the Great Depression, family homelessness first surfaced as a significant social problem in the 1980s (Burt, 1992). Driven by the lack of a national housing policy, decrease in federal assistance to the poor, and the dramatic growth in female-headed households that shifted millions of families into poverty, the number of families experiencing homelessness has steadily increased. Now, one in five families is now headed by a woman alone (U.S. Census Bureau, 2009-2013); these families are poorer than traditional families, elderly individuals, and those who are disabled—and are at the greatest risk of becoming homeless.

Family homelessness, once viewed as episodic and situational, has become chronic, with families accounting for 37% of the overall homeless population and 50% of the sheltered population (HUD, 2014). The 2014 U.S. Housing and Urban Development (HUD) Point-In-Time (PIT) count of people who are homeless on a single night in January—using HUD’s literal definition of homelessness (e.g., families in emergency shelter, transitional or supportive housing, and safe havens, or families living in places not meant for human habitation such as cars, parks, and abandoned buildings)—reported that 216,261 family members were homeless. Of these, 23% (135,701) were children under the age of 18 (HUD, 2014). Given the voluntary nature of the PIT count that misses many communities and does not include families doubled-up with neighbors, acquaintances, and sometimes strangers, this is an undercount that sets a floor on the number rather than a ceiling.

Using the definition of family homelessness in the education subtitle of the McKinney-Vento Act, the U.S. Department of Education reported that more than 1.2 million school-aged children were homeless during the 2012-2013 school year, and 1.4 million in the next school year (U.S. Department of Education, 2014, 2015). Adding the number of homeless children in the U.S. who were not yet school aged in 2013, almost 2.5 million children (2,483,539) were homeless in America in 2013 (Bassuk, DeCandia, Beach, & Berman, 2014).
A typical homeless family is comprised of a single mother with her two young children (Burt et al., 2000). Most mothers head their households alone, and have limited education and few job skills or work experience (Bassuk et al., 1996; Hayes, Zonneville, & Bassuk, 2013). Early research estimates that 26 percent of the mothers are young parents under the age of 25 (Burt, 1999), and recent national estimates find 22 percent of adults in sheltered families are between the ages of 18 and 30, compared with just 15 percent of adults in U.S. families (HUD, 2011). A family’s loss of housing primarily results from the large gap between income and rent. The unavailability of housing vouchers, combined with low-paying employment, scarce educational opportunities, interpersonal violence, lack of childcare and transportation, and health and mental health problems compound this problem. Last year, the federal government provided only about 17,000 Section 8 vouchers to meet the housing needs of hundreds of thousands of families experiencing or vulnerable to homelessness.

More than 90% of homeless mothers report they had been physically and/or sexually abused over their lifetimes (Bassuk et al., 1996; Hayes et al., 2013). As a result of extreme poverty combined with the high rates of traumatic stress, many mothers develop clinical depressions that often are unacknowledged and untreated. Depression may compromise their capacity to parent and support their families. Stressed by their circumstances, mothers experiencing homelessness have much higher rates of major depressive disorders compared to the general female population. Approximately 12% of women from all socioeconomic groups are depressed (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Kessler et al., 2003). This percentage approaches 25% for those living in poverty and for ethnic/minorities (Grote et al., 2007; Kessler et al., 2003), and 40% to 60% for low-income mothers with young children, and pregnant and parenting teens (Knitzer, Theberge, & Johnson, 2008). Among mothers who are homeless, lifetime rates of depression range from 45% to 85% (Bassuk et al., 1996, 1998; Weinreb et al., 2006; Bassuk & Beardslee, 2014).

Maternal depression and its co-occurring disorders can interfere with obtaining and maintaining housing and services, and limit a mother’s ability to become self-sufficient and parent effectively. A mother’s health and wellbeing also significantly impact her children’s growth and development (Shonkoff & Meisels, 2000; Shonkoff & Phillips, 2000; Bassuk & Beardslee, 2014). Children living with a depressed parent have poorer medical, mental health, and educational outcomes (Center on the Developing Child at Harvard University, 2009; Knitzer et al., 2008; National Research Council & Institute of Medicine [NRC & IOM], 2009a). Depression adds to a mother’s difficulties...
parenting, and may compromise her children’s growth, development, and school readiness (Knitzer et al., 2008).

One in 30 American children experience homelessness annually; 51% are under age five (Bassuk, DeCandia, Beach & Berman, 2014). Children who are homeless experience high rates of physical and mental health problems, and delayed development in early childhood (Bassuk, Volk, & Olivet, 2010; Bassuk, Richard, & Tsertsvadze, 2015; Haskett, Armstrong, & Tisdale, 2015). Ten percent to 26% of homeless preschoolers have mental health problems requiring clinical evaluation. This increases to 24% to 40% among homeless school-age children—two to four times higher than low-income children aged 6 to 11 years (Bassuk, Tsterverde, & Richard, 2015). Homeless children struggle to attend school regularly. Many change schools during the academic year, fall academically behind their peers, are subject to higher rates of school discipline, and drop out of school more frequently (Buckner, Bassuk, & Weinreb, 2001; Fantuzzo et al., 2012; Fantuzzo & Perlman, 2007; Obradovic et al., 2009; Institute for Children and Poverty, 2008).

**Failure of the Federal Response**

The federal homeless service system was created by the federal McKinney-Vento Homeless Assistance Act of 1987 and subsequently reauthorized (Pub. L. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301 et seq.). It provided a range of services that enhanced shelter programs. In 2009, it was consolidated into the Continuum of Care (CoC) Program. The CoCs represented all homeless service stakeholders within designated geographic areas who were charged with overseeing system and service development. They were specifically responsible for system design and management, and resource allocation. Homeless assistance programs were organized according to residential options—rather than to services and supports—and included emergency shelters, transitional housing, and permanent supportive housing (HUD, 2015). Partially depending on resources, programs for homeless families vary considerably across communities.

In the last 15 years, federal policies focused on ending chronic homelessness and, more recently, ending homelessness among veterans. The primary strategy has been to rapidly re-house people using Housing First approaches; this is based on the belief that housing is a right to be extended without any other requirements such as sobriety or lack of criminal involvement. The Corporation for Supportive Housing reported that more than 80% of supportive housing...
residents maintained their housing for at least a year and tended to engage in services even though these were not mandated (Barrow et al., 2004). In the federal Collaborative Initiative to End Chronic Homelessness, participants showed improved housing stability, had fewer days of homelessness, used public housing less, and had reduced health care costs (Mares & Rosenheck, 2010).

In 2009, “Opening Doors,” the first strategic plan to prevent and end homelessness was issued by the United States Interagency Council on Homelessness [USICH] (USICH, 2010). Until “Opening Doors,” the needs of homeless families, youth, and children had not been a federal priority, and the role of services and supports in attaining residential stability had been disputed. Representing 19 federal agencies, this plan provided a roadmap for ending homelessness by promoting interagency collaboration, strengthening public and private partnerships at state and local levels, and aligning mainstream resources. Progress has been made in reducing chronic and veteran homelessness by “developing the ‘technology’ of combining permanent housing and a pipeline of support services,” advocating for congressional support, and prioritizing funding for these initiatives (USICH, 2010).

The most recent update of “Opening Doors” (USICH, 2015a) delayed its original goal of ending chronic homelessness from 2015 to 2017, but maintained its goal of ending family homelessness by 2020. Changes to the plan most relevant to families focus on expanding and adopting “evidence-based Medicaid behavioral health services for children and youth,” evidence-based home visitation and prevention to preserve family attachments, and tools to assess child development (USICH, 2015b). These efforts aim to keep families together and support early child development. They may signal the beginning of strategies that will reduce the gap between the science of child development and policies for homeless children and families (American Academy of Pediatrics, 2006, 2007, 2010; Center on the Developing Child, 2010; Cronholm et al., 2015; Haskett et al., 2015; Moodie et al, 2014; National Scientific Council on the Developing Child, 2015; Shonkoff & Phillips, 2000). Although the 2015 amendment takes a small step forward, mainstream mental health services cannot meet the needs of homeless families. Treatment is limited by an absence of evidence-based interventions for this subgroup (Bassuk, DeCandia, Tsertsavadze, & Richard, 2014), lack of availability of services and access to care (Hayes & DeCandia, 2012; Stagman & Cooper, 2010; Shipman & Taussig, 2009).

As described by the USICH (2010), housing is essential for ending homelessness. It is also the platform from which services can be accessed: “…stable housing is the foundation upon which people build their lives. Absent a safe, decent,
affordable place to live, it is next to impossible to achieve good health, positive educational outcomes, or reach one’s economic potential. Indeed, for many persons living in poverty, the lack of stable housing leads to costly cycling through crisis-driven systems like emergency rooms, psychiatric hospitals, detox centers, and jails. By the same token, stable housing provides an ideal platform for the delivery of health care and other social services focused on improving life outcomes for individuals and families. Researchers have focused on housing stability as an important ingredient for the success of children and youth in school. When children have a stable home, they are more likely to succeed socially, emotionally, and academically.” (p.7)

Although there is consensus about the essential role of housing and the need for selected supports for various subgroups of families, the nature and mix remains uncertain. The evidence for effective strategies to address family homelessness is extremely limited (Bassuk, DeCandia, Tsertsvadze, & Richard, 2014), with no practices recognized in the evidence-based practice registries (Herbers & Cutuli, 2014). A critical review in 2011 of programs targeted to homeless families and children indicated that no studies had sufficient evidence to be rated as having positive effects that met the guidelines of the What Works Clearinghouse Standards for Evidence-Based Practices. The authors noted: “In most cases, this is because quality evidence that evaluates the program effects doesn’t exist” (Herbers & Cutuli, 2014, p. 203). A recent systematic review that appraised and synthesized evidence on effective housing and service interventions addressing family homelessness also reported substantial limitations in our knowledge base (Bassuk, DeCandia, Tsertsvadze, & Richard, 2014).

Preliminary research from other studies along with the experience of frontline providers in the field suggest that housing is critical, but for many families housing alone is not sufficient for ensuring ongoing residential stability, self-support, and well-being of family members (Bassuk & Geller, 2006; Bassuk, DeCandia, Tsertsvadze, & Richard, 2014). The role of services has remained a hotly debated area with many, including USICH, contending that homelessness should function only as a “crisis response system” with services having little place because they have limited impact on immediate outcomes (USICH, 2015a & b). Because of sharply differing perspectives and a dearth of research findings, the role of services in addressing family homelessness requires a much closer look.

Additional information is now available with publication of initial data from the Family Options Study: Short Term-Impacts of Housing and Service Interventions for Homeless Families (HUD, 2015)—the first large scale randomized control trial investigating what housing and service interventions work best for families experiencing homelessness. The goal of the study was to investigate the types of housing and
service interventions that work best for homeless families. The study enrolled 2,282 families in 12 communities, randomly assigning them to three interventions—permanent housing subsidies (SUB), community-based rapid re-housing (CBRR), project-based transitional housing (PBTH), and comparing each of these to one another and to usual care (UC). Many outcomes were investigated but the researchers focused on housing stability, family preservation, self-sufficiency, adult wellbeing, and child wellbeing (HUD, 2015).

Reporting on data from 20-month follow-up after enrollment, the study found that homeless families who were given priority access to subsidies had the largest improvement in housing stability, and that benefits extended to various outcomes of wellbeing (e.g., decreased family separations, decreased domestic violence, less psychological distress, increased school attendance, fewer schools attended, and increased food security). The only adverse finding was that employment rates among these families decreased. In contrast, families randomized to CBRR showed no improvement in housing stability and no other benefits except increased food security and speedier exits from shelter. Those in PBTH showed some improvement in housing stability but not among those who had been doubled up, and these benefits did not extend to other outcomes. Rapid re-housing was the least costly intervention, while PBTH was the most expensive. Based on these findings, the researchers concluded that “for most families, homelessness is a housing affordability problem that can be remedied with permanent housing subsidies without specialized homeless-specific psychosocial services” (HUD, 2015).

While the exploration of housing options in this study was meticulously investigated, the findings about the impact of services fell short due to the study design. The nature, frequency, intensity, and duration of services in the four interventions were not specifically described across the agencies in the 12 communities. Although specific attention was focused on case management, the services provided were inadequately described. Given this limitation, the conclusion that “homeless specific psychosocial services” are unnecessary goes beyond the existing data. Additional research is necessary to determine the nature and mix of services, how they should be bundled with housing, and how they should be accessed before any definitive conclusions can be reached about the need for services. The overall findings of the Family Options Study at 20 months support the general consensus that housing is essential for ending homelessness, but the study provides far less information about the role and impact of services.

In a public panel discussion (September, 2015), researchers involved in the Family Options Study joined federal policymakers from HUD and USICH to
Recent federal policy has focused on resizing the problem to match available resources.

discuss the current implications of the study. They acknowledged the importance of the findings in furthering our evidence base, but were skeptical about mobilizing the public resources necessary to obtain the large number of housing subsidies to end family homelessness. They also focused on the accuracy of the findings about rapid re-housing, the least costly option, since the study was conducted when rapid re-housing was in its infancy. Much attention was given by HUD and USICH toward working with communities to learn more about its growth and successes. At the same time, because of high cost and limited outcomes, the place of transitional housing was questioned.

Assessment of homeless families is in its infancy. Gewirtz and colleagues (2008) reported that the homelessness system “lacks infrastructure or expertise in children’s mental health” and that many programs do not routinely screen or assess homeless children or mothers (p. 1). Families’ needs across various domains (e.g., housing, economic self-sufficiency, education, health, mental health) are not comprehensively evaluated and children’s needs are infrequently addressed (DeCandia, Bassuk, & Richard, in press). Use of standardized assessment instruments is rare (DeCandia, Bassuk, & Richard, in press) as tools are often lengthy and complex. Currently no evidence-based assessments or instruments have been developed specifically for homeless children (Bassuk, DeCandia, Tsterverde, & Richard, 2014).

Coordinated assessment, also called coordinated entry, is a federal strategy intended to identify families with the most acute needs; a primary goal is to identify families that need intensive housing and services that tend to be more costly (e.g., permanent supportive housing). While prioritizing chronically homeless individuals and referring them to permanent supportive housing has been effective, research is less clear about how to match the needs of families with specific housing alternatives (NAEH & HUD, 2015). Various tools have been developed to support the coordinated assessment process, including the Vulnerability Index-Service Prioritization Decision Assistance Tool for Families (F-SPDAT) (OrgCode, 2013), and the Alliance Coordinated Assessment Tool Set (NAEH & HUD, 2015). Many communities have begun to use the Vulnerability Index-Services and Prioritization Decision Assessment Tool (VI-SPDAT) (OrgCode, 2013) to drive their coordinated assessment system. Originally developed for chronically homeless individuals, the family version was adapted to assess the needs of homeless parents with children. Although the Family VI-SPDAT assesses level of risk for homelessness and safety issues, it does not fully address the needs of homeless mothers and children and, therefore, needs to be supplemented to include missing domains (e.g., maternal mental health, child development) (DeCandia, 2015).
Critics of coordinated assessment argue it is a strategy to manage the “front door” of shelter—a way of “diverting” families from more costly shelter programs by restricting their eligibility and, therefore, managing scarce resources. Although some communities using coordinated assessment and rapid rehousing report modest gains (Cunningham, 2015; Spellman, 2015), the evidence base is not sufficiently developed to determine how to best stabilize millions of children and families (NAEH & HUD, 2015).

Recent federal policy related to homelessness has focused on resizing the problem to match available resources (e.g., numbers, changes in eligibility), and to determine the mix of services based on the scarcity of funding rather than addressing the complex needs of these families. Instead of advocating aggressively for increased resources for these families, policies are instead directed to the least costly housing options, and to relegating families to mainstream service systems despite barriers to obtaining these services. Federal policymakers seem to view the findings of the Family Options Study as contributing to the evidence base. At the same time, they predict that the positive findings about subsidies will not be implemented at a proper scale because sufficient federal funding will not be made available. As a result, policymakers remain focused on rapid re-housing—the least costly intervention—combined with coordinated entry (Abt Associates, 2015).

**Supports and Services in Family Life**

All families regardless of their socioeconomic status need supports and services at various points in the life cycle and especially during periods where inevitable life stresses, especially losses, may become overwhelming. Few people can live alone, isolated from support, compassion, and instrumental assistance. Close relationships with friends and family serve to ease the strains of daily life, and to protect them in times of economic and social stress. Not only do supports ameliorate stress once crises have occurred, they also can prevent crises.

Support networks are women’s social capital, a resource which poor women and women in crisis must often draw upon very heavily. Just as poverty has been feminized so has homelessness, with the majority of homeless families being headed by women alone. Although we have identified many of the risk and protective factors for family homelessness (Bassuk et al., 1997), little attention has been paid to how economic and personal variables are linked, especially those related to gender issues. These factors are bound together in a constellation of difficulties that must be considered as a synthetic whole (Goodman et al., 2009). Without understanding this interaction, the importance of supports in women’s lives, particularly those with children, can easily be underestimated (Bassuk, 1995).
Women’s self-esteem is largely defined by their connections with family, children, friends, and community. Their identity and sense of self is often tightly tied to their sense of responsibility for other people and their role as caretakers (Belenky, Clinchy, Goldberger, & Tarule, 1986; Giligan, 1982; Peterson, 2000). More recent cross-cultural research extends the study of women’s identity to include how factors such as racism and oppression affect the identities of African American women (Peterson, 2000). Homeless women are devoted to their children as well, and to their dual roles as partners and mothers. When this identity is disrupted by isolation, fragmented supports, and loss of a home, women feel bereft, despairing, and hopeless. Homeless mothers are quintessentially stressed, raising children alone without economic and social buffers that prevent everyday problems from turning into catastrophes.

Essential supports for women alone with children might include pediatric and medical care, transportation, childcare, school supports (e.g., tutoring), and supportive friendships. When these supports are sufficiently depleted, especially in the current housing market, poor women are at increased risk of becoming homeless. Many homeless women have exhausted their supports after months and sometimes years of doubling-up in overcrowded and often substandard apartments, setting the stage for entering emergency shelter. For others, poverty, violence, and the housing shortage sometimes combine to disrupt relationships and dislocate long-term residents, destroying networks that have been years in the making (Bassuk & Rosenberg, 1988).

What happens if your child has asthma and you are living far from your extended family, and your child gets sent home from school in the middle of the day? If a single mother is working at a service-sector job, she may have no flexibility and may have to leave during the day to care for her child. If she has too many absences, she will inevitably lose her job. Even more stressful, if a family has a child with special needs, the demands escalate, options become more limited, and the family can become overwhelmed, especially with the absence of other adults to fill in and provide respite for the parents.

Research and feedback from the field strongly suggest the importance of supports and services for ensuring long-term housing stability for families. In a review of studies investigating the role of housing and services in ending family homelessness, Bassuk and Geller (2006) found “that access to housing vouchers seems to increase residential stability and that case management and other services also contribute to residential stability and other desirable outcomes, including family preservation and reunification” (p. 1). They also document that studies investigating the impact of housing and services on families are limited, and that most of the existing research does
not carefully define the nature, duration, and intensity of services necessary to support particular subgroups of families and children. Although the HUD Family Options Study supports some of these findings, the researchers did not specifically investigate the nature and role of services other than case management—and case management was not carefully defined.