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Programming Serving the Needs of Homeless Adults and Families: A Survey to Determine Current Practices in Transitional Housing Programs within the Interfaith Hospitality Network

Nathan A. Paro
Philadelphia College of Osteopathic Medicine, nathanpa@pcom.edu

Philadelphia College of Osteopathic Medicine

Department of Psychology

Programming Serving the Needs of Homeless Adults and Families: A Survey to Determine Current Practices in Transitional Housing Programs within the Interfaith Hospitality Network

By Nathan A. Paro

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Dissertation Approval

This is to certify that the thesis presented to us by Nathan Paro

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Committee Members' Signatures:

Bruce S Zahn, EdD, ABPP, Chairperson

Robert A DiTomasso, PhD, ABPP

Michael Colbert, PsyD

Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology

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Abstract

Over the last decade the rate of homelessness has continued to rise, putting an increased demand on services for the homeless such as transitional living programs. There appears to be little information about the standards of practice within the field of transitional living programs for the homeless. The current study surveyed directors of transitional living programs that serve women and children within the Interfaith Hospitality Network across the country, in order to compile information such as programing offered, services offered, and outcome measures which are used by the programs to determine success. The results of the survey suggested that there is great variability between and among programs in terms of service rendered, little programing to address mental illness, and a lack of established outcome measures. Implications for transitional living programs, limitations of the present study, and recommendations for future areas of research within this area are presented.

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Chapter One: Introduction

Statement of the Problem

The number of homeless people in the United States has continued to grow, yet there has been a decrease in the rate of published research on homelessness over the last decade (Culhane, Parker, Poppe, Gross, & Sykes, 2007). To illustrate the seriousness of this problem, it is important to highlight the impact of chronic homelessness. In 1996, over 400,000 people in the United States had been homeless for more than one year (Cunningham & Henry, 2007). The continued problem of homelessness has been influenced by factors including unemployment, poverty, limited access to affordable housing, substance abuse, availability of housing subsidies, and domestic abuse issues (Washington, 2002; Bassuk et al., 1997). The rising rate of homelessness has led to an increased demand for resources amongst this population. This increase in demand for resources has also led to flooding of services such as soup kitchens, food pantries, and homeless shelters.

The problem of homelessness comes with broad based effects that impact society as a whole. The lack of support services available to the homeless has also led to the overuse of other public services. The homeless have been found to put increased strain on emergency rooms, law enforcement, and other public resources (Drury, 2008). Therefore it is clear that homelessness not only impacts the homeless but also has a significant impact on society as a whole.

The problem of homelessness also has tremendous costs. This refers to costs felt not only to the individuals who become homeless, but also to the general public. Studies have shown that homeless populations have higher rates of hospitalizations for mental health and substance abuse problems, as well as greater usage of emergency rooms (Culhan et al., 2007). In addition to these greater rates of hospital usage compared with non-homeless individuals, the homeless also

tend to have lengthier stays when they are hospitalized. For example, Culhan et al. (2007) reported that the average length of hospitalization for the homeless is 36 percent longer than that of non-homeless patients. It is hypothesized that these greater stays may be explained by the fact that these individuals do not have suitable shelters to which to return. The overuse of hospitals and emergency services by the homeless can be a costly drain on public services. The effects of homelessness also impact the economy. The financial difficulties that are faced by this population directly impact their ability to contribute to investments and consumption, therefore negatively impacting the gross domestic product.

Although policymakers have recognized a need for services for the homeless, problems still exist in the delivery of services. The U.S. Department of Housing and Urban Development (HUD) began a program in 2008, providing 150,000 units of permanent housing to homeless individuals (Drury, 2008). The problem lies in the fact that these programs provide housing only for the most needy. For example, this program by HUD provides housing only to individuals who present with chronic homelessness that is co-morbid with substance abuse, serious mental illness, developmental disability, or chronic physical illness (Drury, 2008). This leaves a significant chunk of homeless individuals, who do not have co-morbid disorders, without access to services. This group, who are often referred to as the "new homeless," consist of individuals and families who have lost work, cannot meet rent costs, or experienced housing foreclosures.

It is clear that there is great competition for funds for social service and charity dollars to fund programming for the homeless. For this reason, it is important to ensure that the programs that are funded to serve the homeless are effective. There are limited resources available to provide aid to homeless programming. Therefore, the funds that are available must be used to do the most good. It is important to have efficient means to evaluate both the successes and

shortcomings of public service programming such as transitional housing. This can ensure that the programming that does exist is doing the greatest good. The proposed study will be a survey of short term and transitional housing programming for the homeless. This survey will attempt to capture a picture of the current state of programming for the homeless by assessing the different services that are provided and the skills that are developed amongst consumers. The results of the proposed survey will be useful in establishing the standards of practice within this field, in helping program administrators to determine those aspects of their programs that are lacking and could be augmented and by providing information to consumers, legislators, and the general public about the extent of services provided within transitional housing programs.

Purpose of the Study

The current study will be a survey of short term and transitional housing programs for the homeless. It is anticipated that the information provided by this survey will help to provide, to the program directors, useful information that can be used to evaluate and possibly modify the current scope of services. This will be achieved by collecting data that can be used to establish the standard of practice with regard to supportive programming for the homeless. In addition to being beneficial for program administrators, the information provided by this survey would also be useful to consumers, funders, and the general public.

Consumers have both a right and a need to be provided information necessary to properly evaluate the services they are considering using (Culhan et al., 2007). This may even be considered to be a part of the process of obtaining a truly thorough informed consent. This helps to move consumers toward taking active roles in their recovery from homelessness and is consistent with the basic tenets of Recovery-informed care. Theoretically, this would allow consumers to have an understanding of those services that are available within different programs

which would aid in their informed decisions for their care. This type of approach can be a helpful in order to set the stage for a program's expectations for consumer participation toward recovery. This is an important factor in helping to empower the participants who will embark on the journey from homelessness toward independent living (Washington, 2002).

Programs for the homeless depend heavily upon contributions from outside sources. Funding for such programming comes from a variety of areas including private donors, interfaith charity organizations, and government funders. The proposed survey may help to provide important information to contributors, funders, and policymakers by compiling detailed information about programming for the homeless, including program characteristics, trainings, and components (Culhane et al., 2007). This data will be useful to show where different programs stand and also can help to point out areas where programs can be improved. Additionally, the information provided can also tell agencies what further funding is needed and how future contributions could be used to increase and improve programming.

Chapter Two: Review of the Literature

Causes of Homelessness

Homelessness Defined.

The homeless consist of individuals who have patterns of unstable housing. Factors including mental illness and substance abuse have contributed to homelessness in the past and have impacted the stereotypical view of who the homeless are. Although the homeless are made up of individuals with mental illnesses and those who have substance abuse problems, this represents only one segment of the population.

One segment of the homeless population that has been growing recently involves families. This is often influenced by poor financial resources. Although some homeless families are headed by fathers or by both parents, the majority, by far, are headed by homeless mothers. Most homeless families consist of a single woman in her late twenties and at least two children under 6-years-old (Rog & Buckner, 2007). This segment of the homeless is typically impacted by domestic violence. Individuals who live in abusive relationships sometimes become homeless in order to escape their abusive partners.

Family homelessness has also been impacted by job loss, housing foreclosures, and unstable finances, any of which can leave entire families without housing. This group does not always fit the general perception of the homeless because they often have places to live. They may be living in hotels, cars, in and out of shelters, or even staying with extended family. These housing arrangements tend to be short term and very unstable.

Risk factors.

There are a number of risk factors that can lead to individuals becoming homeless. Risk factors such as physical health, socioeconomic status, ethnicity, mental illness, and education level have been identified within the literature.

Physical health has been indicated as one factor that contributes to homelessness. One study found that a significant portion of homeless people who were interviewed attribute their homelessness to physical or mental health problems (Crane, Warnes, & Fu, 2006). These individuals reported that they were unable to sustain permanent housing due to the ways in which their physical and mental health problems impacted their functioning. It is also conceivable that once one becomes homeless that it may be more difficult to recover from physical health problems and maintain their physical health.

One of the more obvious risk factors for homeless is income. Homeless mothers, for example, have been found to have income levels that are significantly lower than the national poverty level (Rog & Buckner, 2007). In a 1996 study of female-headed, homeless families, Bassuk et al. found that half of the sample made less than $8,000 per year. People who have lower incomes have fewer housing options and may have greater difficulty paying their rent. In addition to fewer financial assets, the homeless have been observed to have different money management strategies when compared with individuals who have stable housing. For example, homeless people are less likely to commit money towards building financial safety nets (Martens, 2002). It is unclear whether or not this characteristic is a result of a lack of finances or is a general trait of this group.

Another risk factor that has been identified for homelessness is ethnicity. The literature indicates that homeless families are more likely to be members of ethnic minority groups (Rog &

Buckner, 2007). According to Burt et al., in 1999, 62 percent of homeless families were members of ethnic minorities (as cited in Rog & Buckner, 2007). African Americans have been identified as having some specific disadvantages for emerging from homelessness. For example, families from this group have been shown to have fewer chances of finding permanent housing than do whites and Hispanics (Rocha, Johnson, McChesney, & Butterfield, 1996 as cited in Camasso, Jagannathan, & Walker, 2004).

Another risk factor for becoming homeless is having a mental illness. A clear relationship between homelessness and mental illness has been identified throughout the literature. Research that used data from the United States, Great Britain, Australia, and Canada has shown that one-third of homeless adults had a previous history of psychiatric hospitalization (Martens, 2002). A longitudinal study of women in an urban community in Michigan also found that mental illness was a leading factor associated with homelessness (Phinney, Danzieger, Pollack, & Seefeldt, 2007). Some of the more common psychological diagnoses that are given to the homeless include depression, schizophrenia, and substance abuse (Martens, 2002).

In addition to these previously noted risks, there are various other risk factors that have been found with individuals with homelessness. People who are homeless tend to have lower levels of education when compared to non-homeless populations (Martens, 2002). Phinney et al. (2007) found in their sample of homeless women that individuals with less than a high school education were more likely to be homeless. Another factor that specifically relates to families is the trend of absent fathers. Families that are homeless are more likely to have fathers who were absent from the family when the children were growing up (Martens, 2002). It should be noted however, that a number of shelters that serve homeless families target homeless mothers and do not always allow adult men to live there. It is unclear whether or not this may help to explain the

findings by Martens (2002). Social support systems often serve as protective safety nets for individuals. Homeless people tend to have lower levels of social support and greater levels of family conflict. Another trend is that families with greater numbers of children and families headed by older adults tend to have lengthier shelter stays (Camasso, Jagannathan, & Walker, 2004).

Protective factors.

There also appear to be some protective factors that have been identified as helping to prevent individuals from becoming homeless. One protective factor that has been identified is the number of adults in one's immediate family. Findings suggest that greater numbers of adults living within the family has been paired with a greater likelihood of stable housing (Rog & Buckner, 2007). This is due to the increased likelihood of a secure income existing within the family unit because of the greater presence of working adults. Single adult families may have much lower incomes, making them more susceptible to becoming homeless. Other protective factors include having access to housing subsidies, cash assistance, a high school diploma, and having a large social support network (Martens, 2002). Strong social support networks, in particular, have been shown to serve as key buffers that can prevent individuals from becoming homeless.

Why does homelessness exist?

There are a number of variables that have been identified in relation to homeless. In the past, much attention was given to personal variables that contribute to homelessness such as mental illness and substance abuse. More recent research has focused on structural risk factors. Structural risk factors consist of variables that are due to the structure of the economic system in

which we live. The main structural variables that have been investigated include poverty, economic conditions, lack of affordable housing, and reduction in entitlement benefits (Ji, 2006).

Poverty

One obvious factor that contributes to homelessness is poverty. A low income level can directly lead to individuals and families becoming homeless. A sudden loss of income can lead to homelessness as well. These unfortunate life circumstances can make paying for housing costs or for rent very difficult or even impossible to keep up with. When one's income becomes too low to cover the basic costs of living, he or she is at risk for housing instability.

Even when faced with hardships such as poverty, many families can acquire social services and emergency aid that can help to keep them from becoming homeless. Many communities have emergency supplies such as clothing and food that are available to those in need. The provision of these goods can, at times, provide enough relief to help keep people in their homes. Income can often be supplemented by welfare benefits such as supplemental income, free health clinics, and food stamps. These types of aids help to reduce other financial strains that can often lead to homelessness and often help to keep families from becoming homeless. Ji (2006) found, in a study looking at major metropolitan areas, that the reduction or loss of entitlement benefits is one key structural factor that leads to homelessness. This point illustrates the fact that such services are imperative to impoverished families.

Unemployment

A factor that leads to poverty and subsequently to homelessness is unemployment. Once someone becomes unemployed, his or her chances of becoming homeless increase. There is also a clear relationship between the length of unemployment and homelessness; the longer one has been unemployed, the more likely one is to become homeless (Gould & Williams, 2010). This

fact indicates that the topic of homelessness in the United States is a timely one, especially considering the increased rates of unemployment and the increased lengths of unemployment observed across the country recently. According to Gould and Williams (2010), the number of families in emergency shelters is positively related to the unemployment rate. This is a strong indicator that job loss influences housing instability.

Limited access to affordable housing

Another factor that impacts homelessness is the lack of affordable housing. Since the 1990's, there has been a decrease in available, affordable housing (Rog & Buckner, 2007). The combination of the decreased availability of affordable housing paired with the recent economic downturn has made the task of acquiring stable housing increasingly difficult. In fact, the lack of affordable housing has been identified as one of the main reasons for homelessness in the United States (Ji, 2006). The homeless also report this to be one of their main problems. Barrow and Zimmer conducted a needs assessment survey of homeless individuals, indicating that the absence of access to affordable housing was their primary need and their main reason for being homeless (Barrow & Zimmer, 1998).

Substance abuse

Another factor that contributes to homelessness is substance abuse. Addictions to drugs and alcohol can often be precipitating factors leading to homelessness. One study looking at homeless women found that substance use was one of the top two factors associated with homelessness within this sample (Phinney et al., 2007). Substance abuse is an all encompassing disorder that impacts a number of the risk factors to homelessness including physical health, personal finances, and social functioning. It is conceivable that an individual who is addicted to a substance may reprioritize housing in order to fund his or her addiction. As previously stated,

a strong social support network is a key factor in avoiding homelessness. It is also known that substance abuse issues often cause turmoil in the addicted person's life and can be damaging to his or her social support network. However, it should also be stated that, according to Barrow and Zimmer (1998), only 9% of homeless individuals surveyed indicated a need for alcohol treatment. This finding suggests that this problem may not be as severe as previously believed, but it still represents a significant problem within the field.

Severe mental health issues

Severe mental illness has often been present amongst the homeless. There is a disproportionately high rate of serious mental illness amongst the homeless. This subgroup also identifies lack of affordable housing as their key problem (Barrow & Zimmer, 1998). A survey of this group found that their main self-perceived need was for housing (Barrow & Zimmer, 1998). In addition, other identified needs of this group included mental health services, medical care, dental care, and financial assistance (Barrow & Zimmer, 1998).

Domestic abuse

Another factor that can lead to homelessness is domestic abuse. This specific factor related to homelessness typically affects women and children. One persuasive reason to stay with an abusive partner is due to the fact that he may be the gatekeepers of income and the source of stable housing. This leaves individuals involved in abusive relationships to make the difficult decision between housing and abuse. Women who are ready to make the decision to leave abusive relationships may also be making the choice to become homeless and poor. This subset of the homeless population struggles through issues such as exposure to trauma in addition to their homelessness.

Homeless families also have been found to experience greater instances of trauma, conflict, and violence. This may be more closely related to poverty in general than to homelessness. According to Rog and Buckner, levels of violence amongst the homeless appear to be similar to those seen in non-homeless families who were equally poor (2007).

Programming for the Homeless

During the period from the mid 1960s to the mid 1980s, programming for the homeless had a relatively narrow focus. Many of the early programs that were set up to benefit the homeless focused mainly on the alcoholic homeless. The goal of this very narrowly targeted approach was decriminalization of public drunkenness (Mercier, Fournier, & Peladeau, 1992). These early efforts worked to help reduce the number of alcoholics in the criminal justice system but may have done little to reduce homelessness.

During the late 1980s, the next wave of programming for the homeless began to take shape. The deinstitutionalization of patients from long term psychiatric facilities changed the face of homelessness (Mercier, Fournier, & Peladeau, 1992). The introduction of new and successful medications helped to reduce the level of care necessary for individuals who had chronic and serious mental illnesses. This led to these individuals being discharged from the long term institutional lifestyles that they had lived within. Many of these individuals had been institutionalized for a number of years and were ill-equipped to live independently. The combination of life skills deficits and the lack of affordable housing, led to an increase in homeless individuals with chronic mental illnesses.

Evaluating Programming for the Homeless

During the period from the mid 1960s to the mid 1980s, there was little research that could be found that focused on evaluating programming for the homeless. In a world where

funding is often scarce and difficult to secure, it is important that fiscal resources are allocated toward programming wisely. The best way to ensure that the funds that are being spent are doing the most good is to evaluate programming for the homeless in terms of benchmark outcomes in order to establish standards within the field.

Moving into the future, it is important to make efforts to evaluate outcomes of transitional housing programming for the homeless. In order to evaluate programs for the homeless, it is necessary to have an understanding of the problems that exist with this group. Barrow and Zimmer (1998) suggested that effective evaluation of programming for this population requires measurement across multiple domains. These include examining information about a participant's income, access to food and clothing, social support, employment, involvement in the criminal justice system, access to health care, and access to social and vocational services (Barrow & Zimmer, 1998). It is also important to measure the personal health status of participants. This includes aspects of both physical health and mental health, such as substance abuse and quality of life (Barrow & Zimmer, 1998). Quality of life tools have been used as reliable measures of one's overall satisfaction with services (Barrow & Zimmer, 1998).

The New Face of Homelessness

Since the 1980s, the face of homelessness has changed greatly. During that time, homelessness was more than simply a lack of stable housing. Homelessness was generally a secondary problem to pre-existing mental illness and substance abuse. Although there are still many people who are mentally ill and are without housing today, this makes up only one subset of this population.

One change within the homeless that has been observed is the increase in homeless families. Before the 1990s, the homeless were typically single adults (Rog & Buckner, 2007). Homeless families typically present as single parents, typically mothers, and their children. A trend of increasing numbers of families in homeless shelters was observed in the late 1990s. One estimate states that within any given year there are 420,000 families that are homeless in the United States (Rog & Buckner, 2007). Included in these families are approximately 924,000 homeless children (Rog & Buckner, 2007). It is important to recognize the fact that these statistics do not account for families who may be living with other family members or who are living in substandard housing.

Invisible Homeless

The stereotypical view of the homeless being single individuals who may have substance abuse problems and may be dressed in tattered clothing does not account for all cases. The term "invisible homeless" has been used to describe homeless individuals who do not necessarily fit the stereotypical view of homeless individuals, which is someone living on the streets. In fact, the invisible homeless represent a group that are often not seen as homeless and who may not even be accounted for in many statistics on the homeless. The invisible homeless consist of individuals who have lost their primary housing but are not yet living on the streets. This includes people who are living with other family members, in hotels, and even in their cars. Individuals who fall under this newly identified category may still be working and have lives that often closely resemble their lives before loosing their primary housing.

For many families identified as the invisible homeless, living in shelters, transitional housing, or on the streets are options used only as a last resort. One reason for avoiding seeking help is that this causes families to give up many things including autonomy and even each other.

One commonality that has been seen with many shelters and transitional living facilities is that they often will not allow adult males to stay there. It appears that many programs separate women and their children from adult males in this field. This appears to be one factor that leads families to avoid seeking shelters. Families often appear to exhaust all other options in efforts to maintain independence and keep their families together.

One common, short term solution used by families to delay moving into shelters is living with family members or friends. A study by Shinn, Knickman, and Weitzman (1991) found that over 75% of homeless mothers had lived with friends or family members for a period of time before seeking shelter programs (Rog & Buckner, 2007). It is important to remember that the invisible homeless are often not accounted for in studies on homelessness. This indicates that estimates about the homeless may be underinflated.

Homeless Mothers

In addition to the many troubles and difficulties of homelessness, homeless mothers face a number of additional problems that make their experiences even more difficult. Rog and Buckner (2007) found that homeless mothers tended to have fewer years of formal education, compared with homeless males. They also found that homeless mothers had fewer job-related skills (Rog & Buckner, 2007). The combination of these two factors makes it increasingly more difficult for homeless mothers to acquire gainful employment. It can be seen how the issue of homelessness amongst mothers is a perpetual problem.

State of the Homeless

The overall wellbeing of the homeless is a factor has been experiencing great decline in recent times. One trend observed by Rog and Buckner was that the homeless have become financially poorer over the period of the early 1990s to the early 2000s (2007). In addition,

weaker finances and poorer general health has also been observed amongst the homeless (Rog and Buckner, 2007). This has been characterized by an increase in the number of reported physical health limitations and psychological distress experienced within the homeless population

Physical health

There are a variety of physical health problems that have been observed in the homeless. One finding showed that 15% of individuals in a transitional living program had co-morbid diagnoses of diabetes, arthritis, asthma, cirrhosis, seizure disorder, Hepatitis C, hypertension, Tourrette's syndrome, Sickle Cell disease, and Parkinson's syndrome (Bolton, 2005). It is conceivable that these physical health problems can impact one's quality of life. It is also conceivable that it may be increasingly difficult to treat these physical health problems within the context of being homeless.

Mental health

Many homeless people suffer from mental illnesses including substance abuse, schizophrenia, depression, psychotic disorders, and personality disorders. Research has shown that the combination of homelessness and mental disorders continue to be problems in both poor and rich countries (Martens, 2002). Not having one's basic needs, such as shelter, being met can exacerbate one's symptoms of mental illness. The presence of mental illness can make it more difficult for individuals to cope with homelessness and to secure and maintain stable housing in the future.

Depression

One category of psychological disorder that has been observed within the homeless is depression. In fact, Pluck et al. (2008) found the levels of mood disorders amongst the homeless

to be disproportionately high. The difficult life circumstances that accompany being homeless and not having basic human needs met often contribute to a depressed mood. Research has shown that mood disorders are a common occurrence among the homeless.

Various studies throughout the literature indicate that a high prevalence of mood disorders exist within the homeless. In fact, it has been found that homeless people in general have significantly more depression than non-homeless people (Pluck et al., 2008). A study by Bolton (2005), found that 27.9% of clients in a transitional living program had major depression diagnoses. In addition to this figure, 24.8% of the sample had a bipolar disorder and 19.7% had schizoaffective disorder. Other studies have shown rates that are alarmingly higher. Pluck et al. (2008) showed that 62% of their sample of homeless individuals had been diagnosed with a depressive disorder. A study by Martens (2002) found that 74% of homeless individuals were living with mood disorders.

According to Lam and Rosenbeck (1972 as cited in Martens, 2002), the quality of life for the homeless was directly related to the severity of their depressive symptoms. One factor that influences quality of life is one's relationships with others, including the strength of their social support system. Therefore, as discussed by Martens (2002), a factor contributing to depressed mood that is a major factor within this population is increased isolation. Isolation from social networks has long been known as a contributing factor to depressed mood and decreased access to social support networks can also lead to homelessness. As previously stated, social support networks often serve as buffers to homelessness, because individuals often lean on their supports to avoid public shelters and transitional living programs. Social isolation is a factor that has even been found to increase the duration of homelessness. A relationship was found in which rates of major depression had increased fourfold because of social isolation amongst the homeless; this is

in addition to less notable increases in the rate of post traumatic stress disorder (Rog and Buckner, 2007).

Anxiety

Anxiety disorders have also been observed within homeless populations. According to Taylor and Sharp (2008), families who are below the poverty line are typically exposed to greater rates of violence. High prevalence of both trauma and post-traumatic stress has also been identified in the homeless (Taylor & Sharpe, 2008). Research shows that the prevalence of anxiety disorders range from 22 to 35 percent among homeless people (Taylor & Sharpe, 2008; Martens, 2002).

A study by Taylor and Sharpe (2008), found that 98% of their homeless sample reported experiencing at least one traumatic event. This figure reflects the statement that post-traumatic stress disorder is also much more prevalent within the homeless population, compared with the non homeless general public. In one sample, 41 percent of homeless people had post-traumatic stress disorder compared with only 1.5 percent in the non homeless general population (Taylor & Sharpe, 2008).

Post-traumatic stress is not simply brought on by homelessness alone. In fact, for most of the homeless, trauma was experienced long before housing was lost (Taylor & Sharpe, 2008). Taylor and Sharp (2008) have suggested that increased exposure to traumatic events may be more directly related to poverty and not to homelessness alone. Regardless, it is clear that issues of anxiety are especially prevalent amongst impoverished individuals, regardless of the stability of their housing.

Psychotic Disorders

Another category of psychological disorder that has been seen within the homeless is psychotic disorders. As previously discussed, the homeless of the past were often characterized as individuals with serious mental illnesses. Some more recent studies have shown that up to 20 percent of the homeless in the United States suffer from psychotic disorders (Martens, 2002). It should be noted, however, that rates as high as 40 percent have even been reported (Martens, 2002). More conservative estimates indicate that 15 percent of homeless people have psychotic disorders (Cougnard et al., 2006). Findings have shown that psychotic disorders, much like the previously discussed mental health conditions, are disproportionally higher amongst the homeless.

A study by Cougnard et al. (2006) found that homeless persons were twice as likely as non homeless persons to have psychotic disorders. This study showed that homeless individuals with psychotic disorders also have a greater likelihood of having co-morbid disorders such as substance abuse. It also appears as though people with psychotic disorders may have an increased likelihood of becoming homeless.

Homeless individuals with psychotic disorders appear to have greater access to psychiatric care. According to Cougnard et al. (2006), this group appears to have a greater rate of psychiatric service use, when compared with non-homeless individuals with psychotic disorders. This indicates that opportunities to receive psychiatric services may be more available to homeless individuals who have mental illness.

Substance abuse

Substance abuse is another problem, commonly found with the homeless. It affects all subgroups of the homeless including mothers (Roger & Buckner, 2007). It has also been

identified as a factor that may lead to homelessness and a factor that works against individuals emerging from homelessness (Martens, 2002). Research in the United States has shown rates of substance abuse among the homeless to be between 29 and 50 percent (Martens, 2002). Studies of homelessness in countries such as Germany, have found rates of substance abuse to be up to 91 percent (Martens, 2002). An evaluation of a Philadelphia based transitional living program found that 61% of the 122 participants had an active problem with substance abuse or had a history of past substance abuse. These findings indicate that substance abuse is a serious problem among the homeless.

Substance abuse seems to be distributed unevenly across the homeless. In fact, it has been found that older homeless individuals are more likely to present with substance abuse problems than younger people. There also appears to be an inverse relationship between age and alcohol problems among homeless females (Martens, 2002). According to Martens (2002) more alcohol problems have been identified in younger homeless women, compared with older homeless women.

Substance abuse among the homeless does not stand alone. Homeless people with substance abuse issues often present with other co-morbid disorders. Mood disorders, anxiety disorders, and psychotic disorders are frequently present in homeless individuals with substance abuse problems (Martens, 2002). This illustrates the complexity of problems that the homeless face. In addition to factors previously mentioned, substance abuse problems can also be a source of great strain on social relationships. Sosin and Bruin (as cited in Martens, 2002) found that drinking problems often lead to the reduction in the protective nature of social networks. As previously mentioned, damage to social networks has been linked to a decrease in one's quality of life and as a precipitant to homelessness.

Impaired quality of life

An important factor when considering research on the homeless is the individual's perceived quality of life. It is clear that the effects of homelessness involve difficulties that go far beyond simply not having housing. As previously stated, homelessness affects all aspects of one's life. Therefore, homelessness has a strong effect on one's quality of life.

The homeless, if only defined by their lack of housing, have lower quality of life levels. It is easy to imagine that individuals who do not have their basic human needs met would be likely to have lower quality of life ratings. Transitional living programs for the homeless have demonstrated an ability to improve the quality of life ratings in many participants. A study by Bolton (2005) involved the administration of a self-report measure to a homeless sample in order to effectively measure the sample's perceived quality of life. One Philadelphia based transitional living program was able to help clients meet the quality of life improvement goals of 54% of their clients (Bolton, 2005).

Isolation

One factor that influences quality of life is isolation from others. Isolation works in two distinct ways against the homeless. One way that it works against the homeless is by distancing or separating them from the sources of supports in their lives. Individuals with high quality social support systems are likely to have people to fall back on during times of need. Isolation from one's support system can remove this safety net. Isolation serves as both a cause of homelessness and as a side effect of being homeless.

Another way in which isolation works against the homeless is by influencing mental illnesses such as depression (Martens, 2002). As previously discussed, psychological disorders are highly prevalent among the homeless. Isolation from one's social support network can work

only to further exacerbate his or her previous mental health problems. Cougnard et al. (2006) found that individuals with psychotic disorders were five times more likely to be single and to lead more isolated lives.

Transitional living programs for the homeless have demonstrated effectiveness in being able to decrease participants' levels of isolation. One transitional living program was able to meet the socialization goals of 72% of their clients by reducing patterns of isolation (Bolton, 2005).

Living skills

Another area of deficit that has been observed in individuals who are homeless is in the area of living skills. Living skills are defined as the abilities to carry out the tasks necessary for everyday living. This category of skills includes tasks such as paying bills on time, performing tasks necessary for keeping the house, budgeting time and effectively managing resources. Adults who have deficits in living skills may be more susceptible to losing housing and becoming homeless. A transitional living program evaluated by Bolton (2005) was able to demonstrate the ability to help 73% of their clients improve their general living skills. Improvements such as this are expected to serve individuals throughout their lives and help to prevent recidivism after graduation from the program.

Services Available to the Homeless

There are three main categories of assistance that are commonly accessed by the homeless. These categories include programming that serves to temporarily meet the immediate needs of the homeless, to services that provide a longer term solution. These services include hospitalization, emergency assistance, and longer term aid.

Hospitalization

The medical and psychiatric hospital systems are often among the first sources of treatment experienced by the homeless. Consumers have reported that this introduction to homeless services as a relatively unpleasant one (Drury, 2008). In many cases, homeless people have been found by police sleeping on or wandering the streets and are subsequently hospitalized (Drury, 2008). It is easy to understand the reason why this experience is perceived as unpleasant. This process could easily be interpreted as a message that they are an unwanted segment of the population or a problem that needs to be temporarily removed.

It is clear that these treatment methods are not successful treatments for the problem of homelessness and provide a quicker, temporary fix to a complex problem. After their short hospitalization, homeless patients report being discharged with the same problems that they were admitted to the hospital with (Drury, 2008). These patients report leaving the hospital with no housing, no money, little access to food, and no clean clothing (Drury, 2008). This practice provides little help for the homeless other than stabilizing them and providing very temporary shelter.

Hospitals do little to help the overall treatment of the homeless besides providing a meal and a safe place to stay. Hospital staff has reported that homeless patients seem to be looking for "the hotel treatment" (Drury, 2008). This really is not a system designed to treat the problems of homelessness on a long term basis. In fact, this practice can be viewed as harmful to the homeless by further stigmatizing them. In addition to stigma, the use of hospitals by the homeless is often a misuse of services. This can be detrimental to society in general by clogging up medical services to provide less necessary treatment. This can also contribute to financially strain an already fragile medical financial system which, in turn, increases costs for everyone.

Emergency Assistance

Another category of aid that the homeless benefit from is emergency assistance. Emergency assistance is typically characterized by short term aid that aims to help serve the immediate needs of the homeless. These include benefits such as temporary rental assistance and housing subsidies (Camasso, Jagannathan, & Walker, 2004). Other programs such as food pantries, soup kitchens, charity programs, and welfare may also be considered emergency assistance. Other forms of emergency assistance include temporary shelters and interfaith, community-based night shelters. Programs like these can be lifelines for those who are on the verge of becoming homeless (Camasso, Jagannathan, & Walker, 2004).

Transitional Living Programs

Another category of assistance for the homeless consists of longer term transitional living programs. Transitional living programs aim to provide longer term shelter and care for the homeless. In addition to providing more permanent housing, transitional living programs also provide other programming and skill building services in order to bridge the gap between homeless shelters and permanent housing (Camasso, Jagannathan, & Walker, 2004).

Transitional living programs typically consist of multifamily housing facilities (Camasso, Jagannathan, & Walker, 2004). In addition to the provision of housing, transitional living programs also provide access to social services, skills training, and assistance in finding permanent housing, health care, and jobs (Camasso, Jagannathan, & Walker, 2004). These additional services are the key to helping individuals acquire the necessary skills and community links that aid the homeless in moving toward self-sufficiency, more permanent housing, and the prevention of future homelessness (Barrow & Zimmer, 1998).

Despite the great benefits that transitional living programs provide, there are still many things that are criticized about this approach. Some believe that this approach can harm by stigmatizing residents further (Barrow & Zimmer, 1998). Others criticize that transitional housing programs serve as a drain on resources that would be better allocated to permanent housing (Barrow & Zimmer, 1998). Another strong criticism of transitional programming is that it often excludes homeless individuals with other co-morbidities. For example, there are a number of transitional living programs that exclude individuals with substance abuse problems, severe mental illnesses, certain physical limitations, and on the bases of gender.

Providing comprehensive services

Unlike shelters and hospitals, transitional housing programs aim to provide services that are more comprehensive. In addition to providing longer term assistance, these programs provide consumers with education components, job development services, opportunities to learn leadership skills, navigation to resources, and referrals (Washington, 2002). These comprehensive services are provided to help consumers achieve their ultimate goals of more stable and permanent living environments.

Transitional living programs run on a continuum ranging from low demand programs to high demand programs (Barrow & Zimmer, 1998). Low demand transitional housing is characterized by fewer rules, regulations, and training components. On the other hand, high demand transitional living programs have more structure, more rules, and have a greater emphasis on programming, skills training, services, and assessment. High demand programs aim to establish more comprehensive services including skills-building trainings and are often established with the goal of serving families. This is due to the belief that homeless families

have more complex problems and require treatment that is more highly structured (Barrow & Zimmer, 1998).

Research has shown that both high demand and low demand approaches are effective. Both low demand and high demand style programs have been able to demonstrate the ability to increase the likelihood of acquiring more permanent housing (Barrow & Zimmer, 1998). One reason why high demand programs fall short is due to their high attrition rates (Barrow & Zimmer, 1998). A study by Westat, Inc. National Evaluation of the Supportive Housing Demonstration Program found that only 57% of clients graduated from transitional housing programs (Matulef et al., 1995 as found in Barrow & Zimmer, 1998).

Characteristics of programs leading to success

Transitional living programs have a number of differences and variable success rates. Programs that are successful typically have lower staff- to- client ratios and clear program rules (Camasso, Jagannathan, & Walker, 2004). Programs with less structure have displayed poorer outcomes. Camasso, Jagannathan and Walker (2004) have, therefore, recommended that transitional living programs demand high service participation, shorter program duration, and more stringent program rules in order provide the optimal outcomes.

Measuring success in transitional living programs

A number of indicators can be used in order to measure the success of transitional living programs. Some common markers of success include increased economic self-sufficiency and improved overall quality of life (Camasso, Jagannathan, & Walker, 2004). It appears, however, that housing placement and program graduation seem to be the variables that are given the most merit (Barrow & Zimmer, 1998, Camasso, Jagannathan, & Walker, 2004).

The acquisition of more permanent housing is almost always the main definition of success used by transitional living programs. Camasso, Jagannathan, and Walker (2004) reported that the designers of the transitional living programs that they investigated believed that graduation is the most necessary condition needed to gain permanent housing (Camasso, Jagannathan, & Walker, 2004). One drawback to this thinking is that one can not recognize success until the program is completed.

There are other short-term measures of success that can be taken after graduation from the program. This typically includes learning about housing status after completing the program, length of time needed to acquire housing, type and quality of housing, and the residents' overall satisfaction with their housing (Barrow & Zimmer, 1998). Long term measures are necessary in order to determine if permanent housing is sustained or if other problems persist. Barrow and Zimmer (1998) recommended that investigators take a quick and simple approach to follow-up information. They suggest that investigators simply find out whether or not program graduates are currently housed and the number of days they have been homeless since graduation. It can be difficult to collect follow-up on individuals who are not housed and become homeless due to their lack of housing stability. This fact indicates that follow-up information will always be skewed to look better than reality.

Research has shown transitional living programs to be effective at increasing housing placement rates. According to Matulef et al. (1995 as in Barrow & Zimmer, 1998), 56% of participants in transitional housing went on to find more stable housing following participation in the program. This figure included a 70% placement rate for individuals who graduated the transitional living program and 30% of individuals who did not graduate (Matulef et al. 1995 as in Barrow & Zimmer, 1998). These findings suggest that graduation from a transitional living

program can more than double one's chances of finding housing. Therefore there are clear benefits, likely related to skills that are developed through the completion of these structured programs.

There has been evidence supporting the importance of graduation from transitional housing programs as being necessary in leading to the attainment of more permanent housing. In a program evaluation of four transitional housing programs in New Jersey, Camasso, Jagannathan, and Walker (2004) found that graduating from a transitional housing program significantly increased the likelihood that an individual would find permanent housing. It was also found that graduation from a transitional housing program led to a decreased likelihood in temporary housing placements (Camasso, Jagannathan, & Walker, 2004). It is important to mention that not all individuals graduate from transitional living programs. In fact, graduation rates range from 38% to 58 % (Camasso, Jagannathan, & Walker, 2004). Despite this, the findings by Matulef et al. (1995 as in Barrow & Zimmer, 1998) indicate that even partial participation in a structured transitional living program can produce clear benefits for participants.

It is safe to assume that the change that occurs during a transitional living program stay does not occur only at the point of graduation. Instead, skills must be built and acquired gradually. It is therefore important that transitional living programs gather information about change throughout the curriculum in order to better understand what factors indicate success. This can be helpful in order to track progress early on and throughout the duration of the program. This can also be helpful to predict failures and avoid pitfalls. Identifying early shortcomings within the program may give staff the opportunity to intervene to avoid

programmatic failure and help ensure completion of the program and increase success rates for participants.

One factor that may be used to measure success during the course of the program is self-sufficiency. Self-sufficiency is often a goal of transitional living programs that is, at times, understated. Barrow and Zimmer (1998) defined self-sufficiency as a movement from welfare towards work. This is based on the theory that individuals who have financial stability are likely to be more self-sufficient. To measure this, investigators gathered information about income and employment (Barrow & Zimmer, 1998). Self sufficiency is a goal that is considered to be significantly more difficult for people with serious mental illness to achieve (Barrow & Zimmer, 1998). Therefore, this measure would be most useful for homeless individuals that are functioning at a higher level, such as those commonly found in transitional housing.

Other studies of the homeless have used measures that were far less stringent. Bolton (2005), in a study looking at homeless populations with mental illness, measured success simply by the concept of "doing no harm." According to this, a program was deemed successful if either a positive change or no change was observed. Less stringent measures such as these may be necessary in more fragile populations who are prone to high dropout rates. This approach, however, is clearly flawed because the information that it produces is rather limited.

Housing placement rates

The rates of placement in housing after graduating from transitional living programs vary. A study by Bolton (2005) looked at housing stability measures and found that 84% of clients had stable housing (Bolton, 2005). A study looking at programs from New Jersey found successful housing placement rates of 25%, 27%, 56%, and 58% (Camasso, Jagannathan, & Walker, 2004). In the same programs 12%, 24%, 33%, and 41% of graduates who were not able

to find permanent housing placements went on to find other forms of temporary housing (Camasso, Jagannathan, & Walker, 2004).

Length of homelessness

The length time that an individual or family has been homeless is an important predictor of successfully finding more stable housing. It has been shown that there is a negative relationship between the length of time that one is homeless and the likelihood of finding more permanent housing (Camasso, Jagannathan, &Walker, 2004). Those who have a more chronic history of homelessness are less likely to secure permanent housing in the future.

Needs of the Homeless

The homeless have a number of needs that have been identified in order to help improve their quality of life. This includes areas such as housing, employment, acquiring services, and other personal social issues.

Housing

It is of little surprise that people who have deficits of their basic human needs put things such as hosing at the top of their needs. Housing is central to building a future (Browne, Hemsley, & St. John, 2008). In Herman, Strutening, & Barrow's (1994) study looking at the self- perceived needs of over 1,200 homeless people, permanent housing was identified as the number one need.

Housing is also considered a necessary component for maintaining wellness. According to Perham and Rickwood (2003 as in Browne, Hemsley, & St. John, 2008), the loss of housing is an important risk factor for the onset of mental illness. Housing is an important factor in helping to establish friendships, develop social networks, and work (Browne, Hemsley, & St. John,

2008). It has therefore been suggested that public policy should focus directly on ensuring that affordable housing is available for all (Browne, Hemsley, & St. John, 2008).

Income

In addition to housing, the homeless are also interested in securing a regular source of income. In one study, over 70% of respondents endorsed the fact that obtaining a job and gaining a steady income was a main goal (Herman, Strutening, & Barrow, 1994). In order to meet this need, programming has been added to help the homeless learn to improve job skills in order to increase their marketability. Many programs for the homeless also devote resources to helping them find employment (Herman, Strutening, & Barrow, 1994).

Problems with income are often at the root of homelessness. Sometimes, individuals have become homeless due to their mismanagement of personal finances. In order to address this shortcoming, the opportunity to learn money management skills has been identified as a necessary component of programming (Herman, Strutening, & Barrow, 1994). This finding falls in line with self- reports from the homeless who have a desire to learn skills such as budgeting (Washington, 2002).

Employment

The lack of employment is one problem that is seen throughout the homeless population. In fact, job training and leadership skills were two of the services identified as most helpful to individuals who graduated from transitional living programs (Washington, 2002).

Health Care

Health care is yet another need that has been identified by the homeless (Herman, Strutening, & Barrow, 1994). Homeless people often have medical problems to manage that go untreated due to pressures from their other needs and from lack of resources. These untreated

medical conditions tend to cause more damage as they remain untreated. It has been suggested that these conditions could be treated at a lower cost if treated earlier (Herman, Strutening, & Barrow, 1994).

Social Support

Another area of identified need for the homeless involves increasing their level of social support and developing and preserving relationships. As previously mentioned, social support systems are often a first line of defense against homelessness. Many agree that the homeless need help in order to work towards improving relationships with their families and friends (Herman, Strutening, & Barrow, 1994). Getting along with other people in general was noted as a significant need (Herman, Strutening, & Barrow, 1994).

Programming

Another, more broadly defined, area of need for the homeless includes their desire to participate in and gain access to programs developed for their benefit.

Increase access to mental health services

The homeless have also displayed a need for mental health services. Herman, Strutening, & Barrow's survey of homeless people (1994) indicated that they needed increased access to mental health services. Specifically, they identified needing help in coping with "nerves and emotional problems" (Herman, Strutening, & Barrow, 1994). A need was also identified in areas of drug and alcohol abuse (Herman, Strutening, & Barrow, 1994).

Assistance and benefits

The homeless also require assistance and education on how to acquire and maintain services. Herman, Strutening, & Barrow (1994) found that this population had a significant need for acquiring veteran's benefits. The need for assistance was also indentified in areas including

learning how to get services provided by agencies, getting public assistance, and getting social security (Herman, Strutening, & Barrow, 1994).

Needs of Families

Families comprise one of the fastest growing segments of the homeless population. In total, families make up over one-third of all the homeless (Paquette & Bassuk, 2009). Contributing to this growth are recent increases in housing foreclosures and unemployment rates, as well as the limited availability of affordable housing (Paquette & Bassuk, 2009). Families who are faced with homelessness are left with a number of needs that require fulfillment to end the bouts of homelessness and prevent recidivism.

One need that has been identified is the need for education. Most heads of homeless families are women in their late twenties (Burton & Aron 2000 found in Paquette & Bassuk, 2009). Most of these women have not graduated from high school, leaving them poorly marketable for employment. This fact highlights the need for an educational component.

Mothers who are homeless often have extensive histories of abuse. According to Paquette and Bassuk (2009), almost 92% of homeless mothers have experienced sexual or physical abuse at some point during their lifetimes. This indicates a strong need for mental health services to address psychological issues such as depression, anxiety, and post traumatic stress disorder.

It appears that the frequent abuse observed in this population has translated to increased rates of psychological disorders. For example, homeless mothers are more than three times likely to have post traumatic stress disorder (Paquette & Bassuk, 2009). In addition, according to Bassuk et al. (1996 as found in Paquette & Bassuk 2009), approximately half of homeless

mothers experienced a major depressive episode while homeless. More recent figures have found rates of depression to be as high as 85% amongst the homeless (Weinreb et al. 2006).

Homeless mothers also show a greater need for care for their physical health, compared with the non-homeless populations. According to Bassuk et al., (1996 as found in Paquette & Bassuk, 2009) homeless women are three times more likely to have chronic physical health problems that have gone untreated.

Challenges for homeless families

Homelessness can often dismantle the structure of families. Parents, for example, are often displaced through emergency services. The burden of homelessness on parents can easily lead to a decrease in their ability to provide loving, nurturing, guidance, teaching, and safety that would normally benefit children (Paquette & Bassuk, 2009). In homeless shelters, some roles formerly taken by parents are redistributed to shelter staff or to other family members who may provide temporary housing (Schulz, 2009). This can sometimes lead to conflicts concerning rules and values between parents and other adults in charge at living facilities.

There is great inconsistency amongst family shelters and their admissions and eligibility criteria (Schulz, 2009). Many family shelters do not allow males (Schulz, 2009, Paquette & Bassuk, 2009). This typically includes fathers but sometimes is applied even to adolescents. This can cause great stress on some families, leading fathers to become invisible which, in turn, can lead to change in the family structure (Paquette & Bassuk, 2009). In fact, according to a survey by the U.S. Conference of Mayors (2006 as in Paquette & Bassuk, 2009) found that more than half of families would have to break up in order to gain placement in a shelter.

Challenges for Parents

There is little question about the amount of stress that homelessness can bring to a parent. It is a common occurrence for parents of homeless families to be divorced either before or after the onset of homelessness (Rog & Buckner, 2007). As previously mentioned, fathers are often removed from their families in order to comply with shelter rules.

Another challenge is the reduced freedom that comes with many homeless treatment programs. A program described by Camasso, Jagannathan, and Walker (2004) requires residents to follow rules such as not drinking and not allowing outsiders into the facility. Some programs also have rules for how free time is to be used and how to discipline their children (Camasso, Jagannathan, & Walker, 2004).

Challenges for Mothers

Women are one of the largest growing segments of the homeless population in the United States (Martens, 2002). Of all the families who have been identified as homeless, 90% are headed by women (Martens, 2002). Other estimates show that 65% of homeless women have custody of their children, compared with 7% of fathers (Paquette & Bassuk, 2009). Parents who are homeless are also faced with the challenge of raising very young children. Of a sample of homeless families, 42% have at least two children under the age of six (Paquette & Bassuk, 2009). Homeless mothers are faced with a number of challenges.

Mothers who become homeless often come from very difficult life circumstances. They often fight an up-hill battle in trying to raise children, keep a home, and earn an income on their own. Being solely responsible for carrying out these tasks can be very difficult for mothers who do not have financial resources. For mothers who are faced with financial strife, this can be a setup for a path leading to homelessness (Paquette & Bassuk, 2009).

One of the main challenges that are faced by homeless women is extreme poverty (Rog & Buckner, 2007). In addition to this, they are also faced with lower social support (Rog & Buckner, 2007). They have less contact with members of their support networks and have more conflicted relationships. They also present with a lack of skills and abilities with regards to education and employment (Rog & Buckner, 2007). Homeless mothers have higher rates of substance abuse, compared with mothers of poor families (Rog & Buckner, 2007). Homeless mothers also report poorer health than non-homeless mothers and are more likely to have mental illness (Martens, 2002). Despite this difference in perceived health, homeless women typically have higher rates of access to health care for physical problems (Rog & Buckner, 2007). Homeless women also have drug and alcohol related problems. According to Martens (2002) homeless women are more likely to use illegal drugs and alcohol.

Challenges Faced by Children

The stresses of homelessness that affect parents have an impact on children as well. Rog and Buckner (2007a) reported that during the 1980s families with children began seeking services in homeless shelters meant for adults. Moving into the late 90s, 34 percent of the homeless were made up of families (Rog & Buckner 2007a). It has been estimated that 420,000 families with 924,000 children are homeless each year (Rog & Buckner 2007a). Chronic homelessness can also have serious effects on the well-being of children.

The lack of stability in the life of homeless children leads to serious mental health deficits. As many as 1 in 5 homeless children will be separated from their parents (Paquette & Bassuk, 2009). The reasoning for this includes voluntary separation to prevent trauma from homelessness, involuntary separation due to a parent's hospitalization, incarceration or substance abuse treatment, and the practice of excluding older boys and men from family shelters (Paquette

& Bassuk, 2009). A study by Martens (2002) found that homeless children under six-year-old were 52% more likely to have developmental delays. Mental health and behavioral problems, developmental delays, learning disabilities, poorer school performance, poorer physical health, and exposure to violence have also been observed as results of homelessness (Schulz, 2009, Rog & Buckner, 2007).

Homeless children have higher rates of psychological problems. According to Bassuk et al. (1996 as found in Paquette & Bassuk, 2009), 25% have experienced violence within their families. As many as 3 times as many homeless children experienced emotional and behavioral problems, when compared with other low income families (Gewirtz et al., 2008 as cited in Paquette & Bassuk, 2009). This indicates that homeless children would benefit from services such as psychotherapy to address emotional and behavioral problems and exposure to trauma.

Homeless children also show cognitive delays. According to the National Child Traumatic Stress Network, homeless children are four times more likely to have developmental delays. They also show that this population is twice as likely to have learning disabilities. Also, one-third of homeless children repeat a grade. These findings indicate that educational programming and afterschool learning support may be extremely beneficial for homeless children in order to help to bring them to their grade level proficiency. (2005 as cited in Paquette & Bassuk, 2009)

Children growing up homeless have also been found to have poorer physical health. Homeless children have greater rates of acute illness symptoms such as fever, diarrhea, asthma, and ear infections (Martens, 2002). According to Paquette & Bassuk (2009), homeless children are four times more likely to experience respiratory infections, twice as likely to have ear infections, and are five times more likely to experience gastrointestinal problems. This may be

related to the fact that homeless children also experience other physical health problems that contribute to illness, such as malnutrition and obesity (Paquette & Bassuk, 2009). It has been hypothesized that physical health deficits are mostly due to a lack of access to affordable health care and a lack of education (Paquette & Bassuk, 2009). Minor health problems may become de-prioritized when experienced in the light of the wide spread difficulties associated with homelessness. Homeless children, like their parents, would benefit from access to medical treatment.

There is evidence suggesting that the negative effects of homelessness on children are reversible. Research has shown that the negative effects and delays in the mental health, physical health, and school performance of homeless children can often be overcome once more permanent housing has been reestablished (Rog & Buckner, 2007). Children prove to be relatively resilient.

Empirical Support for Programming

The conceptual framework behind the transitional housing approach seems to be poorly defined. According to Camasso, Jagannathan, & Walker (2004), there is a lack of empirical evidence supporting the idea that preparing families for housing is the superior to alternative approaches. The authors go on to say that despite this lack of empirical support, the trend of transitional housing has been supported by both legislation and by other funding (Camasso, Jagannathan, & Walker, 2004).

Permanent Housing

The main goal that has been observed across transitional living programs is to help participants move towards more permanent housing. This goal has been pursued by different

programs that have used different methods. Finding permanent housing is not only a program goal, but it is also the main measure of success used for transitional living programs.

One differing characteristic across transitional living programs is the level of active participation required of consumers. Greater investment in participation is sometimes thought to reduce the personal freedom of residents. Some programs that have higher levels of active participation appear to produce graduates who have a greater likelihood of securing permanent housing (Camasso, Jagannathan, & Walker, 2004).

Transitional Living Programming

One aspect of transitional living programs that sets them apart from other less structured homeless services is the amount of training and skill-building opportunities that are offered. Transitional living programs offer a variety of programming aimed at helping improve the skills of consumers. These skills are believed to help consumers to secure stable housing, and to help reduce recidivism. Programming offered by transitional housing programs include employment training activities, case management, health education and assessment, life skills training, home management skills, parenting skills training, conflict resolution classes, child care services, after school programming, counseling, and housing relocation services (Camasso, Jagannathan, & Walker, 2004).

Components of Successful Programming for the Homeless

The problem of chronic homelessness is one that goes deeper than housing. This indicates that the provision of basic needs such as temporary shelter, food, and clothing are not sufficient to solve the problems that the homeless face. To thoroughly address the problem of homelessness, programs must take a comprehensive approach. The following will demonstrate some of the many gaps left by traditional shelter programs for the homeless.

Richards, et al. (2009) identified a number of programmatic components that are believed to be necessary in order to s address some of the problems of homelessness successfully. The authors indicate that short term shelter relief is not enough. Instead, the authors indicate that successful programming for the homeless must aim to provide longer term and more permanent housing options such as those offered in transitional living programs (Richards, et al., 2009). They go on to outline the following areas found in successful programs, including outreach and engagement, mental health and substance abuse treatment, supportive housing, and systems collaboration (Richards et al., 2009).

Richards et al. (2009) reported about the importance of meeting the basic needs of the homeless. This includes providing food, clothing, and shelter. These basic provisions are necessary in order to facilitate further growth and skill acquisition. Key aspects of the engagement process that have been identified include using a multidisciplinary team approach, ensuring a low client to staff ratio of approximately 10:1, making staff available for client contact 24 hours a day, making treatment plans tailored to individual's needs, and providing regular home visits (Richards, et al., 2009). Evidence indicates that programs meeting these guidelines produce clients who have improved housing stability, improved participation in mental health treatment, participation in substance abuse treatment, and primary healthcare utilization and treatment (Richards, et al., 2009).

Supportive housing represents a program model that encompasses transitional housing, permanent housing, single-site and scattered-site models (Richards, et al., 2009). This model often targets individuals with disabilities and those consumers who require a diverse set of needs. One commonality of successful, supportive housing is imposing rent control. Richards, et al. (2009) suggest that rent be limited to 30-50% of tenants' income. Richards et al. (2009) point

out that stable housing and a safe and secure environment are prerequisites for individual's successful participation in mental health and substance abuse treatments. They go on to discuss the importance of case management and of linking consumers to psychiatric services and other community resources. The authors also indicate that intensive case management plays a key role in helping consumers obtain both financial and health care benefits (Richards et al., 2009). However, one key obstacle to supportive housing type programs is that tenants do not always voluntarily participate in the programming that is offered.

Another component that has been identified as necessary for a successful program is coordinated health care. This includes a comprehensive approach to the treatment of mental health, substance abuse, and physical health (Richards, et al., 2009). Richards et al. (2009) note that agencies that serve the homeless have greater chances of success when they provide a multidisciplinary approach and set out to serve the diverse sets of needs of the homeless. This involves programming that provides for or links individuals to mental health services, substance abuse treatment, housing services, benefits and income support application assistance, formal linkage to primary care and dental care, educational training and vocational services, legal consultation, and other supports (Richards, et al., 2009).

Successful transitional housing programs do far more than simply provide temporary housing. Unlike shelters, transitional living programs provide a greater length of housing and programming that focuses on teaching skills and providing necessary services that go far beyond providing basic needs. They provide services that teach job skills, house maintenance skills, and money management skills (Camasso, Jagannathan, & Walker, 2004). These skills help participants to go on to secure and maintain more permanent housing.

Funding

Government Funding

The federal government made the funding of homeless assistance a priority in 1987 with the passing of The McKinney Homeless Assistance Act (Camasso, Jagannathan, & Walker, 2004). This act was passed due to the growing numbers of homeless individuals and homeless families who were in need of support and shelter. Under The McKinney Homeless Assistance Act, the United States Department of Health and Human Services was authorized to make $20 million available to states for the provision of transitional housing to homeless families (Camasso, Jagannathan, & Walker, 2004). The act was designed to provide homeless people with temporary shelter and social services to help them attain more permanent housing.

Private Funding

Funding for programming and services for the homeless are also supported by private contributions. A number of private donors, agencies, and faith- based groups often provide contributions to fund and run different services for the homeless.

Program Evaluation Defined

A program evaluation is a category of research that is applied to human service programs. Program evaluations are applied for the specific reason of helping administrators make decisions about the allocation of resources. The information provided by an effective program evaluation can also inform decision makers within an organization about whether or not program goals are being accomplished. This information can then be used to decide not only whether or not the program should be modified, but also whether or not there is a less expensive means to accomplish program goals. (Royse, et al., 2006)

As with other forms of research, a program evaluation involves a specific blue print. A program evaluation aims to answer a research question about the programs functioning. Following this, a review of the problem and the literature is to be conducted. A plan to evaluate the program is then drawn up. Following this, information about the program is gathered and analyzed. (Royse, et al., 2006)

A program evaluation does, however, have some differences from regular research. A program evaluation has a predetermined use. Other forms of research may be used to inform programming, but a program evaluation is performed with the specific intention of impacting the functioning of a specific program. A program evaluation goes beyond the goal of pursuing knowledge; it pursues information in order to inform an organization of its strengths and weaknesses. Another fundamental difference is that stakeholders are waiting to use the results of the evaluation before it is completed. Managers use this information to target areas of a program that may need to be changed and to decide where to allocate an organization's resources most effectively.

Purpose

There are two main reasons why program evaluations are carried out. One reason is that a program answers to an external funding agency. The other reason is to allocate funds to the most successful component within an agency that has competing components. (Royse, et al., 2006)

Chapter Three: Method

The purpose of this chapter is to discuss the processes involved in this study. The proposed study was a survey that aimed to sample the characteristics of programs for the homeless and the attitudes of program directors. The procedure and measures that are later described were proposed to gather exploratory information about the services provided by programs for the homeless. An online survey was utilized in this study to obtain detailed information about the current state of programming for the homeless in transitional housing programs within The Interfaith Hospitality Network across the United States.

Participants

Program leaders from transitional housing agencies within The Interfaith Hospitality Network across the United States were included in the sample to participate in the proposed survey study. Programs that will be included in the sample were ones that provide services for the homeless, including temporary or transitional sheltering. Invitations to participate in an online survey were sent to programs across the country via email in order to prevent restricting the sample to any one state or region. This helped to obtain an overview of what programming for homeless individuals consists of across the country in The Interfaith Hospitality Network. The study aimed to sample 150 established programs. This included programs that have been in operation for at least one year. Programs were recruited through internet searches and referrals from other participants from the Family Promise website via the Interfaith Hospitality Network (IFHN). The IFHN consists of over 165 affiliates in 41 states and the District of Columbia. Family Promise is a non-profit network of faith-based organizations and congregations with the goal of meeting homeless families' immediate needs for food, shelter, comprehensive supportive services, and the prevention of homelessness. The ultimate goal of Family Promise is to help

homeless and low-income families achieve sustainable independence. An invitation to participate in an internet-based survey was distributed to program leaders across the IFHN to gather information about their perceptions of their individual programs. Program directors were surveyed directly due to the assumption that they would have direct access to information about their programs and knowledge of the programming offered from their organization.

Ethical Considerations

The design of the proposed study was a survey style study. This type of research has very little risk involved. The surveys were not coded so that individual directors or programs would not be linked to any responses. Furthermore, this survey consisted of items that focused specifically on program characteristics and therefore would have very little personal risk to participants. One potential risk of this study was that the results could put pressure on programs for the homeless to offer more comprehensive services. The only direct cost that the participants would be burdened with was the time needed to fill out the survey. Participation was voluntary and participants were able to withdraw from the survey at any time. The anonymous nature of this survey served as a factor to protect individual programs and their directors from being identified. Informed consent was given as a part of the cover letter that accompanied the survey. This was also addressed in a statement at the beginning of the survey, asking that participants consent to participate in the study by completing the survey. This outlined the minimal risks, minimal costs, and purpose of the study.

The proposed study also had a number of potential benefits. The information provided by the proposed survey may help to inform and improve programming for the homeless. The information that this survey aimed to explore represents an area of research that has been underdeveloped within the literature. Program directors might benefit from the results of this

study by having information about the state of their fields across the country and by learning about aspects of their programs that may be developed further to improve their services. This information could also be of great benefit to consumers seeking to assess available services and funding agents. Although there could be some minimal risks associated with the proposed study, it appeared that the potential benefits of this research would outweigh those.

Survey Research

Survey research is a method often used and well suited to examine generalizations of large groups of people such as transitional living program directors (Pearson, 2008).

Strengths and Weaknesses of Survey Research

The Colorado State University's Writing Guides, Survey Research (2011) outlines a number of benefits to using online survey research. The Writing Guide indicates that this method of research is both cost effective and time saving. Mailing questionnaires can be an expensive venture. The use of online survey services often offer more cost savings. They also conserve time. The transmission of cover letters, surveys, reminder letters, returned surveys, and respondent questions are much faster with the use of an online format. Use of internet-based surveys reduces geographical limits, opening up research to a greater area that could potentially include a global population. Other benefits of this type of research include the fact that it is easy to make changes to questionnaires and letters. Online sampling also eliminates the process of data entry by organizing and sorting data as it is collected. According to the Writing Guide, research has shown that response rates are higher with electronic surveys compared with other survey mediums. Last, online survey data offer a greater sense of anonymity. According to the Writing Guide, research has indicated that respondents are likely to answer more honestly to surveys that are presented online, when compared with paper surveys or interviews.

Survey research is subject to a number of limitations. The limitations of survey research will be discussed in the following paragraphs

Surveys rely heavily on wording and format (Kazdin, 2003). Surveys may contain linguistic cues that can provide clues about what may be the most desirable answers (Thorkildsen, 2005). In other words, it may be obvious what the investigators are seeking to study and knowledge of this may influence the respondent's answers. The anonymity of web-based and mailed surveys is predicted to balance this out. In addition, the overall appearance of items and the order in which items are presented can also influence survey research (Kazdin, 2003).

Another weakness of survey research is related to return rates. According to Heiman (2002), the return rate of surveys can be very low, with only 10-20% returned. This can lead to a sample that may be unrepresentative of the population (Heiman, 2002).

There are a number of techniques that can be employed in order to help maximize the return rate of surveys. According to Heiman (2002), it is important to include a cover letter that describes the reason why it is important for the respondent to complete the survey. It is also necessary to provide respondents with information about the investigators, including how they can be contacted (Heiman, 2002). Return rates can be improved if surveys are well designed, including closed-ended questions or brief, open-ended questions that can be completed quickly and easily (Heiman, 2002). Another technique that has been suggested to improve return rates is that investigators send a follow- up letter or email, reminding respondents to complete the survey (Heiman, 2002).

Survey research is also subject to distortions. Kazdin (2003) defines distortions as "the alteration of participants' responses in some way in light of their own motives or self-interests."

This point sheds light on the possibility that individuals may respond to surveys in a way that may put them or their organization in a more positive light.

The Colorado State University's Writing Guides, Survey Research (2011) also outlines a number of weaknesses with using online survey research. When conducting online research, investigators are limited to sampling individuals who have access to computers and to the internet. There may be technical problems with hardware or software such as malfunctions in the survey or data collection software. These are problems that could compromise the integrity of the data and could potentially lose the data completely. Last, it is difficult to assure a level of confidentiality and anonymity. The Writing Guide suggests that it is difficult to guarantee this due to the open nature of most online networks.

Data Collection Procedure

Participants were recruited by conducting an internet search of transitional programming for the homeless. Specifically, programs were selected from the Interfaith Housing Alliance's website directory of programs. The principal investigator compiled a list of programs and their director's email addresses in order to distribute the survey via an email invitation. Surveys and cover letters were e-mailed to each program director. An invitation to participate in the survey was sent out to 150 program directors through email. The directors were sent the survey, using the web based survey service, "Survey Monkey." A second email invitation was sent to program directors four weeks after the initial invitation in order to maximize participation in the survey.

Measures

The measure that was used in the proposed study consisted of an electronic, web-based survey. The survey was distributed to program directors through e-mail, accompanied with a cover letter. The cover letter accompanying the survey included a general overview of the

purpose of the study, approximate time needed to complete the survey, information about informed consent, and contact information. The overview was brief and lacked specific detail in order to avoid contaminating the information collected and influencing the participants' responses. The contact information of the Principle Investigator and the Responsible Investigator allowed participants to have access to the investigator in order to answer questions or to access follow-up information about the study.

The study used a brief survey that was conveniently and easily distributed via the internet. The survey consisted of 34 multiple choice and open ended questions that were used to gather information about the programs sampled. Respondents also had the opportunity to explain or amplify their responses in the "comments" box after each question. The survey items were designed, based on what the literature has indicated as necessary aspects of programming in order to produce positive outcomes for homeless individuals coming from transitional housing programs, which would lead to the establishment of more permanent housing in the future. Survey items aimed to extract information about currently existing transitional living programs, such as the availability of staff, inclusion and exclusion criteria, and what specific types of programming are offered, such as health care, dental care, life skills training, vocational services, and mental health services.

The survey was designed using the online Survey Monkey software program. This program is easy for investigators to use in order to customize a user-friendly web based survey. The program is relatively inexpensive and provides an efficient way to distribute a large number of surveys to programs across the country. In addition, the program also provides an efficient means to collect and condense the data submitted by respondents. The Survey Monkey online

software has, therefore, been identified as an effective tool to distribute and collect data for the purposes of the proposed survey study.

Data Analysis

The data from the collected surveys were compiled through the Survey Monkey online software and analyzed by comparing frequency distributions for each item. Ranges, means, and modes across items were also analyzed. This process allowed the investigator to make generalizations about the attitudes of program leaders, as well generalizations about the programming that is offered across the transitional living programs that were sampled.

Chapter 4

RESULTS

The data were collected from a variety of programs that offer services to homeless families across the United States. A total of 43 directors of programs for the homeless responded to the survey, which sampled various characteristics about these individual programs including information about funding, programing, and measuring success. Of the programs sampled, 24 were described as long-term shelters that offered families to stay for longer than one week's time (55.8%). Thirteen programs were described as transitional living programs that offered long term sheltering with housing placement at the completion of the program (30.2%). The remaining five programs consisted of short term, emergency shelters and day centers providing temporary hospitality services (11.6%).

Funding for these programs comes from a number of different sources. According to the present sample, an average of 39% of program's funds come from private contributions. Faith-based contributions, on average, represent an additional 25.44% of a program's total funding. The smallest portion of funding for these programs, on average, came from government contributions, which comprised an average of 21.6% of total funding. Most of the directors who responded to this survey item (27/41) reported that 29% of their funding comes from other sources that were not mentioned.

The programs sampled had varying capacities for the number of families that they could serve at one time. The modal response was that 19 programs served fewer than four families (44.2%). Ten programs served between five and eight families at one time (23.3%). Eight programs reported having the capacity to serve 17 or more families (18.6%). Five programs

could serve between 9 and 12 families (11.6%). Only one program reported having the capacity to serve between 13 and 16 families (2.3%).

The programs that were sampled also varied in terms of staffing. The average program reported having 1.83 full time staff members and 2.36 part-time employees. The modal number of full time staff members and part-time staff members were the same: one for each category (46.5% full time, 25.6% part-time). An additional 16 (37.2%) programs reported having two full-time staff; four reported having three full time workers (9.3%), and each of only three programs reported having 2.5, four, and seven full-time staff members (2.3% each). Eleven programs reported having three part-time workers (31.6%); eight programs reported having 2 part-time workers (18.6%); four programs reported having five part-time workers (9.3%), and 2 programs reported having four part-time workers (4.7%). Programs for the homeless also reported being supported heavily by large numbers of volunteers.

An overwhelming majority of the programs surveyed reported a low family- to- staff ratio. Thirty-five of the sampled programs indicated that they have a family- to- staff ratio of less than 10 to 1 (81.4%). Six programs reported a ratio of 10-19 to one (14%) and two programs reported a ratio of 20-29 to 1 (4.7%). Twenty-three of the programs reported that families have five to nine hours of contact time with staff per day (53.3%). Eighteen programs reported having less than five hours of contact time for families (41.9%). Only two programs indicated that families received 10 to 14 contact hours per day. Staff was reportedly available five to nine hours per day for 26 of the programs (60.9%). Nine programs had staff available for 10 to 14 hours per day (20.9%) and 8 programs reported that staff were available to families for more than 19 hours per day (18.6%).

Housing placement rates were assessed through this survey. The modal rate of placement reported by 21 of the programs indicated that it takes between two and three months for families to acquire permanent housing (48.8%). Eleven program directors indicated that it takes greater than four months to find permanent housing placements (25.6%). Nine of the respondents reported that it takes three to four months for families to find permanent housing (20.9%) and only one indicated that it takes between one and two months to place families (2.3%).

Of the 43 programs that responded to the survey, only 13 reported using a graduate mentoring model (30.2%).

Programs serving the homeless often have a number of exclusionary criteria. An overwhelming majority of program directors, 35, indicated that they exclude individuals with serious mental illness from participating (81.4%). Twenty-one directors reported that individuals with criminal backgrounds were excluded (48.8%). Only seven programs reported excluding males over the age of 18 from participating (16.3%). Other exclusionary criteria included active domestic violence issues, sex offenders, and single individuals without children. The majority of program directors, 36, also reported excluding individuals with active drug and alcohol problems (83.7%).

No programs in the current data set reported having in-house substance abuse treatment available. Of the 43 agencies that responded, 27 referred individuals to outside agencies for substance abuse treatment (62.8%). Thirteen of the programs indicated that they do not require individuals to participate in substance abuse treatment (30.2%).

The results of the survey showed that the majority of programs do not require rental payment. In fact, 30 of the program directresses indicated that no money was required from participants for rental payment (69.8%). Twelve directors reported that 20-39% of each

participant's income is required for rental payment (27.9%) and one indicated that greater than 70% of each participant's income is required for rent (2.3%).

The results of the survey provided information on some of the components of the individual programs. All of the program directors indicated that budget planning education was provided (100%). Most of the programs (38) indicated that they provided participants' assistance with securing entitlement benefits (88.4%). Forty-two of the directors indicated that their programs provided intensive case management (100%).

The survey gathered further information on the availability of case management services including the amount of weekly case management hours required for families and the family-to-case manager ratio. The modal amount of time required for families to work with case managers was two to three hours per week for 20 of the programs (46.5%) Thirteen programs reported that fewer than two hours of case management were required per week (30.2%); 5 reported that four to five hours were required (11.6%); three reported that six to eight hours were required (7%), and two indicated that more than eight hours of case management were required per week (4.7%). The modal ratio of case managers- to- families was less than 10 to 1, which was reported by 33 directors (76.1%). Eight directors indicated a ratio of 10 to 19 families to one case manager (18.6%), and one program indicated a ratio of 20 to 29 families to one case manager (2.3%).

The survey also provided information about the availability of mental health services. The results indicated that the majority of programs (29) provide no mental health services (67.4%). Supportive individual counseling was provided by seven programs (16.3%). Supportive group counseling was provided by one program (2.3%). Six programs reported that both supportive and individual counseling were provided to participants (14%).

Most of the directors indicated that they refer individuals to outside agencies for mental health treatment (69.8%). Four programs indicated that mental health services were available but optional (9.3%), and two programs reported that mental health services were mandatory (4.7%). Only seven programs reported that mental health services were unavailable at all (16.3%).

The survey also gathered information about programing offered for children. No programing was offered for children by 17 of the programs (39.5%). Skills trainings were offered by seven programs (16.3%). Daycare services were offered by nine programs (20.9%). Last, tutoring services were provided by 20 of the programs (46.5%).

The survey gathered further information on health services and their availability to participants. The majority of the program directors indicated that healthcare services were not provided to participants (83.7%). Twenty-seven programs indicated that they refer out to other agencies to provide primary medical care (62.8%). Families were referred out for dental care services by 24 programs (55.8%).

Of the programs that responded to the survey, 41 reported that they provide assistance toward applying for benefits and income support (95.3%). Fifteen of the program directors amplified their responses. These directors indicated that their programs work towards helping individuals acquire social security disability, child support, employment assistance, food stamps, and Medicaid benefits.

The respondents reported a number of educational trainings for residents. Only seven directors indicated that their programs did not offer educational training (16.3%). GED training was provided by 16 programs (37.2%); four programs offered English as a second language training (9.3%); two programs provided higher education training (4.7%); three programs

provided SAT and ACT preparation (7%); five programs provided literacy training (11.6%); 15 programs provided computer skills training (34.9); 23 programs provided financial literacy training (53.5%); four provided vocational training (9.3%), and 25 provided homelessness prevention education (58.1%).

Programs reported providing a number of different life skills trainings. Only six of the programs reported providing no life skills trainings (14%). Life skills trainings that are provided, according to the respondents, included 18 that provided nutrition counseling (41.9%); 12 that provided health and wellness education (27.9%); 25 that provided training focused on regaining independence (58.1%); 8 that provided anger management training (18.6%); 15 that provided socialization skills (34.9%); 29 that provided credit counseling (67.4%); 12 that provided home and property management skills (27.9%), and 28 that provided parenting skills training (65.1%). Additionally, directors reported offering skills trainings on topics such as substance abuse, mental health, navigating health insurance, and tenant's rights.

Most of the programs that responded to the survey (41) reported providing services to assist residents in attaining employment (95.3%). Twenty-five of the programs offered employment finding services (58.1%); 41 provided resume preparation assistance (95.3%), and 34 provided preparation for job interviews (79.1%).

The majority of program directors (28) indicated that there are other programing components that are not currently offered that they would like to incorporate into their services (71.8%). Directors indicated the desire for the following program components: after-school programing, child care, mentoring services, improved employment placement connections, family mentoring, GED training, life skills, parenting skills, health and wellness education,

homeless prevention programing, in- house supportive counseling, vocational skills training, and nutrition counseling.

Qualitative analysis of comments yielded several themes when looking at how programs for the homeless measure success. The most frequently reported definitions of success appear to be placement in more permanent housing and finding employment. Other factors that programs use to determine success include access to childcare, increasing incomes, increasing savings, strengthening of support networks, and elimination of dependence on supportive services. Some programs described having more comprehensive ways to measure success, including follow-up measures looking at sustained independence following completion of the program. The duration of independent living that defines success varies across the programs. Some define success as sustaining independence for six months, for one year, and for two years. No programs described using formal assessment of outcome measures as a means of defining or measuring success along a variety of psychosocial adjustment variables.

The majority of programs (28) indicated that they employ methods for tracking the length of graduates' stay in housing after completing the program (66.7%). The frequency of contact between organizations and their graduates vary greatly from program to program. Fourteen respondents expanded upon their answer, providing more detailed information about their frequency of contact with graduates. The modal response indicated that ten programs contact their graduates on a monthly basis. Four programs reported making contact with graduates four times per year. Two programs reported making contact either once a year or twice per month. One program indicated that contact is made every six months. Some programs taper follow up contact. These programs start with weekly a check-in, move down to monthly contact, and finally yearly contact.

Quality of life is a factor that is measured by only 9 of the participating programs (20.9%). The majority of the programs represented in this survey (34) reported that they do not measure participants' quality of life (79.1%). Programs that do measure this factor report administering surveys at multiple points of the program. Some areas that are specifically explored include self-esteem and self-sufficiency. Furthermore, it was not determined if those programs use formalized Quality of Life measures that have established reliability and validity.

The availability of after-care services to families who graduate from these programs vary. Some offer material and monetary assistance such as temporary rental assistance, food assistance, furniture, household supplies and fuel assistance. Ongoing case management is one of the most commonly reported aftercare services offered by programs. Others match graduates with ongoing mentoring. Few respondents indicated that transportation, support groups, and life skills trainings are offered to graduates after completion of the program. Some program directors indicated that all of the services provided within the program remain available to graduates; however, other directors indicate that no aftercare services are offered.

Last, respondents provided information about their yearly operating budgets. They reported operating budgets for their programs that range from $85,000 to $3,300,000. The average operating budget was $305,038.

Chapter 5

DISCUSSION

The programs surveyed seem to offer a number of important services to help transition homeless families into more permanent housing. The research on homelessness has identified many programing components that are believed to lead to the successful transition from homelessness. These include training in budget planning, assistance in securing entitlement benefits, and intensive case management, all of which appear to be commonplace amongst the programs surveyed.

The majority of programs also offered some programing for children. Tutoring services were provided by many of the programs. Daycare services were also offered, but by fewer programs. Programs serving homeless families could put more effort towards building programming for children. The families that are often served by transitional living programs consist of mothers and their children. Therefore, the numbers of children served by such programs must far outnumber the adults. It is important that emphasis be put towards establishing programming to address the needs of this subpopulation. This would be beneficial on two different levels. One, it would help to improve the skills of the individual children, which may focus on building social skills, counseling, or life skills. This could also create windows of time for the parents to focus on their own skill building experiences.

Relatively few programs provided educational services. GED preparation, ESL education, literacy training, computer skills, and vocational training were often not incorporated into these programs for the homeless. Programs could focus on educational services to help

increase the employability of their participants in order to ensure that they are able to obtain and sustain employment.

Some formal educational programing specifically targeting issues of homelessness was more common. Education on homelessness prevention and financial literacy training were more often a part of these programs, but were still present only in somewhat less than 60% of the programs. These represent key components to helping prevent recidivism. Although many programs do address these topics, it should be a keystone in the education process of all participants across programs serving this population.

Many programs offer training opportunities. Some of the training opportunities that are often seen across these programs focus on important topics such as regaining independence, credit counseling, and parenting skills trainings. Other less common trainings offered by programs included nutrition counseling, health and wellness education, anger management, and social skills trainings. One potential problem seems to be that even if organizations do offer a variety of training and educational opportunities, they are not always mandatory components of the program and may go under-utilized. Although they are in the minority, a substantial percentage (14%) of the programs sampled reported not offering any formal training to participants.

The literature has demonstrated that mental health diagnoses are highly prevalent amongst the homeless population. Despite this fact, the current survey shows that mental health services are rarely offered within the programs sampled. Programs that did offer mental health counseling often referred out for this service.

It seems that mental health counseling would be a key aspect of helping the homeless to be successful by obtaining permanent housing and preventing recidivism. The research has

indicated that this group is more likely than the general population to be exposed to violence and trauma. Many transitional housing programs serve women and families who have been displaced from their housing due to issues of domestic violence and abuse. It has also been demonstrated that individuals who have suffered from homelessness are more likely to have been exposed to violence and trauma. It is may not be realistic to expect individuals who have faced hardships such as homelessness, poverty, and exposure to violence to be able to reestablish housing and work without initially addressing mental health issues related to depression, anxiety and trauma. Resources should be focused on making mental health services available and accessible to these individuals. Despite these glaring facts, the results of the survey show that almost 70% of the programs sampled do not offer any counseling services. This is a clear deficit that should be addressed further by programs.

It may be argued that mental health services such as counseling are out of the scope of programing for individuals who utilize transitional housing programs. But it is hard to deny the fact that this population is vulnerable to mental health issues including, but not limited to, depression, anxiety, and exposure to trauma. All of these are issues that are likely to contribute to and even perpetuate homelessness. The fact that this area of programing is rarely addressed by such programs is startling, especially when other services such as medical and dental care are attended to at much higher rates.

The results indicated that the programs sampled often excluded individuals with serious mental illnesses. These individuals are likely excluded due to the fact that these programs do not have the mental health infrastructure to provide adequate services to this population. This highlights another deficit in the field of transitional living programs.

Some of the programs sampled reported that they excluded adult men from participation. The exclusion of men could potentially cause further hardship to families who have already experienced a number of difficulties. These exclusionary criteria can lead to the splitting of families by removing fathers and even adult children from the family unit. It also excludes them from receiving available services from which they are likely able to benefit. Adult males would also benefit from the skills, trainings, and resources that transitional housing programs provide and could also contribute to their family's ability to overcome homelessness.

Many programs reported excluding individuals who were experiencing active domestic violence. Because most homeless families are made-up of single mothers and children who have been affected by domestic violence, this leaves a large gap (Rog & Buckner, 2007). It is likely that many of the women who have been displaced from their housing have experienced domestic violence. Excluding individuals based upon these criteria elbows out a group who clearly would benefit from such services.

One area of concern that was brought to light by the present survey is that there is no consensus within the field about how to measure the success of transitional living programs. Success hinges on more than simply completing the program and finding housing. Success is likely to be influenced by the acquisition of skills and knowledge. In order to truly have a measure of success, programs must employ longer-term tracking to account for relapse rates. It is, therefore, recommended that efforts be made to employ longitudinal studies to follow individuals after completing such programs. This can produce valuable information about what aspects of programing lead to longer-term success and what factors contribute to recidivism.

Although some programs in the present study did report following their graduates for up to two years, this was the exception rather than the rule. Some programs measure success as

improving the quality of life of participants. Only 21% of the programs surveyed take into account quality of life measures as indicators of program success. It should be noted, however, that it was unknown if the measures used were empirically valid and reliable. If programs are going to maximize their success, it is important that measures of success be agreed upon; therefore, more effort should be focused on longer-term outcome measures that track program graduates.

It seems that a greater emphasis should be placed upon getting post intervention measures and maintaining connections with program graduates. Although some programs appear to make efforts to continue communication with their graduates, it seems that most programs struggle with this area. The findings indicate that the use of graduates to mentor current participants is under-utilized. Individuals who have had success at emerging from homelessness are assets that should be harnessed.

The literature has indicated that lower client to staff ratio is one factor that has been linked to success in transitional living programs (Camasso, Jagannathan, & Walker, 2004). Although the information provided by this survey cannot speak about the success of the programs, the data do indicate that most of the programs have low client to staff ratios. In fact, 35 of the 43 programs surveyed met the ideal client to staff ratio of less than 10 to 1, suggested by Richards, et al (2009).

Limitations

This study was subject to a number of limitations. One limitation comes from the fact that there were a small number of respondents. Also, the sample was not completely homogeneous. Although many of the programs did define themselves as transitional living

programs, most defined themselves as strictly long-term shelters and a few described themselves as "other."

The nature of a survey-based study also leads to limitations. It is possible that there may have been clues in the context of the survey that lead respondents to give answers that they may have believed were more desirable. This could have contaminated the data.

It is also worth mentioning that the survey was an internet- based survey. This further limited the sample to individuals who were a part of programs that had internet access and organizations that had a valid and up to date website. There was also the possibility that some respondents may have had difficulty completing the online survey. If they were not able to send the data properly, some responses may not have been submitted. Some respondents had to drop out of the survey because of technical problems with recording and with submitting their data over the internet. For example, one program director reported being able to complete the survey successfully but indicated that he was not able to finish the survey and send the data.

Recommendations

This study has helped to identify a number of recommendations that may be applied in order to improve transitional living programs for the homeless. The following recommendations are offered.

Program directors should work towards implementing a more empirical approach. Measurement should start with the implementation of a standardized intake assessment. This can be useful by helping to identify baseline rates that can be tracked throughout treatment in areas such as quality of life, parenting effectiveness, financial literacy, social support, and mood. This is important in order to measure the change that actually occurs in these areas and in order to identify if the interventions within the program are working. This approach can produce a more

concrete measure of programmatic success. In addition, an empirical approach can also help to identify specific areas of weakness for individuals. This information can be used to tailor programing to specifically meet individuals' areas of need.

Programs should also focus on tracking long-term outcome measures. It is important to track program graduates after their completion of the transitional living program. This is important in order to determine what aspects of programing lead to longer term success and lead to the prevention of recidivism. This can also be helpful by identifying specific factors that lead to relapse to homelessness.

It is recommended that programs implement standard life-skills training that address topics such as financial planning, financial literacy and budgeting skills. These components are believed to be necessary in order to help improve participants' long-term financial stability which, in turn, may improve their ability to sustain longer term housing.

Programs should implement further services directed towards children. There are many children who belong to the families that participate in transitional living programs. It is likely that the children who are a part of these families have experienced their own hardships related to their experiences with homelessness. In order to determine what services are most appropriate for children who have experienced homelessness, a proper needs assessment should be conducted for this population.

Basic mental health services should be made available to families. The literature has indicated that psychological problems are highly prevalent amongst the homeless. This is important to address due to the fact that mental health conditions such as depression and anxiety can impede one's ability to function. If these problems go unaddressed, programs may be sending families out to rebuild their lives with damaged tools. It is important to address these

treatable mental health conditions in order to set individuals up with the greatest chances for success.

Last, it is recommended that all programs use former graduates to mentor current participants of transitional living programs. Graduate mentors can be an important addition to programing for a number of reasons. Graduates can help reinforce the various aspects of programing that proved to be the most helpful. Graduates also serve as models who can demonstrate how various skills are applied. In addition, graduates who have had success following participation in a transitional living program can also help to build hope for individuals currently participating in the program. This, in turn, can help to build self-efficacy. This approach can also be beneficial by helping to keep past graduates involved, which may serve to keep the skills that they learned sharp and may make it easier for programs to follow-up on graduates and collect outcome data.

Directions for Future Research

There are some areas of research that could be explored further. Emphasis on this area could lead to the improvement of programing for the homeless.

Future research could focus on identifying the specific aspects of transitional living programs that lead to sustained housing. In addition, a focus could also be placed on identifying those factors that help to prevent recidivism. This studied showed that there are many different services offered by transitional living programs, but there is little information about what pieces of programing lead to successful sustained housing.

Transitional living programs may also benefit from more longitudinal research. This would allow investigators with the opportunity to track the long-term outcomes of individuals who participate in transitional living programs. This could help to identify factors that may lead

to recidivism and factors that act as buffers against recidivism such as community support and peer support.

Future research could also focus on the effects of mental illness and substance abuse on homeless individuals in transitional living programs. The literature has clearly identified a considerable rate of mental illness and substance abuse amongst the homeless. Homeless mothers who have been victims of domestic violence and abuse have been identified as the main participants of most transitional living programs and clearly represent a population that may have mental health issues. This under treated area within transitional living programs warrants further research.

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Appendices

Appendix A

Subject: Research Study: Transitional Living Programs for the Homeless

Dear Director/Program Administrator,

Your name has been selected from a list of professionals who are involved in providing important services to the homeless. As you are well aware, homelessness is a serious national crisis today and the importance of quality programming to address this problem cannot be overstated. Here at Philadelphia College of Osteopathic Medicine, we have a long tradition of serving underserved, vulnerable individuals in our urban healthcare centers.

At the present time there exists no systematic information about the nature and characteristics of transitional living programs for the homeless such as yours. Such information could be useful in enhancing the quality of programs as well as providing a basis for advocacy and funding.

With this in mind, I would like to invite you to participate in a brief survey about transitional living programs for homeless families. As a doctoral candidate in Clinical Psychology at the Philadelphia College of Osteopathic Medicine, I am interested in learning more about the components and features of programming for homeless families that best helps them to eventually acquire and maintain permanent housing.

The information provided by this survey may help to provide useful information to program directors and administrators that can be used to evaluate and possibly modify the current scope of services. This will be achieved by collecting data that can be used to describe the current practices with regards to supportive programming for the homeless. In addition to being beneficial for program administrators, the information provided by this survey may also be useful to consumers, funders, and the general public.

We request your participation in this survey to gather data, which we believe will be of value in determining the program components that are most effective in addressing the needs of homeless families while in transitional living programs. We estimate the length of the survey to be 10 minutes or less. The Principal Investigator for my study is Dr. Bruce S. Zahn, Professor and Director of Clinical Training in the doctoral program in Clinical Psychology at the Philadelphia College of Osteopathic Medicine.

There is no identified risk to participation. Individual anonymity will be maintained, as only aggregate/group data will be reported. This study has been approved by the Philadelphia College of Osteopathic Medicine Institutional Review Board (Protocol #H11-060X).

If you encounter any difficulty in accessing the survey, or have any questions or concerns about participation not covered in this disclosure please feel free to contact the principal investigator, Dr. Bruce S. Zahn, telephonically at (215) 871-6498or by email at brucez@pcom.edu.

By completing the survey, you are indicating your consent to participate in the study. All individual responses will be kept confidential. Thank you in advance for your participation!

To complete the survey please click the following link: https://www.surveymonkey.com/s/KR3YJRV

Survey of Transitional Living for Homeless Families

1. What is your title within this program?

2. Please specify the percentage of funding obtained through each source listed below.
    a. Private contributions ____%
    b. Faith based contributions ____%
    c. Government contributions ____%
    d. Other (please describe)_____ ____%

3. How many families can your program serve at any one time?
    a. Less than 4
    b. 5 to 8
    c. 9 to 12
    d. 13 to 16
    e. 17+

4. How many full-time staff members are employed by your program?

5. How many part-time staff members are employed by your program?

6. How many volunteer staff does your program have?

7. What title best describes your program?
    a. Short term emergency shelter (less than one week stay)
    b. Long term shelter (greater than one week stay)
    c. Transitional living program (long term sheltering with housing placement)
    d. Support and hospitality services (day center providing laundry, food, and clothing services but no sheltering)
    e. Other (please specify) _____

8. What is the family to staff ratio (i.e., number of families per staff member)?
    a. 50+ to 1
    b. 40-49 to 1
    c. 30-39 to 1
    d. 20-29 to 1
    e. 10-19 to 1
    f. Less than 10 to 1

9. How many contact hours do consumers have with professional staff each day?
    a. Less than 5 hours per day
    b. 5 -9 hours per day
    c. 10 – 14 hours per day

d. 15 – 19 hours per day
e. More than 19 hours per day

10. How many hours a day is staff available to consumers?
    a. Less than 5 hours per day
    b. 5 -9 hours per day
    c. 10 – 14 hours per day
    d. 15 – 19 hours per day
    e. More than 19 hours per day

11. What is the average amount of time it takes for consumers to acquire permanent housing placements?
    a. Less than 30 days
    b. Between 1 to 2 months
    c. Between 2 and 3 months
    d. Between 3 and 4 months
    e. More than 4 months

12. Does the program utilize graduate mentoring model?
    a. Yes
    b. No

13. Does the program exclude (check all that apply)
    a. Individuals with serious mental illness
    b. Individuals with criminal backgrounds
    c. Individuals with active drug and alcohol problems
    d. Men over the age of 18
    e. Other (Please specify) _____

14. Are substance abuse treatment services provided?
    a. In house substance abuse services
    b. Individuals are referred out to other programs for substance abuse treatment
    c. No substance abuse treatment is required

15. What % of an individual's income is required as a rental payment?
    a. 0%
    b. Less than 20%
    c. 20 - 39%
    d. 40 – 59%
    e. 60 – 79%
    f. Greater than 79%

16. Does the program offer the following components?
    a. Budget planning
    b. Assistance in securing entitlement benefits
    c. Intensive case management services

17. How many hours of case management are consumers required to participate in per week?
    a. 0 hours
    b. Less than 2 hours
    c. 2 – 3 hours
    d. 4 – 5 hours
    e. 6 – 8 hours
    f. More than 8 hours

18. What is the case manager to family ratio?
    a. 50+ to 1
    b. 40-49 to 1
    c. 30-39 to 1
    d. 20-29 to 1
    e. 10-19 to 1
    f. Less than 10 to 1

19. What mental health services are provided?
    a. None
    b. Supportive individual counseling
    c. Supportive group counseling
    d. Both supportive individual and group counseling

20. Which of the statements listed below best describes the mental health services available in your program?
    a. Unavailable
    b. Mandatory
    c. Available but optional
    d. Referred out for service

21. Does the program offer the following programming specifically for children? Check all that apply.
    a. No programing
    b. Skills training
    c. Day care services
    d. Tutoring

22. Are medical/health care services provided?
    a. No
    b. Yes

23. Does the program provide assistance toward applying for benefits and income support?
    a. No
    b. Yes
        i. If yes, please specify: _____

24. Do families receive primary medical care?
    a. No
    b. Yes, in house
    c. Yes, referred out

25. Do families receive dental care?
    a. No
    b. Yes, in house
    c. Yes, referred out

26. Does the program provide educational training (circle all that may apply)?
    a. none
    b. GED preparation
    c. ESL education
    d. Higher education training
    e. SAT/ACT preparation
    f. Literacy training
    g. Computer skills
    h. Financial literacy training
    i. Vocational training
    j. Homelessness prevention education
    k. Other (please specify)

27. Does the program offer life skills training (circle all that may apply)?
    a. No formal education offered
    b. Nutrition counseling
    c. Health and wellness education.
    d. Training focused on regaining independence.
    e. Anger management training
    f. Socialization skills
    g. Credit counseling
    h. Home and property management
    i. Parenting skills training

j. Other (please specify)

28. What services are offered to assist the head of household in attaining employment?
    a. None
    b. Job finding service
    c. Resume preparation
    d. Interviewing preparation

29. Are there other program components not currently offered that you would like to offer?
    a. No
    b. Yes, if yes please specify: _____

30. What measures of success are used by your program?

31. Does your program measure Quality of Life among participants?
    a. No
    b. Yes, if yes please specify: _____

32. What after care services are offered to consumers after leaving your program?

33. What is your program's operating budget?

34. Does your program have a method of tracking family's length of stay in permanent housing following graduation from your program?
    a. No
    b. Yes, if yes how often do you make contact with past consumers to monitor progress? _____