

# **The Minnesota Supportive Housing and Managed Care Pilot**

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**Child Study Final Report**

Prepared for Hearth Connection by:



THE NATIONAL CENTER ON  
**Family Homelessness**  
*for every child, a chance*

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We dedicate this report to the homeless children in Minnesota and hope our efforts help to improve their quality of life.

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## Executive Summary

This is one of the first studies describing the characteristics of homeless children and their parents in Minnesota. Under the umbrella of Hearth Connection's Supportive Housing and Managed Care Pilot, this report examines the individual and social needs of homeless children served by Project Quest, a program of the Amherst H. Wilder Foundation in Saint Paul, and by Journey Home, a program of Blue Earth County Human Services in Mankato. Conducted by the National Center on Family Homelessness (NCFH), this descriptive study provides a snapshot of the children and their families at two points in time— 62 children in mid-2005 and 54 children in mid-2006. The data from this study paint a vivid profile of lives in turmoil and distress as well as a hopeful picture of the ways in which vital human services can mend and heal.

This sample of formerly homeless families and children consist of a group not fully described in previous literature. These families are primarily headed by women alone, who tend to be older (on average, 37 years), have 3 children with an average age of 11 years, have been episodically or chronically homeless, had lived in shelters or on the streets, and have complex mental health and substance use issues. Many of the parents had received medication and outpatient treatment, some had been hospitalized for mental health problems, and almost one-quarter had made a suicide attempt at some point in their lives. A smaller number had been in substance use treatment facilities. Although currently housed, most are unemployed, citing mental health and substance use issues as the primary reason for not working. The families currently depend on rental subsidies and benefits. Overall these families are more severely impaired than families who use shelter once or twice and then stabilize.

The children have experienced high levels of exposure to a range of traumatic stresses, including homelessness itself. They have an astonishingly high rate of post traumatic stress disorder (PTSD) and its associated symptoms, including behavioral problems, but given the scarcity of trauma-specific services available for children in most communities, many are untreated. Already having difficulty in school, many of these children have Individualized Education Programs (IEPs) and are enrolled in special education. Adequate after school activities are lacking.

Over the one year of the study—from 2005 to 2006—the characteristics of the parents and children remained relatively constant with the following exceptions. Although the number of children with PTSD as well as various behavioral problems were reported to have increased from 2005 to 2006, these changes were not statistically significant. Further, the increases may have been artifacts of their enrollment in the program; providers may have gotten to know them better and the children may have been less guarded once they were in safe environments. It is also possible that some children were reacting to the stress of living in a residential program.

The most striking finding of the study was the decrease in unmet service needs in many critical areas of the families' lives. By mid-2006, all families were living in stable housing with the help of a rental subsidy. Further, 100% had health insurance. The majority of the children were receiving most of the services they needed, and the proportion of children receiving these

services increased over the year of the study. However, because of the relatively small sample size, the study was unlikely to identify small to moderate differences especially among subgroups of children. With this limitation borne in mind, it is notable that more school-aged children were enrolled in school in 2006 than in the prior year. Further, despite more health problems reported in 2006 than in the prior year, the numbers of children receiving services were much higher. However, those receiving services for behavioral problems remained about the same over the course of the study. Given the devastating and often long-term impact of traumatic exposure on children, it is imperative that these needs be addressed

Many families requested additional information about the range and availability of specific services, saying that non-educational activities were least available and greatly needed. Many parents expressed the view that “there is not enough ...for the kids to do.” In the focus groups, they discussed the lack of adequate after-school activities and the costs of these activities. They specifically requested more mentoring and summer opportunities for their children.

The findings from this study both support current efforts in Minnesota’s social supports programs for homeless families and suggest further program and policy recommendations:

- All services for homeless families and children should be recovery-drive and trauma-informed.
- All parents and children should be systematically assessed for histories of trauma, mental health and substance use issues and educational and job needs.
- Community-based trauma-specific services for children should be identified and programs should develop clear routes for timely referrals.
- The unmet mental health, substance use, and trauma histories of the parents should be systematically identified and addressed.
- Comprehensive employment support including job counseling, education, supported employment, and real job opportunities must be part of the program.
- Parenting supports should be provided.
- Increased after-school, mentoring, and summer activities for the children are critical.

## **PART 1: INTRODUCTION**

This study examines the emotional, behavioral, health and educational characteristics and source needs of children and youth at Project Quest, a program of the Amherst H. Wilder Foundation in Saint Paul, and Journey Home, a program of Blue Earth County Human Services in Mankato, serving families in the Minnesota Supportive Housing and Managed Care Pilot. This study contributes to a better understanding of the personal and social dynamics of homeless children in these two geographic areas in Minnesota and hence a better understanding of the strategies and resources necessary for improving service delivery.

### **A. Context and Study Background**

The Minnesota Supportive Housing and Managed Care Pilot is a demonstration program designed to assess the effectiveness of an innovative approach for addressing the needs of chronically homeless individuals and families living in Minnesota. The experience of homelessness and the associated stresses that result from economic, social and psychological dislocations can negatively affect the health and well-being of parents and their children. Children may, for example, suffer from poor nutrition, and have high rates of acute and chronic medical problems. The stressors experienced by children often result in developmental delays and emotional and behavioral problems, such as depression and anxiety. These issues often negatively impact academic performance. This demonstration program is designed to address the complex and interrelated needs of this population.

Services target single adults and families whose homelessness is exacerbated by other conditions including mental illness, addictions, health problems, and histories of trauma. The Pilot seeks to establish a coordinated system of care whereby participants may easily access affordable housing, health care, and social and behavioral health services. To achieve this goal, each participant is paired with a ‘primary provider’ – an experienced human services professional who assists the individual or family in obtaining and securing housing as well as ensuring their access to appropriate support services. The Pilot is being implemented by Hearth Connection, a nonprofit organization, and is funded by the Minnesota Legislature.

This pilot is being evaluated through four interrelated studies. This Child Study, supported by the Family Housing Fund, collected data that describes the children's characteristics and needs, the services they received, and changes in key indicators for children at 2 points in time, mid-2005 and mid-2006. In addition, a process evaluation was designed to examine the pilot's implementation and outcomes annually from the perspective of multiple stakeholders, an outcome study focused on participant well-being, and a study comparing the relative costs of enhanced services to treatment as usual.

The Child Study was designed to help guide service planning and delivery for interventions serving homeless children and to inform policy decisions on homelessness. Towards this end, specific evaluation questions include the following:

- What are the needs and characteristics of the children and parents?
- What are the characteristics of the families, particularly their histories of separations and disruptions?
- What services are the children receiving?
- How do adults and children view the availability of services?

## **B. Review of the Literature**

Families with children are now the fastest growing segment of the homeless population and account for more than one-third of the nation's homeless (U.S. Conference of Mayors, 2005). According to Burt, Aron, Douglas, et al (1999), most homeless families are headed by a single woman with children less than six years old. Parents tend to have low educational levels with only half having a high school diploma or a high school equivalency degree. While approximately one-third of parents are working, many rely on government assistance to meet their basic needs. Many homeless families lack support networks, either because they are physically isolated or because they have "worn them out" (Bassuk, Weinreb, Buckner, et al 1996; Letiecq, Anderson, & Koblinsky, 1998). They also tend to have poor housing histories. Families that become homeless are likely to have lived in overcrowded conditions, moved frequently and/or experienced an eviction (Bassuk, Buckner, Weinreb, et al, 1997). Few have lived in their own housing for more than a year (Shinn, et al., 1998). Poor tenant histories further exacerbate homelessness by making landlords reluctant to rent to homeless families.

The causes of family homelessness are numerous and pervasive, but poverty and lack of affordable housing are overriding factors. The official poverty rate in the United States increased over the past four years from a 26-year low of 11.3% in 2000 to 12.7% in 2004 (Department of Health and Human Services, 2006). That is, 37 million people lived below the official poverty threshold in 2004--5.4 million more than in 2000. The poverty rate for children under 18 years old increased from 16.2% to 17.8% over that period. Female-headed families tend to be among the poorest families and are therefore at extremely high risk for becoming homeless.

Homeless families have an average income of approximately \$8000 per year, making it difficult to find affordable housing. Housing is considered affordable when the family pays no more than 30% of their total income for their housing needs (Pelletiere, 2006). In 2005, the "national housing wage" (the amount a person working full-time has to earn per hour to be able to afford a modest two-bedroom unit) was \$15.78, or about \$31,500 per year, well above federal minimum wage and most homeless families' incomes (Pelletiere, Wardrip, & Crowley, 2005).

Traumatic events such as catastrophic illness, accidents, and violence can also contribute to family homelessness by impeding a family's ability to secure decent housing. When families flee domestic violence situations, for example, they often leave with nothing more than the clothes on their backs. These families are faced with the challenge of finding safe housing that is also affordable. The problems of violence may be further exacerbated by resulting mental health and substance use disorder.

While many families experience a single episode of homelessness, for others, ongoing stresses and the devastating consequences of being homeless combine to create additional episodes of homelessness.

Homelessness has a devastating impact on families. For the parent, the experience of homelessness and the associated stress that results from economic, social, and psychological dislocations can negatively affect health and well-being (Webb, Culhane, Metraux, et al 2003). Children in homeless families have lives characterized by instability. The Institute for Children and Poverty (1999) reported that within a single year 97% move, and 22% are separated from their families. In homeless shelters, residential substance abuse treatment facilities, prisons, and other institutional settings, family members are often separated. Studies have documented that 40% to 60% of homeless families have experienced disruption, either because fathers and older male children are not allowed to reside in shelters or parents have placed their children with relatives or in other care settings (National Center on Family Homelessness, 2004; Shinn & Bassuk, 2004).

In contrast to their housed counterparts, homeless children are exposed to unhealthy, overcrowded living conditions, are more likely to suffer from poor nutrition, and have high rates of acute and chronic medical problems such as asthma, diarrhea, and ear infections (Weinreb, Goldberg, Bassuk et al 1998). Despite these medical concerns, homeless children often lack routine medical care and seldom receive mental health services (Parker, Rescorla, Finkelstein, et al 1991). Children in homeless families are also more likely to have been exposed to traumatic stresses (Bassuk, Weinreb, Buckner, et al 1996). In a given year, 25% witness acts of violence (Institute for Children and Poverty, 1999). As homeless children grow older and as stressful and traumatic life events accumulate, many develop serious emotional problems. By the age of eight years, one out of three have a diagnosable mental disorder, including depression, anxiety disorders, and post-traumatic stress disorder (Buckner & Bassuk, 1997). More than 20% of homeless preschoolers have emotional problems serious enough to require professional care, a number that increases to 47% among school age children (NCFH, 1999; Institute for Children and Poverty, 1999). Homeless children are also more likely to experience problems that can affect their academic achievement such as developmental delays, learning disabilities, and behavioral problems (Bassuk, & Rosenberg, 1990; Zima, Bussing, Forness, & Benjamin, 1997). Inconsistent and transient housing causes disruptions in schooling and friendships (Masten, Miliotis, Graham-Bermann, Ramirez, & Neeman, 1993).

In 2003, the Wilder Research Center conducted a study of homelessness in Minnesota (Wilder Research Center, 2004) that included 3,200 adults living in emergency shelters, battered women's shelters and transitional housing facilities. The families were the fastest growing segment of the homeless population. Between 1991 and 2000, the number of homeless families in Minnesota increased 325%. From 1985 to 2000, the number of children experiencing homelessness increased 844%. Most of the children were living with their mothers.

The parents interviewed cared for 1,767 children in temporary housing programs or non-shelter locations. Characteristics of this group include the following:

- The vast majority (82%) of children live with their mothers.

- The average number of children in a family was 2.2.
- The average age of children is 7.1 years with 43 percent under 6 years old. An additional 39 percent were between 6 and 12 years and 18 percent were between 13 and 17 years.
- The majority (63%) were on a waiting list for public or subsidized housing.
- For children over 6 years, parents report that 38 percent have learning or school problems.
- Slightly more than 20% reported a child with an emotional or behavioral problem.
- Parent reported service needs included childcare (30%), dental care (16%), health care (6%) and mental health care (3%). Given this list, it is interesting that 23 percent of parents reported that their child has an emotional or behavioral problem, but did not indicate the need for services related to these problems.

## PART 2: METHODOLOGY

Understanding the complexities of the lives of homeless children, their major characteristics and needs, the services they received, and changes over a one-year period required a study design capable of addressing multiple domains. This section describes the overall study design and its component parts.

### A. Sampling

The parents and children included in this study are families enrolled in two supportive housing programs serving families with at least one child under age 18 years: Project Quest in St. Paul, Minnesota and Journey Home in Mankato, Minnesota. Both programs have developed services for children, including social outings, recreational activities, and psychosocial groups. In these programs, primary providers ask about children's needs when parents first enroll in the program. Direct assessments of children's needs are conducted on an ad hoc basis. More intense services, such as developmental screening or clinical assessments, may be coordinated by the programs but are not systematically or directly provided.

Table 1 provides details about the sampling frame. The study protocol required that the primary parent in each family be identified and given an opportunity to participate in the study. At the beginning of the study in 2005, staff from the two programs identified 48 eligible families. For a family to be included in the sample the primary parent was told he or she would be required to complete a questionnaire and then might be randomly selected to participate in a semi-structured interview and focus group. Of the 48 invitations, 42 parents (87%) agreed to participate in 2005. Of these 42 parents, 38 were located and agreed to participate in 2006, representing a final family response rate of 79%.

The 42 families participating in 2005 included a total of 73 children. To minimize the impact of family level factors on the data, researchers used a stratified sampling strategy and selected one child in each family from each of three age groups for study inclusion (i.e., age 5 and under, age 6 to 11, and age 12-18). If possible, each family could have a minimum of one child and a maximum of three children in the study, and no family could have more than one child in the study in a particular age group. The primary parent was asked to participate in a structured interview in which he or she answered questions about the child. Parents agreed to provide information for 62 of these 73 children (84%) in 2005. In 2006, data were collected from the parents about 54 of the 62 children (73% response rate).

In addition, children age eight years and older were eligible to be interviewed directly after gaining both the parent's and the child's informed consent (dual consent). In 2005, dual consent was obtained from 46 of the 56 (82%) children meeting the age requirement and they were interviewed directly. In 2006, of the 46 original child participants interviewed in 2005, dual consent was obtained from 36 children in 2006, representing a final sample of 64% of those children eligible to be interviewed directly.

<b>Table 1: Sampling</b>		
	<b>2005</b>	<b>2006</b>
<b>Parent Interviews</b>		
Total Eligible	48	42
Interviewed	42	38
Missing/Refused	6	4
<b>Parent/ Children Interviews</b>		
Total Eligible	73	62
Interviewed	62	54
Missing/Refused	11	8
<b>Child Interviews</b>		
Total Eligible	56	46
Interviewed	46	36
Missing/Refused	10	10

## **B. Data Collection**

Data were collected using a mixed methods approach, incorporating a questionnaire, individual interviews and focus groups. The research methods used in this study are described below.

**Semi-Structured Family Case History Interviews.** These interviews were used to guide development of a survey questionnaire to be used during a structured interview with parents and children (described below). These interviews also allowed the researchers to gain a deeper understanding about family members.

A stratified sample of parents, based on family size and composition, was selected from the pool of 42 parents who agreed to participate in the study. Using these selection criteria, 15 families were recommended by program staff at Project Quest and Journey Home and the parent from each family was then interviewed.

The interviews were conducted orally by individuals trained in the research protocol during November 2005. After being asked a question, parents were encouraged to talk freely about their children's histories, characteristics, and needs. The interviews were recorded in the form of hand written notes and tape recordings.

At the beginning of the interview, participants were asked to sign an informed consent document and paid \$20 for their participation. During transcription, four tape recordings were inaudible and the results reported herein are from the remaining 11 case histories. The data from these interviews are embedded in this report's Results section to provide a deeper understanding of the structured interview questionnaire data. Parents' comments are noted with the date in brackets (i.e., [November 2005]).

**Structured Interviews with Parents and Children.** This protocol consisted of three separate interviews using a pencil and paper survey administered by a trained interviewer. Using this protocol, interviewers asked the participant questions and recorded their answers. Interviewers and participants did not deviate from the interview questionnaire protocol.

For all the interviews described below, National Center of Family Homelessness (NCFH) provided the initial interviewer training in 2005 and Rainbow Research trained the interviewers in 2006. All interviews were conducted at a convenient time for the participant and lasted approximately one hour. Parents were interviewed in the program's office or, at the request of the participant, another safe and private location convenient for the participant. At the beginning of the interview, the parent signed an informed consent form and was paid \$20 for participating.

**Child Interviews.** The child interview was conducted with each child age eight years and older after gaining the parent's and the child's informed consent. The purpose of this interview was to gather general information about family relationships, perceived risk-behavior, mental health, exposure to traumatic events and trauma symptoms, and risk behaviors. Children over age eight years were eligible to be interviewed directly. At the beginning of the interview, the child provided informed consent and was given a department store gift card for participating (a \$10 card in 2005 and a \$15 card in 2006).

A survey questionnaire was developed by NCFH that contained a common set of questions asked of all participants. The questionnaire reflected the input from research staff at NCFH as well as input from Hearth Connection and the two participating programs serving families. The child interview questionnaire requested the following information:

1. Demographic characteristics, including age and gender, and family relationships and involvement with other family members.
2. Symptoms related to depression were assessed using the Children's Depression Inventory (CDI), a 27-item, self-report, symptom oriented scale for school-aged children and adolescents (Kovacs, 1985). For each item the child has three possible answers: 0 indicating an absence of symptoms; 1 indicating mild symptoms; and 2, definite symptoms. The respondent selects one sentence from a list of three items that best describes him or her for the past two weeks. Possible scores range from 0 to 54, with higher scores reflecting greater depression. A cutoff score of 19 on the CDI identified children in the upper 10% of the distribution in samples of children who are not in clinical care (Doerfler et al., 1988; Kovacs 1980).
3. Children aged eight to 18 years were asked to respond to a number of items to measure their exposure to violence. A scale was created using 15 items adapted from the "My Exposure to Violence" questionnaire by Buka, Selner-O'Hagan, Kindlon, and Earls (1996). For each type of event that occurred, the child was asked if he or she was a victim or a witness of the event. The child was also asked whether the event occurred in the home, at school, or in the neighborhood, and if the event happened once or more than once.

4. Symptoms relating to post-traumatic stress disorder was measured using the Los Angeles Symptom Checklist (LASC), an instrument containing 17 items (Strand, Sarmiento, & Pasquale, 2005). Children responded to each question using a Likert-type scale of 0 (not a problem) to 4 (extreme problem) to indicate how intensely the child experienced each symptom.
5. Children responded to 23 items developed by the researchers to measure risk behaviors.

**Parent Interviews About Their Children.** The purpose of parent interviews about their children was to gather information about children's demographics, parental involvement, and exposure to traumatic events, behavior, health and service needs, and school history. Data were not collected about all children in a family, rather from a sampling of children intended to represent all children. Parent interviews were conducted through face-to-face interviews during July and August of 2005 and 2006 by research interviewers hired by Rainbow Research in Minneapolis, Minnesota. For most, the parent interviews about children were conducted immediately following the initial parent interview.

A survey questionnaire was developed by NCFH that contained a common set of questions asked of all participants. The questionnaire reflected input from research staff at NCFH as well as input from Hearth Connection and the two participating programs serving families. The questionnaire requested information about the following:

1. Demographic characteristics of the child including age, gender, race and ethnicity, educational history, and involvement with a parent who the child is not currently living with if applicable.
2. To examine perceptions of children's behavior, caregivers completed the Child Behavior Checklist for children four to 18 years old (CBCL/4-18) (Achenbach, 1991). The CBCL/4-18 is a 113-item questionnaire in which each item is scored on a 3-point scale from 0 "not at all true of child" to 3 "very true of child."
3. To examine stressors experienced by uncontrollable life events, caregivers responded to a series of items the child may have been exposed to that caused stress. The researchers created some items and others were adopted from the Life Event Questionnaire (Masten, Neemann, & Andenas, 1991). The primary parent was asked to indicate a yes or no to each item.
4. To develop a general understanding of the child's health, the researchers developed one question from which the parent rated the health of her or his child from poor to excellent. Parents also responded to a series of 13 questions about specific health problems (e.g., allergies, asthma) and were asked to indicate if the child currently suffers from the problem, if the problem is being treated, and if the child has missed any school days because of the problem.

**Parent Interview.** The purpose of the parent interview was to gather demographic and mental health information about the parent, household composition, housing history, and stress associated with parenting. Data for the parent interview were collected using a face-to-face interview during July and August of 2005 and 2006 by research interviewers from Rainbow Research in Minneapolis, Minnesota.

A survey questionnaire was developed by NCFH containing a common set of questions asked of all participants. The questionnaire reflected input from research staff at NCFH as well as input from Hearth Connection and the two participating programs serving families. The caregiver questionnaire consisted of the following:

1. Demographic characteristics of the parents and children were collected using questions developed by the researchers and included the parent's age, marital status, race and ethnicity, educational and employment history, family benefits and entitlements, household composition, and housing stability. Parents were also asked questions about each child (e.g., gender, age, biological status, custody status) and histories of separations.
2. The Parenting Stress Index/Short Form (Psychological Assessment Resources, 1995) was used to identify stressful parent-child systems. Parents responded to 36 items using a Likert-type scale from 1 (Strongly Agree) to 5 (Strongly Disagree). A total stress score of 90 indicates clinically significant levels of stress.
3. Overall mental health of the parents was measured using the Brief Symptom Inventory (BSI), a measure designed to reflect psychological symptom patterns in both clinical and non-clinical populations. The BSI contains the Global Severity Index (GSI), one of three overall global indices that can provide psychometric appraisal at a more general level of psychological well being. A GSI score of .30 is considered normal in adult non-patients, while an average score of 1.19 is found in adult in-patient psychiatric patients. Parents were also asked a series of seven questions developed by the researchers to assess their mental health and substance use history.
4. The researchers developed and asked parents four questions that assessed their perceptions of safety.
5. Service needs for the children were assessed using 19 questions developed by the researchers. For each question (e.g., dental services, medical services, medications, academic help), parents responded if the child was receiving the service during the past year and if their child needed this service.
6. A final section contained several open-ended questions.

**Focus Groups with Parents.** The purpose of the focus groups was to ask parents directly about their perceptions of the program's services. Two focus groups, consisting of six parents from Journey Home and three parents from Project Quest, were conducted in October 2006 after data from the structured interviews were analyzed. Program staff selected the parents and arranged

for them to be present at the program site location. The researchers developed focus group questions and conducted the interviews. During the focus groups, parents were encouraged to respond freely to the questions.

At the beginning of the interview, participants provided informed consent and were paid \$20 for their participation. The interviews were recorded in the form of hand written notes and tape recordings. Each interview was transcribed and the original documentation was destroyed. The results from these interviews are embedded in the results section to provide a deeper understanding to the structured interview questionnaire data. Parents' comments are noted with the date in brackets (i.e., [October 2006]).

### **C. Limitations**

Because the sample size of this study was small, the results may not be representative of all families with children participating in the two programs. Though it would be ideal to interview every parents and child in the pilot, fiscal and practical constraints restricted the number of individuals interviewed. Researchers used selection protocols for participation in the study that attempted to recruit a representative sample. Secondly, the data were collected through self-report, semi-structured interviews and focus groups. Some of the responses provided by the participants are outside the normal range for the entire group (e.g., the number of times homeless). In such an instance, the median rather than the mean was used to describe the variable under consideration. Finally, caution must be exercised in interpreting the data from 2005 and 2006. Because of the relatively small sample size, small to moderate differences between the groups in 2005 and 2006 may not have been identified. The findings are a snapshot of children and parents over a one year period within a population in which some families had been in the Pilot for a considerable period while others for only a short time. Further, differences in the groups between 2005 and 2006 cannot be attributed to the program since a comparison group was not used and moderating/mediating variables were not identified. Consequently, differences between children may or may not be the result of exposure to programs and services provided by the program.

## PART 3: RESULTS

The results from the structured interviews described in this section include findings from participants who completed interviews in both 2005 and 2006.

### A. Family Unit

The typical family unit consisted of a female-headed family with 3 children who were on average 11 years old. This is in striking contrast to the Wilder Research Center data (Wilder Research Center, 2001), indicating that most families in their study consisted of approximately 2.2 children who were on average 7 years old. About one-third of the families in the present study included a second adult, such as the parent's significant other or another immediate family member. The language most commonly spoken in the household was English.

By the end of the study, in 2006, all families had rental subsidies and were living in stable housing. However, most families in the study reported prior lengthy experiences of residential instability, including multiple episodes of homelessness. Of those who had been homeless, most reported living in shelter, but about one-quarter reported having living on the streets or in an abandoned building, park or car (see Table 2). Even over the course of the study, about half the families reported moving at least once.

	N	%	Number of times (average)
Ever lived in a shelter	31	81.2	2.7
Ever doubled-up	25	65.7	2.5
Ever lived on streets	9	23.6	1

The interviewer asked the children to describe their experiences living in temporary accommodations. Some children found shelter acceptable:

- *"It was like just staying in a house. I made friends in the shelter, but other than that nothing changed."* [Summer 2006]
- *"It was fun because there were so many kids there and everything..."* [Summer 2006]
- *"It was just not having a place of your own. It was okay there."* [Summer 2006]

For other children, however, temporary accommodations were more challenging:

- *“I didn’t like the rules. You had to be with your mom at all times, at all the shelters.”* [Summer 2006]
- *“Weird. Too much security stuff.”* [Summer 2006]
- *“I wanted my mom to get another house. I thought we would be homeless forever. There were some fun times and some really sad times, too.”* [Summer 2006]
- *“There are some schools I went to but I don’t remember my teacher’s names... I had to change schools – like three schools in the 6<sup>th</sup> grade.”* [Summer 2006]

## B. Children

In 2005 and 2006, parents answered questions about their children. Children age eight years and older were eligible to be interviewed directly in a structured interview with the consent of both the parent and the child. This section describes the results and includes comments from the semi-structured interviews.

**Demographics.** The children in this sample ranged in age from under a year to 18 years and consisted of 26 girls and 28 boys. Almost half were African American.

<b>Children</b>		
<b>Age (Average)</b>	11.3 years	
<b>Age by Gender</b>	Boys	Girls
Less than 6 years	4	4
6 – 11 years	10	7
12 – 18 years	14	15
<b>Race/Ethnicity by Gender</b>		
African American/Black	15	10
White (Hispanic)	10	13
Other (Hispanic)	3	3

**Children Family and Relationships.** Many of the children experienced instability and disruption in their family lives. The vast majority live with a single parent (generally their mother), and more than half had lived away from their parent(s) at some point in their lives. In contrast to prior reports in the literature, most of the children in this study described relationships with supportive family members and friends. Most have at least one sibling who is a regular part of their life, and more than half report being close to a grandparent, aunt, uncle, or cousin. In addition, some children still maintain contact with the parent they are not living with. Finally, almost all the children reported having friends who were a regular part of their life.

**Children's Educational History.** Schools are an important part of children's lives. In 2005, 42 children (85.7%) were enrolled in school. In 2006, the number increased to 46 (92%) in 2006. Parents reported that their children had changed school an average of 4.2 times. Although only 5 children had repeated a grade, half of the children had individualized education plans (IEP). An IEP is a legally binding plan that is designed to provide extra support and resources for children who have special needs. Only 2 children with diagnosed learning disabilities did not have an IEP.

One parent described the difficulty of trying to get an IEP for her son and how the program advocated for her.

*"They [the program staff] will get you the things you need for your child. My oldest son has ADHD and in school they do an individualized education plan and his school they are kind of putz 'n around with it and... [the program worker] is kind of advocating for me and saying my son is kind of falling behind and very frustrated... so it is there and we'll eventually get it, but I was really worried because my son is really struggling right now... but [the program worker] advocated for me...saying we really need to do something right now instead of waiting until the middle of the school year"... [The case worker] is kind of like your backbone."* [October 2006]

Although it takes time to establish an IEP and get extra help for children, this support is quickly eroded when a child moves to a new school. Startlingly, parents reported that their children had changed schools an average of 4.2 times.

**Parents' Perception of Children's Behavior.** One common way of gauging the well-being of children is to find out whether or not they have behavior problems at home. See Table 4 below. Using the Child Behavior Checklist (CBCL), parents reported that their children had numerous internalizing and externalizing (acting out) problems. An average score on the CBCL is 50 and higher scores mean they are experiencing considerable emotional distress. Scores over 60 are generally considered high enough to indicate a need for clinical help.

According to Table 4 below, most of the children in all age groups scored between 50 and 60 indicating that they were experiencing distress. In 2006, the younger boys, 4-11 years and the older girls, 12-18 years, had clinical behavior problems—suggesting that they needed professional help. These scores were statistically significantly higher than those reported in 2005.

<b>Table 4: Child Behavior Checklist: Mean Scores in the Clinical T Range</b>				
Total Program Score	2005		2006	
	M	SD	M	SD
4 – 11 years (N=17)				
Boys (N = 10)	45.8	7.8	60*	15.7
Girls (N = 7)	56.3	18.3	53.4	17.7
12 – 18 years (N=27)				
Boys (N = 13)	56.1	10	56.2	14.2
Girls (N = 14)	62.7	15.3	56	17.5
Internalizing				
4 – 11 years (N=17)				
Boys (N = 10)	46.8	9.4	57.6	13.1
Girls (N = 7)	57.7	14.5	54.6	16.9
Externalizing				
12 – 18 years (N=27)				
Boys (N = 13)	52.3	9.6	54.3	14.3
Girls (N = 14)	59.1	15.8	51.3	12.6
4 – 11 years (N=17)				
Boys (N = 10)	43.9	10.9	60*	15.5
Girls (N = 7)	55.3	17.9	52.3	12.7
12 – 18 years (N=27)				
Boys	55.6	11.1	55.1	13.3
Girls	62.4	13.8	60	17.7
* p < .05				

**Children's Exposure to Trauma and Violence.** Children in this study are growing up in environments in which they are exposed to various, often unremitting, traumatic events including multiple moves and witnessing and experiencing different types of violence. Despite their young age, over half the children in this study had experienced a major death of family members close to them. These children had also witnessed an average of 3.7 violent events (e.g., seeing someone beaten, seeing someone chased, hearing gunfire) and been victims of an average of 1.6 violent events (e.g., being assaulted, being in a natural disaster, being chased, or being in a bad accident) (see Tables in appendix). These violent events tended to occur at home or in the community.

Not surprisingly, in 2005, 10 children (16%) were diagnosed with PTSD and 13 (24%) in 2006—rates higher than in the general population. This diagnosis was most common among older children, possibly reflecting difficulties in conducting assessments of younger children.

	Year			
	2005		2006	
	Age (Years)		Age (Years)	
	6 – 11	12 – 18	6 – 11	12 – 18
No PTSD	8	5	4	6
Partial PTSD	1	10	4	7
Full PTSD	3	7	4	9

**Children’s Depression.** The Children’s Depression Inventory indicated that slightly more than 13% of the children in this sample were depressed in 2005, similar to rates found in the general population, which is about 10%.

Despite the unusually high levels of trauma experienced by these children, the rate was only slightly higher than the general population. In 2006, only two children (5.3%) manifested symptoms of depression, possibly reflecting their more stable housing status at the end of the study.

**Children’s Health Service Needs.** Parents indicated that their children were not in good health. On a scale of 1 to 4 where “1” represents excellent health and “4” represents poor health, in 2006 parents reported an average score of 3.4. Common health problems include headaches and behavior issues. Less common problems included ear infections, fevers, and bronchitis/colds. Although the numbers of health problems reported in 2006 were somewhat higher in 2005, the number of children receiving treatment was also higher (64% in 2005 and 78% in 2006). In contrast, the percentages of children receiving services for developmental and behavioral problems were approximately the same in 2005 and 2006, and were less than those receiving service for medical problems.

<b>Table 6: Children's Health Problems</b>				
	2005		2006	
	Has Problem	Received Treatment	Has Problem	Received Treatment
	N = 62		N = 54	
<b>Health Problems</b>				
Allergies	6	5	10	7
Asthma	9	8	7	7
Bronchitis/Colds	3	2	2	1
Ear Infections	2	1	5	4
Eczema	8	6	8	8
Headaches	13	7	15	10
Stomach Problems	6	1	8	5
<b>Developmental Problems</b>				
Speech Problems	9	8	5	4
Physical Disability	2	2	1	1
<b>Behavioral Problems</b>				
ADD	12	6	12	6
Hyperactivity	12	6	9	4
<b>Health Status</b> (1=excellent; 4=poor)				
	3.5		3.4	
<b>Missed School Days</b>	7		6.6	
<b>Emergency Room Visits</b>	1.3		1.1	

**High Risk Behavior.** Although few children reported using any substances, for those who did cigarettes, marijuana or alcohol was the substances of choice. Girls in the 12 to 18 year old age group (N = 17) were more likely than boys (N = 8) to report using a substance.

The number of children who reported ever engaging in sexual intercourse increased from five in 2005 to nine in 2006. All children were older than 12 years. Of those who indicated engaging in sexual intercourse, boys were more likely than girls to use protection against pregnancy and sexually transmitted diseases. The number of children reporting ever receiving information on sexually transmitted diseases increased from 17 in 2005 to 22 in 2006, and on AIDS increased from 20 in 2005 to 25 in 2006. Five children younger than 18 years were parents themselves.

Boys between the ages of 12 and 18 years (N = 14) were more likely than girls in this same age group (N = 6) to report engaging in physical violence or carrying weapons. However, compared to boys, girls appear to fight physically at an earlier age. For all children who reported engaging in physical fights, the median number of altercations was about 2 over the course of the study.

Boys between the ages of 12 and 18 years ( $N = 7$ ) were more likely than girls in this same age group ( $N = 5$ ) to report ever being in trouble with the police. Of these, two boys and two girls were arrested for assault, drug use, and theft. Of those arrested, only one boy and both girls were placed in jail.

## C. Parents

**Background Characteristics.** As described in Table 7, the majority of parents in this study were female, although two male parents participated. Parents were on average 37 years old and half were African American. Most were not currently married. More than half had completed at least a high school education; of these, 29 percent reported some education beyond high school.

<b>Age (Years)</b>	Average: 37 Range:22-47	
<b>Gender</b>	<i>N</i>	%
Female	36	95
Male	2	5
<b>Race/Ethnicity</b>	<i>N</i>	%
African American/Black	19	50
White (non-Hispanic)	13	34
White (Hispanic)	2	6
Asian	1	3
Other	2	6
<b>Marital Status</b>	<i>N</i>	%
Currently Married	3	8
Separated, Divorced, or Widowed	13	34
Single	22	58
<b>Education*</b>	<i>N</i>	%
Less than high school	17	45
High school diploma/GED	10	26
Greater than high school	11	29
<b>Employed</b>	<i>N</i>	%
	7	18.4

\*Reported from 2006 data.

Parents reported having between 1 and 11 children, with an average of 3.8. Typically, parents had their first child when they were 21 years of age. Nearly 60% of the parents reported being

separated from one or more children at least once for a few weeks up to several years. Of those parents who reported separations, the most common circumstances included the parent's treatment for alcohol and drug use, parent or child incarceration, or the inability to care or provide housing for the child. One parent indicated that her children had been placed in foster care and two reported child kidnapping.

**Work.** The vast majority of parents in this study were not employed (N = 31, 81.6%). The number of parents who were employed fell slightly from 2005 (N = 9) to 2006 (N = 7) and the number of people looking for work also decreased from 21 in 2005 to 12 in 2006. Most parents cited mental health, substance use problems or other health concerns as the primary reasons for not working. Others indicated health problems or other concerns of their children.

For example, one parent reported that her medical problems along with caring for her two children get in the way of working. Her former job required heavy lifting, which left her with chronic back problems and persistent pain. She explained:

*"I have arthritis in my lower back really bad and then I have a ruptured disk. I have the body of a 65-year old woman; that's what my doctor explained to me."*

With her back problems, this parent found it difficult to care for her daughter, who had a severe neurological disorder, telling the interviewer:

*"It's hard. It's very hard. I just started working now and on the weekends I can't even do that. When I come home I have a hard time taking care of my daughter."*

**Parents' Mental Health Status.** As shown in Table 8, the parents in this study have been struggling with major mental health and substance use issues over their lifetimes. Twenty-nine percent reported hospitalization for a mental health condition and more than half were involved in outpatient treatment or taking medication for a behavioral health problem. Almost one-third had been involved in substance abuse treatment.

<b>Mental Health Problem</b>	<i>N</i>	%
• Medication	21	55
• Outpatient Therapy	21	55
• Hospitalization	11	29
<b>Substance Use Problem</b>		
• Rehabilitation	12	32
• Detoxification	5	13
<b>Other</b>		
• Attempted Suicide	9	24

Not surprisingly, parents in this study experienced significantly higher levels of mental health distress on Brief Symptom Inventory than the normal adult population, but have far fewer

symptoms than adults in an inpatient psychiatric unit. The parents in the study had approximately 2.5 times as many symptoms as adult non-patients in the general population in both years of this study. No differences were reported in the number of symptoms in 2005 and 2006.

**Single Parenthood.** In this study, raising children alone is one of the most difficult challenges the adults faced, as described during the semi-structured interviews:

*“Doing it on your own and having to make sure he’s got clean clothes, getting to and from places, getting home everyday after school. If I’m doing something, being here, because he’s only nine I have to be here, being the only one to cook dinner every night. I have to buy all the games, all the bikes, all the action figures. I’m the only one here to do everything.”* [November 2005]

*“This is the lowest point in my life. Because I’m not working and the kids are older and getting on my nerves. I’ve got a baby. This is burnout. Having teenagers is not easy.”* [November 2005]

A mother of six children talked in detail about her experiences as a single parent. Though she received limited support from family and friends, she described how she has coped and the lessons she has shared with her children:

*“I’ve always been kind of to myself. I find it easier to not have so many people who are forcing opinions. It’s emotional, like a roller coaster. You have your up days and you have your down days. I can get a few in between days where everything is just calm and peaceful and everybody is getting along. I pray for more of those days. Some days I just wish I could be an ostrich, put my head in the sand so I don’t have to listen to it all. The most important thing that I’ve learned is that you can’t group them together as one. They’re very separate individuals with separate personalities. I think that is the hardest thing that I’ve learned and I’m still learning as we go. I tell my kids to look at my life, look at where I’ve been, look at the things we’ve gone through, is this the life you want? Because, I’ve had a hard life. I’ve struggled with so many things, but if this is the life that you want, don’t go to school, don’t pay attention in class and get in trouble. They’ve set goals for themselves and I’m going to do everything that I can to help them reach their goals. I want them to look back on my life and say we had a lot of hardships but things are better now.”* [November 2005]

Most families in the study were homeless more than once. One mother of six children – four of whom are still with their mother – talked about her family’s experiences with frequent moving. They were homeless for three years and spent much of that time moving in and out of homeless shelters, motels, and friends’ homes. Throughout this time, the children remained in her care. She describes how difficult this period was for her family:

*“My children didn’t like it at all. They were staying in the Day’s Inn, and my daughter spent a month in the hospital with a kidney infection. It was rough. We stayed in cars, in people’s basements, a lot of places. It was really hard for them having so many different schools. They’d make friends, then be there only a month and end up at another school [and] start all over again. They also have learning disabilities and it was really hard for them to be disrupted. So we’re*

*just now trying to catch up with dealing with all the emotional problems that they have. I'm working on it. We're stable and they are getting better and better everyday."* [November 2005]

Another parent reported having trouble motivating her children, a problem she believed is the result of her family having to move so many times:

*"We moved a lot. We moved out of state. But the point is, we were in one state, my kids went to couple different schools and I find them making friends is a problem. And they want friends. They have a problem. If they get a friend and they leave, they lose contact with them. Moving has affected my kids and I need them to be more active. Like my kids don't want to go to the program they give to the kids. They don't want to do nothing. They [the program staff] have someone new who comes to my house and talk to them to see if she can help to persuade them to come on in. My kids don't do nothing, and they need to do something...besides just sitting in the house."* [October 2006]

These anecdotal reports were supported by scores on the Parenting Stress Index: 48.6% of the parents in the sample in 2005 and 45.7% in 2006 had a total stress score above 90, indicating clinically significant levels of stress requiring professional help. .

**Domestic Violence.** Among the stresses experienced by some parents was an ongoing lack of physical safety. In 2005, five parents reported being afraid of a current partner or a friend or family member; this number decreased to three in 2006. The number of parents who reported being physically victimized decreased from 11 in 2005 to 4 in 2006.

Feeling safe is fundamental to well being. When discussing domestic violence during the semi-structured interviews one caregiver and the mother of four children shared her experience with the researcher:

*"I graduated from high school, got married and started having a family. Life changed – my husband was very abusive. Before we were married there was some banging on the table with his fist but I didn't know too much of it until after, that's when it started really coming out and he totally changed."* [November 2005]

While she attempted leaving on a few occasions, she returned. She explained the reasons for her decision:

*"You're so used to being abused, then when you get out of it you're so scared. You don't know what's going to happen, where you're going to live. He said I was ugly, that nobody would want me, and to this day I struggle with that. Some people say 'I don't know why you let that bother you.' I don't think they quite understand the trauma."* [November 2005]

## **D. Services**

**Benefits and Entitlements.** Families in this study cobbled together a number of different benefits to meet their basic needs. About one-third of the families received food stamps worth

approximately \$340. Less than 10 percent of families received WIC. Overall, between 2005 and 2006, the numbers of families receiving these benefits decreased slightly. By 2006 every family in the study had health insurance. Similarly, nearly all the families received a rent subsidy. The median amount of rent paid by the family in 2005 was \$120 and increased to \$173 in 2006, while the majority of families who received help paying for housing decreased from 35 to 32, respectively. One parent described the cost of the family's housing:

*"We spent a lot of money on hotels. We spent a lot of money staying with this person and that person, having to actually physically pay someone money to stay at their homes. Then a week later be put out and have no where to go."* [November 2005]

In both years, parents reported that their children received help with health and dental services; educational services such as school supplies, academic help, and special education; and non-educational services such extra-curricular activities or summer camp.

Areas in which parents and their children were least likely to receive services included group/family counseling, and receiving help dealing with the impact of violence and other traumatic stresses. Table 9 shows the changes in service needs from 2005 to 2006. Fewer children overall were in need of health/behavioral services as well as educational services in 2006 than in 2005. More children requiring treatment for trauma were identified in 2005 than in 2006, although in both years the numbers of children still in need of treatment were about the same. It is possible that some of the children with post trauma responses were being treated in individual and group/family counseling.

Although parents' and their children's needs are generally being met, there are still some significant gaps. Although more children were receiving non-educational services in 2006, a greater number of children still needed them as compared to 2005. The greatest area of unmet needs seems to be non-educational services, such as extra curricular activities, mentoring and summer camp.

<b>Table 9: Children's Service Needs</b>				
	2005		2006	
	Received	Still Need	Received	Still Need
<b>Medical/Behavioral Health</b>	N	N	N	N
Health Services	20	4	29	3
Medications	22	3	28	2
Dental	19	7	25	3
Health Supplies	11	4	14	5
Individual Counseling	16	4	18	1
Group/Family Counseling	11	7	13	5
Treatment for Trauma	10	11	6	5
<b>Educational</b>				
Developmental Assessment	16	2	15	3
Special Education Services	21	2	25	1
Academic Help	18	4	22	2
School Supplies	22	5	27	3
<b>Non-Educational</b>				
Extra-Curricular Activities	9	5	19	9
Mentoring	9	11	11	9
Summer Camp	10	8	16	8

## **E. Experiences in the Pilot**

In general, participants were thankful for assistance from the pilot:

*"It is a second chance. Thank God for that!"* [October 2006]

*"I have another chance to do it again."* [October 2006]

“[The program] *Helps you to become more self-sufficient*” [October 2006]

*“To me, the whole goal is to get on your own. They help you to develop your budget.”* [October 2006]

*“The fact that they pay the rent and it frees up your money... It helps to pay for other programs that you probably couldn’t afford paying \$600 a month rent.”* [October 2006]

*“My kids enjoy it. I enjoy it. They [my kids] enjoy interacting with other kids. It gets them out of the house. They offer books to my daughter, because my daughter is an avid reader. They help her restructure some of her ideals. They never feel like they never want to be bothered by them [i.e., kids]. In that respect it is healthy for them. A lot of what they are trying to help us do, for me, I feel it has really helped. They help us to become self-sufficient and alumnae of the program. You come back as an example of how well you’ve been. That is part of becoming self-sufficient so you can dictate where your money goes to.”* [October 2006]

**Access to Services and Resources.** In addition to help paying rent, one participant talked during the focus group about how the program helped her furnish a place to live:

*“When I moved in to an apartment... I had nothing... and they helped me to buy... what I needed. If you just tell them what you need, they will help you. ... and the Salvation Army didn’t have any beds at that time, so they [the program] helped buy them for me.”* [October 2006]

During the focus groups, the participants talked about how the program helped them to get into housing faster than being on the waiting list for Section 8. One participant indicated she was number 487 on the waiting list, which would take about two years.

*“For our county there is up to a two year waiting list and there is no other place to live. It was fast. It helped me and my family get into a home without waiting for two years and wondering what are we going to do for housing.”* [October 2006]

Entry into Section 8 housing may be complicated by an applicant’s history. One participant said that being part of the program has given her family another chance to move forward:

*“This program is helpful for people who can’t get Section 8. I mean that you can’t get on Section 8 ...because there are certain things...like for me..., my background. I have like a domestic violence on my record... and it is a misdemeanor...but they said that any family violence or any like drug charges... you can’t fight that, but you have to appeal... A few months back I went in to apply for Section 8...but because I was evicted...my landlord was a racist... she threw me out for no reason. She didn’t come to me about it, but I don’t throw parties. She got me evicted...and when I got homeless again, I went to Theresa House and they referred me to Journey Home... And I am not putting myself and my kids back through this just to get back on the list again... and there should be more programs out there for adults and people who can’t get Section 8...I am trying to finish school and to work and everything so I don’t have to depend on these programs, but it is kind of hard when you have three kids...So you try to battle with depression issues within your self as well. It’s hard.”* [October 2006]

Many of the participants described a lack of available funds for immediate expenses. For some, the rent the program pays helps to free up money for other necessities such as clothing or fees for children's extra-curricular activities. One participant talked about how limited the family is financially and how saving for a security deposit can take a long time:

*"When we moved in to our apartment, they helped us with the deposit. Most deposits in Mankato are the same amount of rent. So for a family, you are looking at \$700 and even when you're working and on public assistance, and doing both, there is no way you can come up with \$700. ... I don't know anyone who has a savings account... You could probably save for a year... Most families live month to month and don't have the ability to save... They also help with the transition of going from Journey Home into Section 8 or going on your own."* [October 2006]

Case managers appear to play an important role:

*"I don't know what all services are available, but when you talk to your case worker and she'll ask what you need or what they can give you to help you out or something and if you tell them what your looking for or what you need, they'll let you know."* [October 2006]

*"It's kind of on a needs basis. We just went off Journey Home and onto Section 8 and we had just moved into a house and lived there for six months and all of a sudden they wouldn't authorize the house we live in, which Journey Home did. The standards for Journey Home for the amount of rent per month was higher than for what Section 8 was, so we had to move onto Section 8 and couldn't stay where we were living, so I went to them said we're forced to move and I have no money for a moving truck and so they helped us with the cost of the moving truck...so I think it depends upon your situation and if you need help."* [October 2006]

**Concerns.** In terms of concerns, parents mentioned not knowing about service options:

*"We're not told what services are available. We just ask, and sometimes they say we can get that for you. But we don't get an outline of what is available to us."* [October 2006]

*"I don't think they should put limits on the kids. When it comes to the kid's needs and the kids activities, they shouldn't be so limited. When it comes to cutting stuff that I need, that's fine."* [October 2006]

Many of the respondents from Mankato talked about the lack of after-school activities for their children:

*"There is not enough out here for the kids to do. There is the library, the YMCA. But I think they should put more out here like a skating rink, a Chuckie Cheese. There needs to be more fun, exciting things for them to do. There is nothing wrong with the library. I take my kids there all the time, and I have the computer, the Internet at home. But to go out to eat and have fun. I know this is a college town, but you have to accommodate everybody, because there are more families coming here. I feel that you have to travel to the city or something or another part of town to have fun... to go skating or to go to Chuckie Cheeses. I just want my kids to have fun as*

*a child as much as they can before they get older, but it's boring out here... I mean, I find things to do with them but, I mean, I'm from a big city. I'd like to have museums out here, something more educational. There needs to be more entertainment, recreational things for them to do."* [October 2006]

During the focus groups, participants described how the programs provided referrals to other community services. Although Project Quest and Journey Home also helped to meet some of the costs associated with extra-curricular activities, these costs often remained prohibitive. Participants want their children to participate in community events but often do not have the funding.

*"For some of the things they have, they want you to pay for them and it's too high... I don't have the funding... for community services... It cost \$20 or \$30 per child and I don't have money to spend like that. I would rather take them to the 'Y' because they have a day care there and will watch your kids while you work out... But I mean they should have a little care thing where you can pay \$5... Like I got a letter from my daughter yesterday talking about some skating thing from the school and it was like \$5 and I can afford that but the ones they do talk about for camp is like \$30 or \$40 and I say, 'child that is too much money' ...for a week, for me it is."* [October 2006]

Some participants felt that allowing children to participate in programs that are not part of or sponsored by the agency would help enrich their social development. One parent shared her opinion of the programming and what she would like to see changed:

*"Just because I am on this program doesn't mean that I'm socially handicapped. They always want to put your kids in some kind of program thing or this or that. No, I want my kids to interact socially out in public. They want to have their program stuff. I want my child to participate in the neighborhood in activities I cannot afford. Like, they have a two week basketball camp, you know. He interacts with kids. I need him to interact socially outside the house. How I worked it out was... I had him go one day a week and he got out and got to see life from a different point of view with different people who weren't in programs and didn't have problems."* [October 2006]

Another parent felt differently:

*"I don't have any of those issues. I mean, my kids are doing just great. They get out; they're active. A lot of the issues you guys have, I just don't have."*

## PART 4: DISCUSSION

This descriptive study documents the needs of formerly homeless children and their parents served by a rural (Journey Home in Mankato) and an urban (Project Quest in St. Paul) program in Minnesota. The study was conducted by the National Center on Family Homelessness (NCFH) under the umbrella of Hearth Connection's Supportive Housing and Managed Care Pilot. It documented that the 62 children initially in the study had extremely high levels of exposure to traumatic stress, including homelessness itself. Not surprisingly, a disproportionate number of the children developed behavioral symptoms and post traumatic stress disorder. With a focus on patterns of service use at two points in time (mid-2005 and mid-2006), this report documented that the children had extensive service needs. Although many were met during the course of the study, the children and their families were still in need of trauma related services, additional mental health support, and after school activities.

Headed primarily by mothers alone, the 48 families (2005) tended to have approximately three children with an average age of 11 years old. Unlike many of the reports in the literature that describe sheltered homeless families (Bassuk, Weinreb, Buckner et. Al, 1996), the parents in this sample tended to be older (average of 37 years) and had experienced repeated episodes of homelessness, including some of long duration, and were struggling with complex mental health and substance use issues. They had received medication, outpatient treatment and some had been psychiatric inpatients, while others had made suicide attempts. A smaller proportion in the sample had been in detoxification and rehabilitation for substance abuse problems. Histories of trauma were not within the scope of the study.

By the end of the study period in 2006, all families were stably housed and supported by rental subsidies and other benefits. By the end of the study, all the families were receiving health insurance. However, the parents' social capital and resources were limited. Nearly half had less than a high school education, and less than one-fifth were currently employed. They cited mental health and substance use issues as the primary reason for not working.

Within this context, how are the children faring? The study documented that the children had experienced high levels of exposure to many traumatic events, mostly in their homes and neighborhoods. These events often are sudden and seemingly random and outside the usual range of a child's experience. The children in this study not only witnessed various violent events but also directly experienced a subset of them. These included a range of violent events such as seeing someone beaten up, hearing gunfire, seeing someone shot or attacked, and witnessing a bad accident. Four children had seen someone violently killed and two found a dead body. Others directly experienced being beaten up and chased, being in a natural disaster and seeing a bad accident. Two children had been shot.

The aftermath of traumatic stress can be profound and long-lasting and may result in psychological symptoms and seriously compromised functioning in critical areas of a child's development. Not surprisingly, many of the children in the study manifested emotional and behavioral symptoms. On the Child Behavior Checklist (CBCL), boys between the ages of 4 and 11 years, and adolescent girls between the ages of 12 and 18 years, had serious problems that

could benefit from clinical intervention. Scores approached the clinical range for many other children, and increases in scores were observed from 2005 to 2006 but because of the small sample size, we were not able to document the level of significance.

Overall, the children in the sample had disproportionately high levels of post traumatic stress disorder (PTSD). This is not surprising given the multiplicity and types of traumatic events these children experienced. Older children were more able to describe symptoms associated with PTSD. In contrast, on the CBCL, younger boys scored in the clinical range for Total Problems and Externalizing behaviors (e.g., acting out). The CBCL—which focuses on total problems and behaviors and adds additional information about the symptoms of the children in the study—supports the contention that many of these children have major emotional difficulties. Surprisingly, children in this study did not have elevated levels of depression as indicated by the Children’s Depression Inventory.

The data indicate these children had significant difficulties in school—possibly a result of their traumatic exposure, post trauma responses and subsequent behavioral problems. Almost half of these children had an individualized educational plan (IEP) and most of this subgroup were enrolled in special education, entitling them to special services. In addition, 30 percent were diagnosed with a learning disability. Parents indicated that they were pleased with the academic services provided by the schools, but requested additional clinical and extracurricular services. Parents also felt that early intervention services for the younger children were comprehensive and adequately provided.

It is also not surprising that given the level of distress and symptoms manifested by many of the children, many parents had high levels of parenting stress. Not only are these caregivers parenting alone in the context of extreme poverty and homelessness, but they also must cope with unsafe and violent environments in which their children are repeatedly exposed to traumatic stresses, predominantly in their neighborhoods.

A major focus of this study was to determine what services the children were receiving. Overall, the parents felt that the children had been provided with needed services in many areas, such as health (e.g., medical and dental), early intervention, and academic supports. For many families, additional service needs were met by the programs. Compared to many programs nationally where only very limited services/ programs are provided for the children, this is a major success. Because of limited resources, children have tended to be ignored and parents have been left to provide for their total care. This is not the case in these two programs in Minnesota where significant and pressing service needs have been met.

However, despite the considerable successes documented by this study, various omissions still remain and can be grouped into two areas. First, parents described a lack of extracurricular activities and summer opportunities. As one parent summed up, “there is not enough out here for the kids to do.” Although there is competition for the scarce resources that exist, many of these children might qualify for participation in mainstream programs. Additional costs, time for advocates to help obtain slots for these children, transportation issues, and the stigma associated with homelessness would all have to be overcome to make this a reality.

Second, trauma-informed and trauma-specific services are generally lacking (Jahn Moses, Reed, Mazelis, et al, 2003). Although parents did not express it in this way, they asked for increased group/family counseling to better address their own needs and the pressing needs of their children. Given the high levels of traumatic exposure experienced by the children and the high rates of PTSD, as well as the complex mental health and substance use issues of the parents, developing programs that are recovery-driven and trauma-informed are critical for the well-being of these families and may possibly play a role in helping them retain stable housing.

What are trauma informed services? Because of the extremely high prevalence of traumatic exposure and PTSD among homeless families and children, all programs must become trauma informed in order to provide responsive services. Trauma informed services assume that all levels of staff in the program understand the dynamics of trauma, the nature of traumatic responses, including “triggers,” and the importance of leveling as much as possible the power differential between staff and clients while maintaining appropriate boundaries. (Jahn Moses, Reed, Mazelis, et al, 2003) Implementing trauma informed services requires that programs adopt an attitudinal and cultural change that helps staff view the provision of services as well as client’s responses through the lens of trauma. To accomplish this, technical assistance/ training must be available for staff at all levels of the program – an activity that requires resources and the buy in of program administrators and decision-makers. At the same time, it is important to engage community stakeholders in activities that support a broader response that encourages them to participate in addressing community-wide safety issues as well as the pervasiveness of violence. As described by Macy, Behar, Paulson et al (2004), this involves a “continuum-of-care model for the care and management of individual and group responses to shared, traumatic events” (p. 217).

Finally, comprehensive family supports should be developed that include parenting resources for the mothers, additional childcare as necessary, and supported employment. Without this additional help, it is unlikely that parents will be able to become self-supporting.

Based on the study findings, we will conclude by making the following recommendations:

- All services for homeless families and children should be recovery-drive and trauma-informed.
- All parents and children should be systematically assessed for histories of trauma, mental health and substance use issues, and educational and job needs.
- Community-based trauma-specific services for children should be identified and programs should develop clear routes for timely referrals.
- The unmet mental health, substance use, and trauma histories of the parents should be systematically identified and addressed.
- Comprehensive employment support including job counseling, education, supported employment, real job opportunities must be part of the program.
- Parenting supports should be provided.
- Increased after-school, mentoring, and summer activities for the children.

The rental assistance and case management provided by the Minnesota programs have provide are a critical first step. They have successfully addressed many unmet needs of the children, but

this should be viewed as the beginning. Additional work needs to be done to develop adequate services to address the issues associated with high levels of exposure to traumatic stress and its associated adverse mental health and educational outcomes. Further, these efforts must be supported by providing additional supports for the children and families as described in this report.

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**APPENDIX: ADDITIONAL TABLES**

Family Move	44
Close Relative Died	38
Witnessed Violence	18
Experienced Physical Violence	15
Parent Ill	13
Other Close Family Member Ill	12
Child Ill	9
Sibling Died	8
Close Friend Died	5
Parent Died	2

Event	Location				Totals
	Home	School	Neighborhood	Elsewhere /Multiple	
Someone Beaten (N = 33)	3	12	6	12	33
Seen someone chased (N = 26)	3	6	13	4	26
Heard gunfire (N = 24)	7	1	7	9	24
Seen a bad accident (N = 20)		1	11	8	20
Suicide of friend (N = 11)			3	8	11
Seen someone get shot at (N = 8)	1		5	2	8
Seen someone attacked (N = 7)	3	1	2	1	7
Seen someone get shot (N = 4)			4		4
Seen someone violently killed (N = 4)			3	1	4
Found a dead body (N = 2)			1	1	
<b>Totals</b>	17	21	55	46	139

<b>Table 3: Child's Report of Experienced Trauma</b>					
<b>Event Child Experienced</b>	<b>Location</b>				<b>Totals</b>
	Home	School	Neighborhood	Elsewhere /Multiple	
Been Beaten-up (N = 18)	2	6	7	2	17
Natural disaster (N = 16)	14		2		16
Chased (N = 11)		4	6	1	11
Bad Accident (N = 10)			5	5	10
Shot At (N = 5)	1		2	2	5
Been Shot (N = 2)		1	1		2
<b>Totals</b>	<b>17</b>	<b>11</b>	<b>23</b>	<b>10</b>	<b>61</b>