

HELPING PEOPLE

THE ROLE OF PSYCHOLOGISTS
AND RECOMMENDATIONS TO
ADVANCE RESEARCH, TRAINING,
PRACTICE, AND POLICY

WITHOUT

HOMES



Report of the APA Presidential Task Force on
Psychology's Contribution to End Homelessness



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

James H. Bray, PhD
APA President
2009

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PRACTICE, AND POLICY

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Task Force on Psychology's
Contribution to End Homelessness

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Available online at <http://www.apa.org/pi/ses/resources/publications/end-homelessness.aspx>

Suggested bibliographic reference:

American Psychological Association, Presidential Task Force on Psychology's Contribution to End Homelessness. (2010). *Helping people without homes: The role of psychologists and recommendations to advance research, training, practice, and policy*. Retrieved from <http://www.apa.org/pi/ses/resources/publications/end-homelessness.aspx>

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ACKNOWLEDGMENTS

We would like to express appreciation to the following individuals, who shared their expertise and provided input as this report was being developed:

Margot Ackermann, PhD, *Homeward, Richmond, VA*

Elizabeth Arnold, PhD, *Wakeforest University*

Peggy Bailey, *Corporation for Supportive Housing*

John Buckner, PhD, *Children's Hospital Boston*

Dennis Culhane, PhD, *University of Pennsylvania*

Barbara Duffield, *National Association for the Education of Homeless Children and Youth*

Peter Fraenkel, PhD, *City College of New York*

Jennifer Frey, PhD, *On Our Own of Maryland, Inc.*

Daniel Herman, PhD, *Columbia University*

Charlene Le Fauve, PhD, *Substance Abuse and Mental Health Services Administration*

Suzanne Wenzel, PhD, *University of Southern California*

We also appreciate the expertise and input provided during the development of the report by the following boards and committees of APA: the Board for the Advancement of Psychology in the Public Interest; the Board of Scientific Affairs; the Committee on Aging; the Committee on Children, Youth, and Families; and the Committee on Ethnic Minority Affairs.

EXECUTIVE SUMMARY

PURPOSE

The 2009 Presidential Task Force on Psychology's Contribution to End Homelessness was commissioned by James H. Bray, PhD, during his tenure as president of the American Psychological Association (APA). The mission of the task force was to identify and address psychosocial factors and conditions associated with homelessness and to define the role of psychologists in ending homelessness.

INTRODUCTION

Each year between 2–3 three million people in the United States experience an episode of homelessness (Caton et al., 2005). The psychological and physical impact of homelessness is a matter of public health concern (Schnazer, Dominguez, Shrout, & Caton, 2007). Psychologists as clinicians, researchers, educators, and advocates must expand and redouble their efforts to end homelessness.

HISTORICAL CONTEXT

Beginning in the 1980s, a large body of research on homelessness began to emerge, spearheaded by researchers and policy analysts from a number of disciplines, including psychology (Buckner, 2008; J. M. Jones, Levine, & Rosenberg, 1991; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Shinn & Weitzman, 1990). This report, while not all-inclusive, is derived from the body of research on homelessness, as well as from clinical practice that has developed over the past 25 years and that continues to develop.

THE PREVALENCE OF HOMELESSNESS

The task force adopted an inclusive definition of homelessness: Homelessness exists when people lack safe, stable, and appropriate places to live. Sheltered and unsheltered people are homeless. People living doubled up or in overcrowded living situations or motels because of inadequate economic resources are included in this definition, as are those living in tents or other temporary enclosures.

The episodic and transient nature of homelessness makes it difficult to estimate its prevalence accurately. In this report, the task force used prevalence data contained in the U.S. Department of Housing and Urban Development's (HUD; 2009a) assessment of homelessness report to Congress and the U.S. Conference of Mayors' (2009) report on hunger and homelessness. HUD reported that 1.6 million people were without homes in 2008, but this is likely to be an underestimate of the number of people living without homes. In the United States, the overall population of people living without homes can be divided into several subgroups, including individual adults; families with children; and unaccompanied youth who have left home, run away, or "aged out" of foster care placements.

PSYCHOSOCIAL FACTORS ASSOCIATED WITH ENTERING AND EXITING HOMELESSNESS

Among those living without homes are people of all ages, races, ethnicities, cultural backgrounds, sexual orientation, and immigration status. Homelessness occurs when a cascade of economic and interpersonal factors converge in the lives of people marginalized in society. When compared with the general population, people living without homes have poorer physical health, including higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS (Zlotnick & Zerger, 2008), as well as higher rates of medical hospitalizations (Kushel, Vittinghoff, & Haas, 2001). Although poor people with alcohol or substance dependence and/or mental illness are clearly at greater risk for becoming homeless and face additional barriers to exiting homelessness, the majority are not involved in alcohol or substance abuse or suffering from mental disorders. The remediation of homelessness involves addressing the risk factors that contribute to homelessness as well as advocating for structural changes, such as increased low-income and supportive housing. As researchers, clinicians, and advocates, psychologists can contribute to preventing homelessness and, where it occurs, intervening to expedite a return to stable housing.

A strong association exists between child welfare agency involvement and homelessness. The pathway between foster care and adult homelessness is complex. History of incarceration is associated with a significantly higher likelihood of being homeless (Burt, Aron, Lee, & Valente, 2001), and former prisoners are at increased risk for recidivism when homelessness is involved (Metraux & Culhane, 2004). There is also a strong link between homelessness and hospitalization. Many argue that deinstitutionalization is directly responsible for the problem of homelessness and for the people who have serious mental illness; however, lack of comprehensive services—especially supportive housing—likely has a greater impact. Finally, much research and discussion focus on the negative mental health outcomes associated with homelessness, despite evidence indicating that many people without housing function quite well (Buckner, 2008; Cowan, 2007; Haber & Toro, 2004; Masten & Sesma, 1999). By also understanding protective factors, including social support that fosters resilience among adults, adolescents, and families living without homes, psychologists can develop targeted prevention and intervention models.

THE ROLE OF PSYCHOLOGISTS IN ENDING HOMELESSNESS

Models that describe how people become homeless include micro- and macro-level perspectives. Promising theoretical models that demonstrate how psychology can better address homelessness include the *trauma model* (Goodman, Saxe, & Harvey, 1991), the *risk amplification model* (Whitbeck & Hoyt, 1999), and the *ecological model* (Toro, Trickett, Wall, & Salem, 1991). To document psychologists' current views and activities related to homelessness, the task force designed and conducted a Web-based survey through the APA Public Interest Directorate in coordination with the APA's Center for Workforce Studies. While the survey suggests that psychologists are significantly involved in a wide range of activities in relation to people who are homeless, the time they spend on these activities is relatively short. Other findings related to working with subgroups, barriers, and attitudes are presented in this report.

REMEDICATION OF HOMELESSNESS

Efforts to remediate homelessness address individual factors, prevention measures, and public policy. The task force reviewed efforts to remediate homelessness at the individual level, including providing housing and a range of supportive services, such as addiction treatment, mental health services, medical treatment, intensive case management, assertive community treatment, critical time intervention, and ecologically based family therapy. The following areas meant to characterize the clinical relationship between the psychologist and people experiencing homelessness are also discussed: building trusting relationships, working as part of a team, assisting with welfare benefits, self-care, hands-on treatment, and detecting other conditions.

Although existing literature devotes considerable attention to treatment-oriented approaches for dealing with the social problem of homelessness, psychologists, other researchers, and policymakers have only recently begun to consider ways to prevent homelessness from occurring in the first place (Burt, Pearson, & Montgomery, 2007; Haber & Toro, 2004; Lindblom, 1996; Shinn & Baumohl, 1999; Toro, Dworsky, & Fowler, 2007; Toro, Lombardo, & Yapchai, 2003). These strategies are discussed in this report. Finally, the report attempts to explain the significant variation in rates of homelessness across developed and underdeveloped nations in order to assist in identifying and tackling the root causes of homelessness around the globe.

RECOMMENDATIONS

In their roles as clinicians, researchers, and educators, psychologists have unique contributions to make to the remediation of homelessness. The task force endorses the following research, training, practice, and advocacy recommendations as vehicles by which the discipline of psychology can contribute to ending homelessness under the leadership of the American Psychological Association.

RESEARCH

To further address the causes, course, prevention, and remediation of homelessness, social science researchers are encouraged to:

- Direct research efforts toward prevention of homelessness in marginalized and vulnerable populations.
- Design and disseminate evidenced-based interventions for work with those currently experiencing homelessness.
- Engage in program evaluation with a focus on mechanisms that support rapid return to permanent housing and methods for sustaining housing in vulnerable populations.
- Conduct research on service utilization among chronically and pervasively mentally ill populations at risk for homelessness.
- Investigate methods to promote resilience in at-risk populations, including children and youth.

TRAINING

To enhance the ability of psychologists to work effectively with populations at risk of homelessness or currently living without homes, the following education and training are recommended:

- Incorporate into graduate school curricula theoretical and applied perspectives of working with diverse and underserved populations at risk for homelessness.
- Develop practicum and internship placements that allow trainees opportunities to work with at-risk populations including sheltered families and adults, children in foster care placements, unaccompanied youth, individuals with chronic mental illness, and persons with substance and alcohol dependence.
- Create continuing education programs that encourage psychologists to engage in work with populations experiencing homelessness.
- Enlist psychologists to offer appropriate mental health education programs to service providers, charitable groups, community volunteers, and the public at large. The focus

of such training should include better understanding of psychosocial factors associated with both the entrance into and exit from homelessness. Educational program content should strive to dispel stigma associated with homelessness as well as with pervasive mental illness and to promote strength-based approaches to working with marginalized populations.

PRACTICE

In accordance with APA guidelines that encourage psychologists to provide clinical and other services to marginalized and underserved people, the task force recommends that psychologists:

- Provide strength-based clinical and assessment services to populations who are homeless or at risk of homelessness, including families involved with child welfare agencies, children in foster care placements, unaccompanied youth, persons experiencing alcohol or illegal substance dependence, and persons of all ages identified with pervasive and/or chronic mental illness.
- Maximize the use of clinical and assessment services by providing them in accessible settings and at times that reflect the needs of the populations served.
- Create meaningful collaborations between psychologists, social workers, case managers, nurses, physicians, teachers, and schools to best serve the multifaceted needs of individuals at risk of homelessness or those who currently are without stable housing.

ADVOCACY

To prevent an increase in homelessness, to better address the needs of those currently without housing, and to promote the rapid exit from homelessness where it currently exists, psychologists are encouraged to advocate at the state, local, and federal levels as follows:

- Advocate for legislation that would fund supportive housing as well as safe low-income housing in urban, suburban, and rural areas.
- Advocate for legislation that would provide a range of needed services, including mental health services to at-risk families, unaccompanied youth, and children and adults with disabilities.
- Advocate for funding for targeted counseling services, education and job training opportunities for youths in foster care, and transitional services for those returning to home placement and/or communities.

- Advocate for an increase in substance abuse and alcohol treatment programs, including services that promote the strengthening of families.
- Advocate for health care coverage for those without homes and those at risk of losing stable or permanent housing.
- Advocate for education and job training and after-school and day care programs to support poor families.
- Advocate for debt forgiveness programs for psychologists and others engaged in research on the prevention or amelioration of homelessness.
- Advocate on an individual basis for persons in need of services, including low-income housing, supplemental income, food, and benefits.

INTRODUCTION

PURPOSE

The 2009 Presidential Task Force on Psychology’s Contribution to End Homelessness was commissioned by James H. Bray, PhD, during his tenure as president of the American Psychological Association (APA). The creation of the task force reflects Dr. Bray’s understanding of the unique role of psychologists as both researchers and practitioners in working with people living without housing and the potential for the profession to improve outcomes in this vulnerable population. The mission of the task force was to identify and address psychosocial factors and conditions associated with homelessness and to explore the multifaceted role of psychologists in ending homelessness.

In addition, the task force was to provide recommendations on how APA can advance the association’s mission statement in three specific areas:

- The role of psychologists in providing clinical services to marginalized people, including those living without homes.
- Remediation of homelessness through prevention and intervention research.
- The advancement of training, research, practice, and policy efforts associated with homelessness within the field and in the community at large.

This report addresses these three areas by providing a historical background for understanding homelessness and current knowledge about the conceptualization and prevalence of homelessness; describing the psychosocial

factors associated with entering and exiting homelessness; presenting the results and implications of a survey about the role of psychologists in ending homelessness; identifying how homelessness can be remediated through prevention, intervention, practice, and policy; and recommending how psychology can advance training, research, practice, and policy to end homelessness.

BACKGROUND

Each year between 2–3 million people in the United States experience an episode of homelessness (Caton et al., 2005).

Homelessness is tied to economic instability and an insufficient supply of affordable low-income housing.

While predominantly concentrated in urban areas, homelessness also occurs in suburban and rural locations across the country and affects people across the life span, from newborns to the elderly (U.S. Conference of Mayors, 2009). For most people, homelessness is a relatively short experience and one that does not recur (Culhane, Metraux, Park, Schretzman, & Valente, 2007). Yet for approximately 10%, homelessness is long term and/or cyclical.

Great diversity—in age, gender, race, ethnicity, and sexual orientation—exists among populations living without homes. Overly represented among such populations are ethnic and racial minorities. Homelessness is tied to economic instability and an insufficient supply of affordable low-income housing. A significant majority of people who lose housing are extremely poor. The economic downturn beginning in 2007 resulted in a new surge of family homelessness as more advantaged people lost their homes

because of job layoffs, high unemployment, and lost savings (U.S. Conference of Mayors, 2009).

The psychological and physical impact of homelessness is a matter of public health concern (Krieger & Higgins, 2002; Schnazer et al., 2007; M. Y. Smith et al., 2000). Many people who lose housing have preexisting chronic health conditions (Schnazer et al., 2007). For some, living in shelters or on the street exacerbates underlying conditions and vulnerabilities (Schnazer et al., 2007; Wilson, 2005). Children living without homes lose opportunities for consistency and a sense of place that nurture healthy development; as a result, they are apt to suffer long-lasting academic and emotional repercussions (Cowan, 2007; Donahue & Tuber, 1995). Adults and children without homes often lack access to health care treatment (Kushel et al., 2001). In addition, homelessness carries a stigma that diminishes self-esteem for many (Phelan, Link, Moore, & Steuve, 1997). The human cost of homelessness erodes health and potential (Herman, Susser, Streuing, & Link, 1997; Koegel, Melamid, & Burnam, 1995). Psychologists as clinicians, researchers, educators, and advocates must expand and redouble their efforts to end homelessness.

HISTORICAL CONTEXT

Homelessness is not a new phenomenon. Throughout American history, especially during times of economic decline and uncertainty, individuals and families have lived without stable or appropriate housing (Rossi, 1989). The scholarly investigation of homelessness is likewise well established (for a more complete historical review, see Milburn & Watts, 1985); accounts of homelessness can be found in both historical and literary works (e.g., Clemens, 1917). Sociological and anthropological studies of homelessness began in the United States and Great Britain in the early 1900s (N. Anderson, 1923) and continued through the Great Depression (Caplow, 1940; Cross & Cross, 1937; Culver, 1933; Locke, 1935; Outland, 1939) and into the late 1960s (Bahr, 1969; Bogue, 1963; Levinson, 1957, 1963).

Conceptualizations of homelessness, as well as the nomenclature given to those without homes, have shifted over the years. During the Great Depression, those without housing were referred to as “tramps,” “vagrants,” and “migrant laborers.” In the 1950s and 1960s, people without housing were widely depicted as chronically alcoholic men who lived on “skid row.” With the deinstitutionalization movement of the 1970s, people who were seriously and persistently mentally ill became equated with homelessness (Arce, Tadlock, Vergare, & Shapiro, 1983; Ball & Havassy, 1984). Such people were often described as “bag ladies,”

“bums,” “panhandlers,” and “street people.” Unfortunately, derisive terms have persisted in common parlance over the years, contributing to the continued marginalization of people living without stable housing (Toro & McDonnell, 1992). Many today still refer to people without homes as “the homeless,” a monolithic and stigmatizing classification that is dehumanizing (Milburn, Ayala, Rice, Batterham, & Rotheram-Borus, 2006; Phelan et al., 1997).

Beginning in the 1980s, a large body of research on homelessness began to emerge, spearheaded by researchers and policy analysts from a number of disciplines, including psychology (Buckner, 2008; J. M. Jones et al., 1991; Kertesz et al., 2009; Shinn & Weitzman, 1990). Over the past 25 years, social and behavioral science, as well as medical research, has grown and taken a more nuanced approach to understanding homelessness. Scholarly attention has focused on investigating subgroups of the homeless population, including families, adolescents, and persistently mentally ill people. A robust literature has identified risk factors that contribute to homelessness and protective factors that may deter it (Buck, Toro, & Ramos, 2004; Buckner, 2008; Culhane et al., 2007). Research has also begun to explore the interface of homelessness with mental and physical illnesses, such as substance abuse, HIV/AIDS, and co-occurring disorders (M. Y. Smith et al., 2000). Models for interventions with homeless populations have also been reported (Fraenkel, 2006). This report, while not all-inclusive, is derived from the body of research on homelessness, as well as from clinical practice that has developed over the past 25 years and that continues to develop.

DEFINITIONS AND THE PREVALENCE OF HOMELESSNESS

DEFINITIONS

Defining homelessness is not without controversy. Disagreement among policymakers, government officials, social scientists, and advocates exists over conditions that constitute homelessness, and by extension, who “is” or “is not” considered to be homeless (Toro & Warren, 1999). Such debates have far-reaching implications. For example, narrow definitions of homelessness may preclude people having access to housing subsidies and vouchers, emergency shelter and/or transitional housing programs, and specific social service programs. While consistent statutory definitions of homelessness have not been adopted, federal, state, and local laws identify ranges of criteria that create a definitional construct of homelessness.

A particularly inclusive federal definition of homelessness is contained in the McKinney-Vento Education Act of 1986 (see <http://uscode.house.gov/download/pls/42C119.txt>), a law that entitles children to remain in local public schools despite their loss of housing. Children and families are considered to be living without homes if they stay in any setting unintended for human habitation or doubled up with relatives or friends. Unaccompanied youths, including those who run away (e.g., leave home without parental permission), are afforded protection under the McKinney-Vento Act. Other federal statutes have not considered adults living in motels or with friends or relatives as being homeless. More recently, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 expanded the definition of homelessness to include those at imminent risk of losing housing due to eviction under specific economic

circumstances, those in temporary institutional settings who lacked prior stable housing, unaccompanied youths, and victims of domestic violence.

While these two laws and others underscore living conditions that are commensurate with homelessness, many statutes and policies are not as inclusive. For example, many incarcerated adults and juveniles, children in foster care placements, and indigent patients admitted to psychiatric and other hospital settings lack stable housing in the community, yet by statute, these people do not meet the criteria for homelessness (Toro & Warren, 1999). People who are discharged or released early from institutional settings and are not protected by statute may be at risk of imminent homelessness or of resorting to living on the streets (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005).

For purposes of this report, we adopted an inclusive definition of homelessness. Homelessness exists when people lack safe, stable, and appropriate places to live. Sheltered and unsheltered people are homeless. People living doubled up or in overcrowded living situations or motels because of inadequate economic resources are included in this definition, as are those living in tents or other temporary enclosures. Gender, age, disability, or other personal characteristics are not included in this definition of homelessness.

THE PREVALENCE OF HOMELESSNESS

Many people live without housing for relatively brief periods (Caton et al., 2005; Culhane et al., 2007). During such episodes, people are dispersed across geographical locations among emergency shelters, transitional housing programs,

motels, stations, abandoned buildings, and the streets. Others live in their cars, in campgrounds, under highways, in tunnels, and in other places that are hard to locate. Many people live doubled up in temporary situations with friends and relatives. The episodic and transient nature of homelessness makes it difficult to conduct research on it or ascertain accurate estimates of its prevalence. In fact, much of the literature depicts experiences of chronic homelessness rather than the experiences of the majority of people who are newly or briefly without homes (Caton et al., 2005; Milburn, Rotheram-Borus, Rice, Mallett, & Rosenthal, 2006)

The actual prevalence of homelessness is a matter of controversy among politicians, advocates, and social scientists. Methods used for collecting data related to prevalence in this population underlie the debate. Two predominant methods are used to collect data: *point-in-time counts* and *period prevalence counts*. Point-in-time counts are “snapshots” of homelessness, currently collected on one identified night in January (U.S. HUD, 2009a). In addition, populations of people without homes are counted across geographical locations. Such locations include shelters, transitional housing programs, and well-known places where people without homes may congregate, such as railroad stations and parks. Not counted on such evenings are people living doubled up in the homes of others, living in their cars, or those dispersed in unknown or hard-to-find locations.

Link et al. (1995) and others disputed the accuracy of point-in-time counts because many people are not in locations where they can legitimately be included. This perspective would appear to be supported by the report of the U.S. Conference of Mayors (2009) on hunger and homelessness. This report found that across 27 U.S. cities, shelters were full, and people seeking beds and other services were turned away (see U.S. HUD, 2009b). Similar accounts have been published in numerous national and local media outlets. It is highly conceivable that such people would not be included in the point-in-time counts, and thus estimates of prevalence through this method are too low.

The other method for counting people without homes—the period prevalence model—relies on the collective reporting by a range of providers of homeless-related services over a 12-month period. Data are gathered from soup kitchens, shelters, transitional facilities, and other programs. This model provides a more comprehensive count of homelessness, but it is not complete. Critics of this method note inconsistency in data collection between and within agencies and the failure to include all service providers as reporters.

These deficiencies in data collection are also reported by U.S. HUD (2009a). Moreover, this model assumes that all or most people living without housing use services, which is not necessarily accurate. The fact that many people are turned away from services—or do not seek them—would suggest that prevalence counts based on this method underestimate true numbers of people living without homes.

Advocates for populations of homeless people regard data of *lifetime prevalence* as more accurate than point-in-time or period prevalence data. Politicians and policymakers are more apt to accept data that may underestimate prevalence. For purposes of this report, we used prevalence data contained in the U.S. HUD’s *2008 Annual Homeless Assessment Report to Congress*, released in July 2009. Although we cite data contained in this government report, we believe that the prevalence of current homelessness is probably higher. These data were collected prior to the downturn in the economy and do not account for the many people who have sought but were denied services over the past year. The

Much of the literature depicts experiences of chronic homelessness rather than the experiences of the majority of people who are newly or briefly without homes.

data are also more likely to capture the experiences of people who are homeless for longer periods. We encourage research that distinguishes the experiences of those who are newly homeless from those who are experiencing chronic homelessness.

Better understanding of the experiences that precipitate homelessness is key to prevention efforts. Research on strategies that support rapid rehousing is also needed.

On the basis of a point-in-time estimate, the U.S. HUD report (2009a) noted the following regarding one night in January 2008:

- There were 664,414 sheltered and unsheltered people in the United States.
- 58% of such people were in shelters or transitional programs; 42% were unsheltered.
- 62% of all homeless people at that point in time were individuals; 38% were part of a family unit.
- 50% of the total adult population on that evening were unsheltered; 27% of the families accounted for were unsheltered.
- 30% of the people counted at this point in time met criteria for being chronically homeless.

Although these data reflect people living in diverse locations in the United States, 50% of the people counted were concentrated in five states: California, New York, Florida, Texas, and Michigan (U.S. HUD, 2009a).

One-year estimates of homelessness were also reported by HUD (2009a) in its one-year report. These data were collected predominantly from shelter and transitional housing programs. During the period of October 2007 through September 2008, approximately 1.6 million people used shelters or transitional housing programs. Of this total population, 68%, or 1,092,600, were individuals, while 516,700 were members of a family unit. In total, HUD reported that 159,142 families were sheltered during this one-year period. The number of sheltered families rose 9% in 2008; the number of individuals remained stable. These data do not contain information on people living doubled up or in other locations. These data also did not include information on unaccompanied youth.

Adults using shelter beds were overwhelmingly male, African American, and older than 30 years of age. Forty percent of sheltered adults were reported to have a disability. Thirteen percent of sheltered adults were veterans. Forty percent of sheltered males ranged in age from 31 to 50 years. The average sheltered family was headed by a female and comprised two to three members. Females not seeking shelter as part of a household were significantly older than those with families. Fifty percent of sheltered children were younger than 5 years of age. Most shelter services were provided in cities, with 32% of services accessed in suburban and rural areas. These data are compelling in that the U.S. Conference of Mayors' (2009) report on hunger and homelessness noted a sharp increase in family homelessness, particularly in suburban areas.

Forty percent of all people seeking emergency shelter came from another shelter or residential program. Another 40% sought shelter after living in a home, either their own or that of a relative or friend. One fifth of all people were most recently housed in an institutional setting such as a hospital, prison, or motel. Emergency shelter stays during the 2008 period tended to be short, with 60% of people staying in particular settings for one month or less. The average period in transitional housing was 6 months, with 20% of people staying more than a year. Lengths of stays in shelters varied according to geographical location, opportunities for alternate housing, and the characteristics of people needing shelter. Longitudinal studies of homelessness describe patterns of shelter stays associated with demographic factors (Bassuk et al., 1997; Caton et al., 2005; Koegel et al., 1995; Stein & Gelberg, 1995).

In response to the economic downturn and expected changes in the prevalence of people living without housing, HUD (2009b) published a *Pulse Report* to track relevant changes in the populations of people without homes. This report provided limited data for the first quarter (January through

March) of 2009. It indicated a significant rise in the number of families with dependent children seeking shelter. These data are commensurate with findings reported by the U.S. Conference of Mayors (2009).

Data reported by the U.S. Conference of Mayors (2009) provided indicators of economic conditions that are associated with increases in homelessness. Of the 27 cities participating in the survey, 76% reported increased demands for shelter. Seven cities reported double-digit increases in family homelessness. Eighty-two percent of cities reported having to make adjustments in shelter accommodations to address the vast increase in demand for beds. Sixty-two percent of cities reported that shelters allowed people to sleep on floors, cots, chairs, and in hallways. Fifty-two percent of cities reported that people seeking shelter were routinely turned away because the shelters were filled to capacity. Eleven cities reported that a limited number of motel vouchers were given to people because there were no vacancies in shelters (U.S. Conference of Mayors, 2009).

As part of its surveys, the U.S. Conference of Mayors also gathers data from cities about the causes of homelessness. The four main reasons reported in 2009 for family homelessness were lack of affordable housing (74%), poverty (52%), unemployment (44%), and domestic violence (44%). Individuals reported lack of affordable housing, substance abuse, and unemployment (U.S. Conference of Mayors, 2009). Increased need was also reflected in an overall increase in request for food assistance (26%) by many people who considered themselves "middle class" (U.S. Conference of Mayors, 2009). These data reflect the experiences of people identified as being without homes. Unaccounted for are those people of all ages whose needs remain invisible but nonetheless real.

KEY SUBGROUPS

In the United States, the overall population of people living without homes can be divided into several subgroups:

- Individual adults
- Families with children
- Unaccompanied youth who have left home, run away, or aged out of foster care placements

We recognize that there are many diverse groups, each of which has subgroups, with particular characteristics and needs. Heterogeneity exists within and between subgroups, and professionals working with homeless people are urged to undergo diversity training and develop multicultural competence. Although there are both distinct and overlapping service needs between subgroups, discussion of each subgroup is separate. Prevention, intervention, and research with populations of people living without housing must focus on the context in which homelessness exists.

ADULTS

Among adults of all ages, housing loss is inextricably tied to structural factors including economic instability and a lack of affordable housing (Zlotnick, Robertson, & Lahiff, 1999). Homelessness may occur following eviction, job loss, relocation, and in some instances, natural disasters such as hurricanes, earthquakes, and fires (Lehman, Kass, Drake, & Nichols, 2007). Rising rates of unemployment, layoffs, and foreclosures unseen since the Great Depression of the 1930s explain the increase in homelessness in the past year (U.S. Conference of Mayors, 2009). Family upheaval

including divorce, separation, and domestic violence can underlie homelessness (Lehman et al., 2007). Prior to losing housing, most adults live with others, particularly in family settings (Caton et al., 2005). Personal factors such as significant substance abuse and/or alcoholism, mental illness, and criminal histories diminish opportunities to obtain employment or other income and may also contribute to homelessness (Caton et al., 2005).

Adults living without housing are characterized by the fact that they are unaccompanied by minor children in a household or family arrangement. Most adults live in shelters, transitional housing, on the streets, or in settings not intended for habitation. Others may be temporarily living doubled up with friends or family members (U.S. Conference of Mayors, 2009). A majority of sheltered adults without homes are men (68%), yet the number of women in this population is growing (Lehman et al., 2007; U.S. HUD, 2009a). Veterans constitute 13% of all sheltered adults (U.S. HUD, 2009b).

The adult population of people living without homes has also grown older (Shinn et al., 2007). The aging of the adult homeless population is linked to several factors, including the overall aging of the U.S. population, a majority of whom live on fixed incomes. Subsidized housing for elders is limited, and current harsh economic conditions have resulted in the loss of employment, savings, and pension benefits. Personal factors, such as a rise in substance abuse and mental illness among elderly people, may also contribute to the loss of housing in this age group (Crane et al., 2005; Deitz & Wright, 2005).

Research has shown that characteristics of homeless adults vary depending on age (Hahn, Kushel, Bangsberg, Riley, & Moss, 2006). For example, homeless single women are older on average than homeless unhoused women with children. Within the adult population, age is often associated with personal factors such as substance abuse or mental illness (Caton et al., 2005). In addition to the provision of appropriate affordable or subsidized housing, social services designed for adult populations must take into account age as well as personal factors.

Among adults who are without housing, the vast majority are only homeless on a short-term basis (Caton et al., 2005; Kuhn & Culhane, 1998). Studies report varying average lengths of shelter stays, but it is widely agreed that only 10% of the adult population meet criteria for chronic homelessness (Caton et al., 2005). Individuals with disabilities, including pervasive mental illness, are more likely to be chronically homeless, due in large part to a lack of appropriate services and housing that match their needs. Certain demographic characteristics are associated with shorter periods of homelessness, including being younger, having a history of employment, and having opportunities for rehousing with friends and family as opposed to relying on housing vouchers. Length of homelessness has not been linked to other demographic characteristics such as gender, race or ethnicity, educational attainment, veteran status, or marital history (Caton et al., 2005).

For many homeless adults, rapid rehousing in the community should be a priority. A number of adults need supportive services in the community, including job training, mental health care, and/or substance abuse treatment in conjunction with their exit from homelessness. A distinct but important minority are best served by supportive housing programs that incorporate case management and other services in varying degrees at residential locations. The immediate identification of the housing, employment, and other service needs of adults when they first enter homelessness is a critical component of work with this population. Psychologists can participate in such endeavors through psychological assessment and referral when appropriate, as members of case management teams, and as advocates for programs that promote rapid rehousing and supportive services.

FAMILIES WITH CHILDREN

Families with children are the fastest growing segment of the homeless population (U.S. Conference of Mayors, 2009). The majority of families without homes are headed by relatively young and poorly educated single mothers who are either underemployed or not working (Aratani, 2009; Friedman, Meschede, & Hayes, 2003). Fifty percent of

children without homes are under age 5 (U.S. Conference of Mayors, 2009). Although young children are overly represented among those without homes, growing numbers of families have school-aged and adolescent children as well. Data concerning the numbers and ages of children in this population may be skewed. When seeking emergency shelter admission, parents often do not report their children who are living elsewhere with relatives and friends (Cowan, 2007). As a result of shelter regulations that bar children over a certain age, especially boys and adolescents of both genders, many older children are not included in census studies. Finally, as discussed in greater detail elsewhere in this report, the interface between homelessness and child welfare involvement results in many children being separated from parents and the placed in foster care. These children tend not to be reported in census studies of homelessness.

A robust literature has investigated families that are homeless in comparison with those that are housed (Buckner, 2008). While significant differences can be found in comparisons of families without homes and those in the general population, few differences exist between extremely poor families with housing and those without housing (Culhane et al., 2007; Huntington, Buckner, & Bassuk, 2008). Families that lose housing tend to have even fewer economic resources and more extensive histories of residential instability and relocation.

Extremely poor families, when compared with those that are less poor, experience cumulative stressors including high rates of exposures to physical and sexual abuse, substance and alcohol abuse, domestic and other interpersonal violence, and family destabilization (Anooshian, 2005; Attar, Guerra, & Tolan, 1994; Bassuk, 1993). Chronic medical conditions and untreated emotional and behavioral disturbances exist at higher rates among poor families than among those in the general population (Bassuk et al., 1997; Graham-Bermann, Coupet, Egler, Mattis, & Banyard, 1996; Weinreb, Buckner, Williams, & Nicholson, 2006). Poor families also are more likely to live in unsafe neighborhoods, often in conditions that are unhealthy as well as dangerous (Garbarino, 2001).

Homelessness itself is a significant stressor for families. Many families double up with relatives and friends prior to seeking shelter. Negotiating a maze of bureaucratic agencies, sometimes daily, for housing and food is exhausting for family members of all ages. Dislocation from possessions, neighborhoods, and important attachment figures, such as extended family members and friends, is destabilizing for children and adults alike (Cowan, 2007). Families lose privacy when they enter shelters and are required to adhere to new rules and regulations, which can upset family hierarchies (Friedman, 2000). Many children without homes

have greater numbers of school absences than their housed peers, compromising their academic achievement as well as their school adjustment and self-esteem (Masten, Miliotis, Graham-Bermann, Ramirez, & Neeman, 1993).

Typical lengths of stays in family shelters vary, in large part due to structural factors such as inadequate supplies of low-income or subsidized housing. In most communities, there are long waiting lists for Section 9 housing and limited vouchers. Some communities have arcane rules and requirements that obstruct families in their efforts to be rapidly re-housed (Bosman, 2009). Larger families tend to have longer shelter stays due to a dearth of subsidized units that can accommodate more than a few people.

Psychologists working with populations of families without homes have opportunities to provide assessment and therapeutic services where needed. Strength-based group interventions for families experiencing homelessness have shown promising results (Fraenkel, 2006; Gerwitz, 2007). Many families in shelter settings have experienced trauma, and mental health interventions and trauma-focused interventions are needed (Health Care for the Homeless Clinicians' Network, 2003). Shelter settings need to incorporate strategies that are trauma sensitive. Psychologists can provide mental health services to individuals and groups in shelter settings and elsewhere, but their services are also invaluable in terms of the training and support they can offer to shelter providers and staff working with the unique needs of this population.

UNACCOMPANIED ADOLESCENTS

Adolescents living on the streets, in abandoned buildings, stations, and other uninhabitable places, as well as in shelters are a unique subpopulation of those living without homes (Tompsett, Fowler, & Toro, 2009). Approximately 7.6% of 12–20-year-old youths spend at least one night per year in a shelter facility (Ringwalt, Greene, Robertson, & McFeeters, 1998). Although poverty contributes to homelessness in this population, causes of adolescent homelessness vary. One strong predictor is family conflict (Milburn et al., 2006). Some adolescents leave home because of abuse or victimization, while others who are gay, lesbian, bisexual, or transgendered may be told to leave when they express their sexual orientation (Cochran, Stewart, Ginzler, & Cauce, 2002). Other adolescents have aged out of foster care or juvenile justice placements and have no home or community to which to return (Haber & Toro, 2004). With few job skills and limited income, adolescents experiencing homelessness can rarely obtain safe and affordable housing. Youths living without homes are at great risk for victimization (Wenzel, Hambarsoomian, D'Amico, Ellison, & Tucker, 2006) and

are often victims of assault and robberies. Living on the streets can amplify maladaptive behaviors (Tyler, Hoyt, Whitbeck, & Cauce, 2001; Whitbeck & Hoyt, 1999). Because they lack legitimate sources of income, some youths engage in behaviors such as sex work that place them at greater risk for harm. Involvement in high-risk behaviors and substance abuse increases exposure to HIV/AIDS as well as other sexually transmitted diseases (Cauce et al., 2000; DeRosa, Montgomery, Hyde, Iverson, & Kipke, 2001).

As with other subgroups, distinctions exist between adolescents who newly enter homelessness and those who are without homes for longer periods or on a more cyclical basis (Milburn et al., 2006; Tompsett et al., 2009). Most research in this area has focused on those who meet criteria for chronic homelessness (Milburn et al., 2006; Whitbeck & Hoyt, 1999). Better understanding of the experiences of those entering homelessness is needed, as are strategies for rapid rehousing. Prevention and intervention work with adolescents who are experiencing homelessness must reflect their age and developmental needs (Haber & Toro, 2004; Masten et al., 2004).

VARIATIONS ACROSS NATIONS

The rate of homelessness varies among developed nations, with the United States, the United Kingdom, and Canada having some of the highest rates (lifetime prevalence of 6–8% for literal homelessness), and other nations (e.g., France and Germany) having much lower rates (lifetime prevalence of 2–3%) (Toro et al., 2007; Toro, Bokszczanin, & Ornelas, 2008). Explaining the significant variation in rates of homelessness can assist in identifying and tackling the root causes of homelessness across developed nations. For example, Shinn (2007) and Toro et al. (2007, 2008) suggested that the breadth and efficiency of health and human services across nations could help explain the variation in rates. Germany and France, for example, have a strong array of such services, including a “guaranteed minimum income,” readily available national health care, and generous unemployment benefits (Helvie & Kuntzmann, 1999; Tompsett et al., 2003). Other factors posited to explain higher rates of homelessness include strong capitalist and individualist national tendencies, intense immigration, an uneven distribution of wealth, and weak family and other social ties (Adams, 1986; Shinn, 2007; Tompsett et al., 2003; Toro et al., 2007, 2008).

PSYCHOSOCIAL FACTORS ASSOCIATED WITH ENTERING AND EXITING HOMELESSNESS

THE HETEROGENEITY OF HOMELESSNESS

Among those living without homes are people of all ages, races, ethnicities, cultural backgrounds, sexual orientation, and immigration status. Diversity also exists in the behavioral characteristics of people living without homes. For example, although poor people with substance abuse and/or mental illness are clearly at risk for becoming homeless and face additional barriers in exiting homelessness, the majority of people who are experiencing homelessness are not substance abusers or mentally ill. And while some people without homes conform to stereotypes of being isolated from family and friends, most are in regular contact with family members. Stereotypes are dangerous, and for every psychosocial factor discussed in this report, there is wide variation.

A discussion of psychosocial factors associated with either entering or exiting homelessness must take into account the multidimensional heterogeneity of these populations. Psychologists working with individuals and groups must be vigilant in exercising multicultural sensitivity and recognizing the strengths and unique characteristics of all people.

POVERTY

Homelessness occurs when a cascade of economic and interpersonal factors converge in the lives of marginalized people. In most cases, income, earned or otherwise, is inadequate either to secure or maintain affordable housing (Shinn et al., 1998). Until 2008, when widespread economic instability resulted in a significant increase in the loss of

housing among blue-collar workers and the middle class (Aratani, 2009), the overwhelming majority of people who experienced homelessness were extremely poor (Burt et al., 1999). Over the past year, the number of people seeking food and shelter has risen exponentially (U.S. Conference of Mayors, 2009). Nonetheless, among people seeking emergency shelter for the first time, most fell well below nationally established indicators of poverty (U.S. Conference of Mayors, 2008).

Discrimination against racial and ethnic minority populations long embedded in American society has resulted in the overrepresentation of people of color, particularly

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African Americans, poor people, and correspondingly, people who are experiencing homelessness (Barbell & Freundlich, 2001; Bassuk et al., 1997; Burt et al., 1999). According to recent estimates, African Americans constitute 42% of the population of people living without homes, Caucasians 39%, Latinos 13%, Native Americans 4%, and Asians 2% (U.S. Conference of Mayors, 2008).

Economic instability is pervasive in the lives of poor people, who are most vulnerable to job layoffs, unemployment, evictions, property and personal crimes, and the long-lasting devastation of natural disasters (Aratani, 2009). Insufficient food, nutrition, and associated health conditions are more common among poor adults and children (Alaimo, Olson, Frongillo, & Breitel, 2001). Chronic health problems, as well as inaccessibility to medical and dental care, increase school absences and limit employment. Inadequate education and

high dropout rates quash opportunities to earn incomes sufficient to meet rising costs of food, transportation, and child care. Against a backdrop of increasing costs and limited assets, poor people compete for affordable housing (Rafferty & Shinn, 1991).

Structural and psychosocial factors combine to heighten the risk of homelessness (D. G. Anderson & Rayens, 2004; Buckner, 2008; Webb, Culhane, Metraux, Robbins, & Culhane, 2003; Wilson, 2005). American housing policies have not adequately addressed the needs of poor and disabled people. Among the most obvious structural deficiency is the well-documented imbalance between the demand for low-income, affordable housing and its limited availability (Bassuk et al., 1997). This disparity between demand and supply—linked to failure to create new affordable housing stock, gentrification, discriminatory housing practices and zoning laws, condemnation of unsafe or substandard housing, and foreclosures of buildings containing otherwise affordable rental units—disproportionately burdens poor people (Aratani, 2009; Lehmann et al., 2007). Community-based supportive housing programs for people with disabilities are also few. At the same time, high unemployment rates; the post-welfare reform restriction of TANF (Temporary Assistance for Needy Families) benefits to some families in need of income subsidy; limitations in supplemental security income (SSI) disability payments; and the continually rising costs of food and other necessary items sink those who are already poor into even greater poverty (Aratani, 2009; Bassuk et al., 1997; Huntington, Buckner, & Bassuk, 2008).

Among populations of poor people, some are at greater risk of homelessness than others (Aratani, 2009; Bassuk et al., 1997; Lehman et al., 2007; Van den Bree et al., 2009). People with pervasive mental illness are less able to obtain lucrative or steady employment and, in the absence of supportive housing, are more likely to be without homes. Other psychosocial risks for homelessness have been well documented in a robust literature: childhood maltreatment, including sexual and physical abuse; intimate partner or other types of victimization; substance abuse; dysfunctional family patterns; and out-of-home placement during childhood (Caton et al., 2005; Herman et al., 1997; Koegel et al., 1995; Stein & Gelberg, 1995). A particularly sobering predictor of adult homelessness is lack of stable housing as a child.

The exit from homelessness depends on addressing the multiplicity of factors that contribute to the loss of housing. In accordance with new federal housing policies, efforts to

expand low-income housing stock and increase supportive housing for disabled people are critical. Additionally, community-based job training and affordable day and targeted social services are key. For many individuals and families, services that foster the creation of community and family supports ease the transition from being homeless to being re-housed (Burt et al., 2007). When needed, access to mental health services and substance abuse treatment is critical to support individuals and maintain families in housing (D. G. Anderson & Raynes, 2004; Wilson, 2005).

The remediation of homelessness involves focusing on the risk factors that contribute to homelessness as well as advocating for structural changes, such as increased low-income and supportive housing.

The remediation of homelessness involves focusing on the risk factors that contribute to homelessness as well as advocating for structural changes, such as increased low-income and supportive housing. As researchers, clinicians, and advocates, psychologists can contribute to preventing homelessness and, where it occurs, intervening to expedite rehousing.

SUBSTANCE ABUSE

National and international surveys of psychiatric morbidity assessing drug, alcohol, and tobacco usage helped define and differentiate substance abuse and dependence and other psychological morbidity among populations of people with and without homes. Lehman and Cordray's (1993) meta-analysis of 16 epidemiological studies of populations of people experiencing homelessness in the United States was performed to provide more precise estimates for the prevalence of alcohol, drug, and mental health disorders from previous research providing a wide range of estimates. Weighted estimates were 28% for current alcohol disorder and 10% for current drug use disorder.

Farrell and colleagues (1998) assessed substance misuse and psychiatric comorbidity among populations of people experiencing homelessness by summarizing results from three surveys: a national household survey, a survey of institutional residents with psychiatric disorders, and a national homeless survey. The household survey included over 10,000 households; the institutional survey interviewed 755 people; and the homeless survey of hostels, night shelters, day centers, and private-sector leased accommodations included 1,061 people. This research reviewed patterns of nicotine, alcohol, and other drug use in the different samples and examined interactions with other psychiatric comorbidity. The authors reported that substance-related disorders were some of the most common mental disorders within the community, with 5% of the household sample, 7% of the institutional sample, and over 21% of the sample of those without homes recorded as

alcohol dependent. Rates of tobacco, alcohol, and other drug use and dependence, which were dramatically higher in the sample of people without homes than in either of the other two samples, were significantly associated with higher rates of psychological morbidity.

Bassuk, Buckner, Perloff, and Bassuk (1998), however, found that the difference in substance use disorders between those who were housed and those who were not housed disappeared when income was controlled in an unmatched case-control design of low-income mothers. While the prevalence of substance use and other trauma-related disorders among poor women was higher than that among women in the general population (as compared with women in the National Comorbidity Study), this research suggests that substance abuse may be more a result of poverty than simply of being labeled homeless.

Future research needs to account for such intervening variables, and future service planning should take into account any disparities of prevalence of substance use and other psychiatric disorders in different subsections of the population. The rates of substance abuse among people who are homeless are significant but do not seem to justify the drug-using stigma aligned with people who are homeless. In fact, practicing psychologists and researchers may be able to identify resilience and protective factors in the majority who are not using drugs to reduce the length and negative consequences of homelessness as it relates to drug and alcohol abuse.

Finally, youths who are homeless have also been found to exhibit high rates of substance-use disorders, including alcohol abuse or dependence and drug abuse or dependence (Rotheram-Borus, 1993). Psychologists can play a role in screening, assessment, treatment, and research of substance abuse and how it relates to entering and exiting homelessness.

MENTAL ILLNESS

While rates of mental illness among people who are homeless in the United States are generally higher than in the general population (twice the rate found for the general population, according to the Bassuk et al., 1998, study), most people who are homeless are not suffering from a mental disorder (only 18% met criteria for current severe mental disorder in Lehman & Cordray's, 1993, meta-analysis).

Furthermore, Bassuk et al.'s (1996, 1998) research even failed to find significant differences in mental disorders between housed and not-housed mothers when controlling for income, challenging the common stereotype of the mentally disturbed

homeless person. Despite this, a complex relationship does exist between homelessness and mental illness.

Both structural and individual factors contribute to homelessness among people with mental illness and poor mental health, including lack of safe, affordable housing, as well as potentially disabling behavioral health issues (O'Hara, 2007). While mental illness may lead to problems that result in homelessness, it does not appear to be a sufficient risk factor on its own, based on comparisons of people who are homeless with mental illness and (a) those without mental illness and (b) those housed with mental illness (Sullivan, Burnam, Koegel, & Hollenberg, 2000). The symptoms associated with mental illness and substance use disorders may not only contribute to a person's vulnerability for homelessness but may also be exacerbated by the experience of homelessness (O'Hara, 2007).

According to the Substance Abuse and Mental Health Services Administration (2003), lack of resources and fragmented, antiquated mental health service systems exacerbate the problem of homelessness for people with mental health problems. Homeless people with serious mental illness find it more challenging to become housed on their own and are at greater risk of chronic homelessness (U.S. HUD, 2001). Between 150,000 and 200,000 people with disabilities, including mental illness, experience chronic homelessness.

Meta-analysis of 16 epidemiological studies of people in the United States without homes revealed the prevalence of mental disorders for any Axis I disorder to be 43%; for a severe Axis I disorder, 18%; and for a lifetime severe Axis I disorder, 32% (Lehman & Cordray, 1993). More recent estimates of mental disorders among people living without homes range up to over 40% (Burt, 2001; Fazel, Khosla, Doll, & Geddes, 2008), with a wide variety of symptoms of mental disorders and diagnosed mental illnesses present, including schizophrenia and other psychoses, mood and anxiety symptoms, paranoia, and obsessive compulsive symptoms and disorders including posttraumatic stress disorder (PTSD) (Connolly, Cobb-Richardson, & Ball, 2008; Olfson, Mechanic, Hansell, Boyer, & Walkup, 1999).

As many as one third of people without homes in the United States, Australia, Great Britain, and Canada report having experienced psychiatric hospitalization (Ducq, Guesdon, & Roelandt, 1997). Rates that might be expected among the general population reported from the National Comorbidity Study (Kessler et al., 1994) estimated that nearly 50% of

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respondents reported at least one lifetime mental disorder, and close to 30% reported at least one 12-month disorder.

Life on the streets and in shelters is stressful and often associated with victimization (Kushel, Evans, Perry, Robertson, & Moss, 2003) and subsequent mental health problems. Women who experience homelessness are at particular risk for victimization (Wenzel, Tucker, Hambarsoomian, & Elliot, 2006). Up to 39% of homeless women experience PTSD as a result of their encounters with violence, which is three times more common than for women in general. Experiencing nonphysical victimization, such as being threatened with a weapon or theft of property, is associated with higher levels of depressive symptoms, and physical victimization is related to lower levels of perceived safety. Consequently, perceived safety partially mediates depressive symptoms in this group (Perron, Alexander-Eitzman, Gillespie, & Pollio, 2008). In one study, homelessness has also been associated with suicide among veterans with diminished social and environmental support (Lambert & Fowler, 1997).

More women than men who are homeless experience mental illness (Marshall, 1996). The National Center on Family Homelessness (see Buckner, Beardslee, & Bassuk, 2004) reported that 47% of homeless women meet the criteria for a diagnosis of major depressive disorder—twice the rate of women in general. Women living in shelters have a significantly increased risk of depression, and homeless women who are on the streets rather than in shelters are 12 times at greater risk of mental health problems and three times more likely to have fair or poor physical health and more sexual partners than other women (Nyamathi, Leake, & Gelberg, 2000; Rayburn et al., 2005). Not all homeless women are alike, however; Bassuk et al. (1996) reported on mental health and other characteristics associated specifically with mothers who are homeless. E. M. Smith and North (1994) studied 300 homeless women (90% of whom were mothers) and concluded that mothers with their children may benefit more from increased social services.

At-risk youths living without homes also have problems with mental health, including mood disorders, suicide attempts, and PTSD (Cauce et al., 2000; McCaskill, Toro, & Wolfe, 1998; Powers, Eckenrode, & Jaklitsch, 1990; Rew, Thomas, Horner, Resnick, & Beuhring, 2001; Rotheram-Borus, 1993). PTSD affects as many as one third of adolescents without homes (Whitbeck, Hoyt, Johnson, & Chen, 2007), as does the co-occurrence of depression and anxiety symptoms with PTSD (Gwadz, Nish, Leonard, & Strauss, 2007). Among 14–25-year-old youths experiencing homelessness, 82% reported psychological symptoms including depression and anxiety (sometimes severe and

chronic) and aggression; 43% reported having attempted suicide (Klee & Reid, 1998).

The risk of mental health problems may be particularly high among adolescents living on the streets, who tend to experience more stressful events and exhibit more psychological symptoms than do youths without homes who have not spent time on the streets (Robertson & Toro, 1999; Whitbeck & Hoyt, 1999). Behavioral problems, such as conduct or oppositional defiant disorder, may be even more prevalent than mental health problems (Cauce et al., 2000; McCaskill et al., 1998; Toro & Goldstein, 2000). Adolescents without homes who perceive a need for mental health services may not know where to go or which services to access (Solario, Milburn, Anderson, Trifskin, & Rodriguez, 2006).

The problem of mental illness and poor mental health among the homeless population affects all strata of the homeless—children and adults. The mental health of children who are homeless is an area of special concern. Not all children without homes experience mental health symptoms; however, the lack of predictability and consistency in their lives makes it harder to meet their psychological and developmental needs. These children can have high rates of mental health problems (Karim, Tischler, Gregory, & Vostanis, 2006), and compared with their housed peers, these children are reported to experience more disruptive behavioral disorders (Yu, North, LaVesser, Osborne, & Spitznagel, 2008).

The high rates of co-occurrence of mental illness and homelessness must be addressed. First, distinguishing between those with and without severe mental illness may be particularly important. Assertive community treatment offered significant advantages over standard case management models in reducing homelessness and symptom severity in homeless people with severe mental illness (Coldwell & Bender, 2007).

Second, the President's New Freedom Commission on Mental Health (2003) made clear the need to address the public mental health system's delivery of service to people without homes and with mental illness. This population is more likely to use hospitals than regular outpatient care (North & Smith, 1993), which is not only more expensive but results in fragmented service and less attention paid to ongoing mental health needs.

Finally, Shinn and Gillespie (1994) argued that although substance abuse and mental illness contribute to homelessness, the primary cause is the lack of low-income housing. Access to this housing is even more difficult for people who are mentally ill and/or have substance abuse

problems. People with substance and other mental disorders experience even greater barriers to accessible housing than their counterparts: income deficits (low levels of social security disability), stigma, and need for community wraparound services. Psychologists can play an important role not only in identifying and treating mental disorders among those who are experiencing homelessness but also in helping to reduce homelessness by providing the needed support to assist individuals in adapting to the community.

PHYSICAL HEALTH PROBLEMS AND ILLNESS

Considerable attention has been given to physical health problems among people without homes (McMurray-Avila, Gelberg, & Breakey, 1999; Zlotnick & Zerger, 2008). When compared with the general population, people without homes have poorer physical health, including higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS (Zlotnick & Zerger, 2008), as well as higher rates of medical hospitalizations (Kushel et al., 2001). Poor physical health is associated with poverty in general but seems to be more pronounced among those who are without homes. Recent studies document the prevalence of traumatic brain injury in adults without homes in Canada, where men are more likely than women to report such histories. Studies with smaller samples in the United States show similar findings (LaVecchia, 2006; MacReady, 2009). Veterans without homes are more likely than nonveteran adults to experience recent traumatic brain injuries.

Poor physical health is related to gender, age, and ethnicity among people without homes and also varies across the key subgroups (Munoz, Pandero, Santos, & Quiroga, 2005). For example, homeless European American women have more health problems and less access to health services than their counterparts (Arangua, Andersen, & Gelberg, 2005). Sexually transmitted diseases including HIV/AIDS are prevalent among some subgroups of people without homes. Age, gender, and ethnicity are linked to such HIV/AIDS risk behaviors as injection drug use and high-risk sexual practices (Song et al., 1999). HIV/AIDS, like other chronic diseases, is associated with poverty and is particularly problematic for some adolescents living on the streets and in shelters (Gillies, Tolley, & Wolstenholme, 1996; Rotheram-Borus, Koopman, & Ehrhardt, 1991; Rotheram-Borus et al., 2003). Sexually experienced adolescents out of home for longer periods engage in more HIV/AIDS-related high-risk behaviors (Milburn et al., 2006). High-risk sexual practices such as unprotected survival sex increase HIV/AIDS risk for gay, lesbian, and bisexual youths living without homes (Cochran et al., 2002; Gangamma, Slesnick, Toviessi, & Serovich, 2008).

HIV/AIDS prevention efforts are effective for some subgroups, including drug addicts and adolescents living without homes (Schumacher et al., 2003; Rotheram-Borus et al., 2003). New research suggests that protective factors as well as risk factors may explain high-risk sexual practices, such as multiple sexual partners and unprotected sex, among homeless adolescents (Tevendale, Lightfoot, & Slocum, 2009).

Access to care and the utilization of services are important issues for people with physical health problems and illnesses, including those living without homes. While considerable attention has been given to physical health problems and illness in such populations, the accessibility of health care and barriers to care are underinvestigated and not well understood (McMurray-Avila et al., 1999). Psychologists working with populations living without homes must not ignore their health problems. Ways in which psychologists can contribute to better health outcomes among people without homes include teaming with local Health Care for the Homeless organizations; assisting in the development and implementation of behavioral interventions for engagement in treatment and adherence to it; investigating psychological factors linked to health care utilization; and collaborating with and training other providers in stigma reduction and in ways to improve healthy behaviors through strength-based approaches that enhance motivation and reduce stigma.

CHILD WELFARE INVOLVEMENT INCLUDING FOSTER CARE

A strong association exists between child welfare agency involvement and homelessness. This association is best depicted by the intersection of three pathways:

- Families without homes are more likely than those that are housed to have their children removed and placed in the foster care system (Bassuk et al., 1997). By some estimates, up to 30% of children in the foster care system have parents who are living without homes (Harburger & White, 2004).
- A significant number of children who exit foster care, either by running away from placements (Nesmith, 2006) or aging out upon turning 18, are likely to end up without stable homes and resort to living on the streets or elsewhere (Mason et al., 2003).
- Severing bonds between parents and children, including through foster care placement, is a strong predictor of homelessness and emotional dysfunction across the life span (Choca et al., 2004; Cowal, Shinn, Weitzman, Stojanovic, & Labay, 2002; Herman et al., 1997; Koegel et al., 1995; Rosenfeld et al., 1997).

Families at greatest risk of child welfare involvement are those headed by relatively young single mothers with more than one school-aged or adolescent child (Park, Metraux, Brodbar, & Culhane, 2004). Other factors contributing to child welfare involvement are parental histories of domestic violence, incarceration, hospitalization, and substance abuse (Bassuk et al., 1997). Among families without homes and seeking shelter, the risk of welfare involvement is especially heightened. In some instances, child welfare authorities are involved with families prior to their loss of housing (McChesney, 1995). Families may have “open” cases of child abuse or neglect that follow them once a loss of housing occurs (Park et al., 2004).

Families that are newly without housing may come to the attention of child welfare authorities because of structural factors intrinsic to shelter systems. For example, certain shelters that restrict adolescents or male children over a certain age facilitate the breakup of families. In light of such restrictions, some parents attempt to place their children with relatives or friends, while others are forced to resort to child welfare agencies rather than place children in foster care (Cowan, 2007).

When children are placed informally with relatives or friends, a breakdown in arrangements may also lead to formalized foster care placement (Cowan et al., 2002; Park et al., 2004). Even in those states that disallow restrictions on children entering shelters, high rates of parent–child separations continue (Cowan et al., 2002). Significant numbers of children are also forced into foster care placement by parental entry into substance abuse treatment, jail, or a psychiatric institution (Kittinger, Nair, & Shuler, 2000).

The very fact of living in shelter environments places families under greater scrutiny and can lead to the filing of child protection reports with child welfare agencies (Friedman, 2000; Friedman et al., 2003). Child welfare authorities in many states remove significant numbers of children from their parents simply because they lost their homes. In these instances, agencies often make incorrect determinations that the inability to provide stable housing is equivalent to neglect (Harburger & White, 2004). Reunification under such circumstances is tied to parental ability to find suitable housing, a Herculean feat in housing markets with high demand and few options for low-income or subsidized housing. The structural deficiencies of the American housing market punish parents and children for the lack of affordable housing and causes inordinate stress for family members (Harburger & White, 2004; Park et al., 2004).

The events and circumstances leading up to the loss of housing are fraught with great stress. With the loss of housing, parents, often accompanied by their children, must negotiate a web of bureaucracies to meet everyday needs for shelter and food. Once sheltered, families are subjected to new and unfamiliar rules and rituals, displacing the autonomy of parents and establishing new hierarchies (Friedman, 2000). These changes in family structure and the challenges of living with numerous strangers can be destabilizing for adults and children (Cowan, 2007; Fraenkel, 2006; Friedman, 2000). Parents and children alike may react to the cumulative stressors of homelessness with increased dysfunction, including explosive behaviors or other maladaptive coping styles.

Precarious family circumstances that contribute to the loss of housing, including domestic violence, substance abuse, and parental mental illness, in some cases legitimately raise concern about children’s well-being and create the need for welfare agency involvement (Health Care for the Homeless Clinicians’ Network, 2003; Kittinger et al., 2000). Suboptimal parenting practices often associated with substance abuse and mental illness may result in child abuse or neglect (Bassuk et al., 1997; Kittinger et al., 2000). Parenting styles that include harsh physical punishment, neglect, or emotional abuse may be observed by residents and shelter staff, resulting in a mandated report to child welfare agencies (Harburger & White, 2004)

Foster care placement has long been associated with poor mental health outcomes (Choca et al., 2004; Landsverk & Garland, 1999; Mason et al., 2003; Rosenfeld et al., 1997). While many children entering foster care have preexisting mental health conditions, a robust literature suggests that severing the parent–child bond, moving children among multiple placements, and poor reunification planning jeopardize children’s mental health during critical developmental periods, often with life-long consequences (Nesmith, 2006; Rosenfeld et al., 1997).

In the absence of other indicators, child welfare agencies should not equate the loss of housing with neglect (Harburger & White, 2004). To the extent possible, caseworkers must attempt to keep families intact. Parenting programs, outpatient counseling services for family members in need, and enrollment in prosocial community activities provide important supports to families. Substance abuse programs that provide placements for children as well as their parents may have beneficial and long-lasting positive effects. Using child welfare budgets to strengthen families in communities is a more practical and inexpensive proposition

Using child welfare budgets to strengthen families in communities is a more practical and inexpensive proposition than foster care placements.

than foster care placements. In addition to providing direct services to families, psychologists can advocate for the funding of comprehensive programs that support families and prevent homelessness.

THE EXIT FROM FOSTER CARE

Many children in foster care placements were neglected and harmed in their homes prior to entry into care (Kittinger et al., 2000). Once removed, children must negotiate the disruption of contact with family members and disconnection from home environments while learning to adapt to the requirements of their foster homes. Not all foster parents are equally well trained or suited to the task of parenting children who are enduring huge psychological loss. The cyclical removal of children wherein one foster placement is replaced with another recreates trauma, loss, and disconnection. Foster children may have difficulty forming attachments, which may lead to maladaptive behaviors, including running away.

Children at highest risk of running away from foster care placements are those who were older when first placed, had multiple placements, and on whom little caseworker resources were expended (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 1999; Nesmith, 2006). Additional risk factors for running away include limited contact with the family of origin, authoritarian foster parents, gender identity issues, and a prior history of elopement (Nesmith, 2006). Children who run away from foster care placements are likely to be difficult to place in alternate settings and ultimately may end up living on the streets (Nesmith, 2006).

Parents with children in foster care placements often do not receive appropriate or comprehensive reunification services (Barbell & Freundlich, 2001; Cowal et al., 2002). Contact may be lost between parents and children during foster care placements. Adolescents who age out of foster care at 18 years of age, especially those who were removed from their families for long periods of time, may lack a stable home to which to return (Barbell & Freundlich, 2001; Choca et al., 2004) and may end up without homes (Courtney et al., 1999; Firdion, 2004; Fowler, Toro, & Miles, 2009; Fowler, Toro, Tompsett, & Hobden, 2006; Toro et al., 2007). In addition to lacking family connections, these youths may also lack the requisite education and job skills that would enable them to support themselves adequately or pay for suitable housing. The same structural deficiencies that cause homelessness in adults may result in the lack of housing for this population of youths (Choca et al., 2004). Recent studies indicate that out of 1,087 former foster care clients, 22% experienced at least one night of homelessness.

THE ONGOING IMPACT OF FOSTER CARE

The pathway between foster care and adult homelessness is complex. Foster care placement is a strong predictor of homelessness in adulthood (Herman et al., 1997). A significant number of children in foster care have mental illnesses that require treatment (Landsverk & Garland, 1999; Rosenfeld et al., 1997). Children in foster care placements often do not receive the mental health treatment that is needed and may continue to exhibit emotional and behavioral disturbances into adulthood (Barbell & Freundlich, 2001; Landsverk & Garland, 1999; Rosenfeld et al., 1997). Continuing maladaptive behaviors may be associated with pervasive mental illness. In addition, inadequate community supportive services may lead to homelessness.

The severing of bonds with parents, siblings, and other important caregivers can have long-term destabilizing effects and affect functioning. Social and community supports may be more difficult to create for people displaced during their formative years. Psychologists must use their clinical skills to treat children in foster care who have experienced cumulative trauma (van der Kolk, 1987). Psychologists can also provide in-service training to foster parents and caseworkers to enhance positive experiences of children in care. Collaboration with other mental health professionals to create strength-based services for youths returning to communities following foster care placement is necessary. Advocacy for the creation of job training and appropriate housing opportunities for this population is key.

INCARCERATED AND INSTITUTIONALIZED POPULATIONS

INCARCERATION

The President's New Freedom Commission on Mental Health (2003) identified the eradication of the co-occurrence of homelessness, mental illness, and involvement in the criminal justice system as a national priority. The term *institutional circuit* describes the movement of people between shelters, jails, prisons, and other institutions in lieu of stable housing (Hopper, Jost, Hay, Welber, & Haugland, 1997), an unfortunate cycle which makes it difficult to achieve stable residence, employment, and family ties. While the associations between homelessness, mental illness, and incarceration are widely established, the multidirectional relationships are complicated and make it difficult to firmly establish policies and interventions that can interrupt the circuit.

The rate of homelessness among the general U.S. population is estimated to be 1.36–2.03%, whereas the rate of recent

Foster care placement is a strong predictor of homelessness in adulthood.

homelessness among jail inmates is 15.3%—an odds ratio of 7.5–11.3% compared with the general population (Greenberg & Rosenheck, 2008). Estimates of the percentage of incarcerated people without homes vary, but recent studies reported 23% (Kushel et al., 2005) and 37% (LePage et al., 2005). As many as 1 out of every 6 incarcerations involves a person who was without housing at the time of arrest (McNiel, Binder, & Robinson, 2005). Inmates who have recently lost housing are more likely to have prior involvement with the criminal justice system and mental health and substance use problems. They are also more likely to be incarcerated for property crimes, which may be a result of “survival behavior” (Greenberg & Rosenheck, 2008), and/or to be arrested for “nuisance offenses” such as indecent exposure and camping without a permit (DeLisi, 2000).

A history of incarceration is associated with a significantly greater likelihood of being homeless (Burt et al., 2001), and former prisoners are at increased risk for recidivism when homelessness is involved (Metraux & Culhane 2004). Different homelessness patterns emerge for those released from prison as opposed to jail. Metraux and Culhane (2006) found that over 60% of study participants released from prison began shelter stays within 30 days of release but had shorter stays and reduced risk of subsequent shelter stays, compared with those furloughed from jail. People released from jail tended to have more extensive histories of prior shelter stays and were at higher risk for future use of shelters. Those who experienced homelessness after release from jail had typically been incarcerated for relatively short periods of time, mostly less than 30 days. This sequence of jail and shelter stays seems to indicate a sustained pattern of residential instability.

Mental health and substance use problems are related to greater risk of homelessness among inmates. Eighteen percent of homeless people arrested had a diagnosis of mental illness (McNiel et al., 2005). Limited access to mental health services, especially inpatient hospitalization, may account for some of this association (Greenberg & Rosenheck, 2008). In addition, when crimes are committed by people with mental illness who are also without homes, police may not identify their mental illness as a primary factor (Lamb & Weinberger, 1998).

Co-occurring severe mental disorders and substance use disorders are of particular concern. Of inmates with mental illness who were also without housing, 78% had substance use problems; in addition, increased duration of incarceration is associated with homelessness and co-occurring serious mental illness and substance use disorders (McNiel et al., 2005).

Street and shelter homelessness and severity of psychiatric symptoms predict increases in nonviolent crime; sheltered status and symptom severity also predict increases in violent crime (S. N. Fischer, Shinn, Shrout, & Tsemberis, 2008). Additionally, a recent study of veterans with bipolar disorder showed a clear relationship between mental illness and both lifetime and recent homelessness (Copeland et al., 2009). Compared with other inmates, those with mental illness are more likely to have been homeless in the year prior to arrest (Ditton, 1999). Inmates without housing are also more likely to have mental illness than inmates who were housed before arrest (Michaels, Zoloth, Alcabes, Braslow, & Safyer, 1992).

The majority of studies of homelessness and police contact involve adults without homes (Thrane, Chen, Johnson, & Whitbeck, 2008), although some research focuses on the arrest of unaccompanied adolescents and their involvement with the legal system. Among a sample of adolescents who ran away, 44% were arrested (Thrane et al., 2008). Externalizing disorders, including substance abuse and conduct disorder, are associated with arrest, and runaway youth with multiple externalizing and internalizing disorders have a greater likelihood of arrest (Chen, Thrane, Whitbeck, & Johnson, 2006). Other risk factors for arrest of homeless and runaway youths include association with deviant peers, prior arrest, and sexual abuse; deviant peer association and prior arrest are the stronger factors for boys (Chapple, Johnson, & Whitbeck, 2004).

This important issue of incarceration and mental illness is a significant societal issue. The Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), signed into law by President George Bush in 2004, authorized a \$50 million grant program to be administered by the U.S. Department of Justice and is an acknowledgment of the need for collaborative efforts between criminal justice and mental health systems. The 2008 reauthorization of MIOTCRA expanded training for law enforcement to respond sensitively to people with mental illness. Although MIOTCRA is not designed specifically to address the needs of people without homes, it is reasonable to expect that it will have positive outcomes for those with mental illness. Given the frequency with which such people are arrested, the types of programs created through this law are extremely valuable to the welfare of those who are mentally ill and without housing.

INSTITUTIONALIZATION AND HOMELESSNESS

The link between institutions and homelessness is longstanding. Many argue that deinstitutionalization is directly responsible for the problem of homelessness and for the people who have serious mental illness.

Communities lack sufficient funding to adequately address the needs of their members with serious mental illness. The lack of comprehensive services—especially supportive housing—has an impact on homelessness. Supportive community-based housing programs for people with pervasive mental illness are critical to breaking the cycle of institutionalization and homelessness.

There is a strong link between homelessness and hospitalization. People without homes have higher rates of hospitalizations for physical illnesses, mental illness, and substance abuse than other populations (Kushel et al., 2001; Salit, Kuhn, Hartz, Vu, & Mosso, 1998). Inpatient admissions for mental illness and substance abuse account for the majority of hospitalizations among veterans living without homes. A great deal of the literature on the relationship between mental illness and homelessness focuses on people with long histories of illness and hospitalization; however, those new to psychiatric hospitalization are also at risk. Among adults with psychotic disorders hospitalized for the first time, 15% had experienced at least one episode of homelessness before or within 2 years of their first admission (Herman, Susser, Jandorf, Lavelle, & Bromet, 1998). Interestingly, over two thirds of the participants in that study experienced their homelessness episode prior to the first hospital admission, suggesting that the homelessness was not attributable to poor discharge planning, which is frequently blamed in other circumstances.

The risk of homelessness after being discharged from treatment settings is affected by such issues as self-discharge against medical advice, lack of community living skills, and paranoia that can impede attempts to locate affordable housing. Among the identified systemic issues are a diminished low-income housing market; hospitals' need to discharge patients once they are psychiatrically stable; short hospital stays, which leave less time to find suitable housing; long wait times for public income or entitlements; and lack of financial resources to pay for security deposits and rent (Forchuk et al. 2008). When people do not have stable housing before admission to hospitals, they are at higher risk of discharge to homeless situations (Lauber, Lay, & Rossler, 2006). Other risk factors include showing less clinical improvement during the hospital stay, receiving fewer therapeutic measures while hospitalized, and being discharged early and without follow-up care after discharge.

Adolescents are also at high risk for homelessness after being discharged from psychiatric residential treatment. Associated factors include a history of substance abuse, a history of running away, being in state custody, or having experienced physical abuse (Embry, Vander Stoep, Evens, Ryan, & Pollock, 2000). Belcher (1991) found that 35% of

young adults discharged from state mental hospitals in Ohio became homeless within 6 months.

Methods to combat the problem of homelessness after discharge from institutions include initiating discharge planning upon admission for those without preexisting housing (Lauber et al., 2006); establishing emotional support during the transition out of the hospital to help facilitate stable housing at discharge (Kuno, Rothbard, Averyt, & Culhane, 2000); making concentrated efforts to find housing; and providing income support and advocacy. Other programs include those that provide subacute, step-down, or day treatment support to people in their communities. Home-based services also foster maintenance of people in their communities. Psychologists must advocate for the funding of such programs and provide clinical services to people at risk for homelessness in community and home settings.

RESILIENCE, SOCIAL SUPPORT, AND RESOURCES

Much research and discussion focus on the negative mental health outcomes associated with homelessness; however, many people without housing function quite well (Buckner, 2008; Cowan, 2007; Haber & Toro, 2004; Masten & Sesma, 1999). For example, while homelessness is clearly a complex and stressful experience for children, most do not meet criteria for clinical levels of emotional disturbances or behavioral dysfunction (Cowan, 2007). By understanding protective factors, including social support, that foster resilience among adults, adolescents, and families living without homes, psychologists can develop targeted prevention and intervention models.

Resilience is defined as “manifested competence in the context of significant challenges to adaptation or development” (Masten & Coatsworth, 1998; Masten & Sesma, 1999; Obradovic et al., 2009). Resilience is achieved when adaptation is positive in light of exposure to severe adversity or trauma. One factor consistently linked to resilience in children is the presence of caring and supportive role models such as parents or other adults. Other factors also associated with resilience include solid cognitive skills, self-esteem, realistic self-appraisal, problem-solving skills, and emotional regulation.

Masten and her colleagues have investigated factors associated with resilience in school-aged children without homes (e.g., Masten & Sesma, 1999). Evidence of resilience among this population of children was associated with high achievement scores and positive school behavior. In addition to solid cognitive skills and low absenteeism, resilient children had positive relationships with parents

and caregivers, including teachers and attachment figures who were invested and somewhat involved in their school experiences. Participation in tutoring and mentoring programs is also tied to school success. Students without homes have benefited academically from such programs, and the consistent and close relationship with a concerned adult has been associated with increased interest in school and lower absenteeism. Mentoring programs at various sites around the country have replicated these results (Eiseman, Cove, & Popkin, 2005; Masten & Sesma, 1999; Obradovic et al., 2009; Wake County Public School System, 2009).

Fostering resilience in people without homes is not solely a concern for children. Families and adults benefit from supportive relationships and enhanced competence. Work with families without homes should address all household members. Many families have histories of trauma that affect adults and children alike (Health Care for the Homeless Clinicians' Network, 2003). Mothers who have not had the opportunity to heal from cumulative traumatic exposures often lack emotional resources needed to be positive role models or involved parents. Children living with depressed or traumatized parents are at risk for depression and behavioral dysfunction (Bassuk, as cited in Health Care for the Homeless Clinicians' Network, 2003). Parenting groups and child-parent therapeutic collaborations are models for building resilience and adaptive coping (Fraenkel, 2006; Gerwitz, 2007). These interventions should continue through the transition to housing and be a readily available resource. Mentoring programs for both sheltered adults and those living independently also foster resilience.

For adolescents, protective factors framed within a developmental context may be linked to resilience and include family, peers, and social institutions such as schools. Emerging research has examined resilience in homeless adolescents from this perspective (Milburn, Rosenthal, & Rotheram-Borus, 2005; Milburn et al., 2009; Tevendale et al., 2009). Groups that provide ongoing support to adolescents once they are re-housed may prove critical to their stabilization. Increased community support and focused services for adolescents who are gay, lesbian, bisexual, and transgendered are urgently needed.

Social support for homeless people is conceptualized in a variety of ways. Basic social support theory posits that people require mutual support and assistance to meet their needs (Benda, 2006). Resources are an important factor; fewer resources among the members of a network affect the ability of the network to support or protect an individual from

homelessness (Eyrich, Pollio, & North, 2003). According to Eyrich and colleagues (2003), social support can be formal or informal. Formal support, for example, is provided by professional service providers, while informal support is provided by family, friends, and acquaintances. Social support can be instrumental in nature and include shelter, food, or money. Support can also be emotional and include acceptance, care, interpersonal connectedness, and concern (Benda, 2006; Johnson, Whitbeck, & Hoyt, 2005).

Social support can have negative aspects, such as when it comes from people engaged in risky or unhealthy behaviors like substance use (Nyamathi, Leake, Keenan, & Gelberg, 2000) or from people who are emotionally draining or hurtful (Eyrich et al., 2003). Negative interactions with network members can exacerbate stress and have negative effects on psychological well-being (Cramer & McDonald, 1996).

Despite the perception that people without homes are completely isolated from social networks, many studies indicate the presence of social support and connection for adults, families, and adolescents. Perceived social support has an effect on psychological symptoms and can buffer the impact of high stress on poor people who are housed or without homes (Bates & Toro, 1999; Toro et al., 2008). It appears that most homeless adults have regular contact with family members (Bates & Toro, 1999; Toro et al., 1999).

Adolescence is prime time for development of social support networks as young people move from dependence and affiliation with family to the formation of primary friend and romantic supports. Social support reduces symptoms of depression and adverse health outcomes for youths without homes (Unger et al., 1998); however, affiliation with deviant peers is associated with increased depression (Bao,

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Whitbeck, & Hoyt, 2000) and antisocial behavior (Heinze, Toro, & Urberg, 2004). Research indicates that 80% of unaccompanied adolescents report having relationships that predate their time on the streets and having more friends from home than from the streets. Runaway and other unaccompanied youth who are experiencing homelessness tend to retain social ties to family, including parents and other family members; however, youths who report abuse at home are less likely to report parents as part of their network (Johnson et al., 2005). Contact with family is linked to returning home (Milburn et al., 2009). Gay, lesbian, and bisexual youth are significantly more likely to report having social network members from the streets.

There are some conflicting findings about social support for extremely poor mothers, with some studies showing less social support available to mothers without homes than to those who are housed (Bassuk & Rosenberg, 1988; Wood, Valdez, & Hayashi, 1990), and others finding few or no differences (Clinton-Sherrod et al., 2007; Goodman, 1991). There may be an intense use of support networks when a family is about to enter homelessness, yet some mothers may find that the members of their support networks are unable or unwilling to house them and thus prevent their homelessness (Shinn, Knickman, & Weitzman, 1991; Toohey, Shinn, & Weitzmann, 2004). Some studies have suggested that children may “protect” mothers from negative outcomes such as mental illness and substance abuse (Banyard, 1995; Shinn & Weitzman, 1990), yet further research is needed.

Findings on social support and other resources for children without homes are also mixed. Almost half of the children in a study of psychosocial adaptation for those experiencing a housing crisis reported having no friends in their social network (Torquati & Gamble, 2001). Although the size of social support networks was not related to psychosocial adaptation, children’s satisfaction with the support received was related to less negative affect. Cowan (2007) reported that despite the fact that sheltered homeless children report a network of friends, the presence of that social support was not sufficient to influence mental health morbidity.

THE ROLE OF PSYCHOLOGISTS IN ENDING HOMELESSNESS

THEORETICAL MODELS

Applying theoretical perspectives to understanding homelessness is not a simple process. The majority of theoretical models pertaining to homelessness explain how people become homeless. Others examine how homelessness affects people, how people exit homelessness, or some combination of these (Goodman et al., 1991; Haber & Toro, 2004; Milburn & D'Ercole, 1991; Milburn et al., 2009; Rew, 2003; Toro et al., 1991; Whitbeck & Hoyt, 1999; Wright, 1998).

Models that describe how people become homeless include micro- and macro-level perspectives. Models with micro-level perspectives focus on individual factors such as a family history of mental illness, current substance abuse, or previous physical and/or sexual abuse. Macro-level models focus on societal, structural, or systemic problems with environment-centered factors such as major societal economic changes (e.g., an economic depression or recession that leads to decreased jobs and housing opportunities or the deinstitutionalization of mentally ill people with the associated decreased funding of mental health treatment services and community-based support services).

Macro-level theories about environmental factors associated with homelessness mainly focus on economic and social trends, including the employment market, family structure and systems, distribution of income, limited resources, and failure of governmental policies (Shinn, 1992; Sommer, 2001). Such structural explanations pinpoint the causes of homelessness beyond the individual, calling for intervention to occur on a broad societal scale (Neale, 1997).

The adequacy of some macro-level models was ascertained by examining the change in environment-centered factors over time to account for trends in homelessness numbers. For example, Burt (1992) posited that if mental illness were responsible for increases in homelessness, there would be an increase in rates of mental illness in the general public as well as in homeless populations. The rates of mental illness, however, remained relatively stable over time, despite rises in the numbers of homeless people, most notably in the 1970s and 1980s.

Deinstitutionalization was targeted extensively as a cause of homelessness, but if it directly caused the problem, it would have had an immediate effect. There was, however, a significant lag in homelessness rates until the late 1970s and 1980s, when former patients began to appear in significant numbers in the homeless population. Furthermore, only a minority (perhaps about 30%) of people who are homeless are seriously mentally ill. This suggests that other factors are at play (Hamberg & Hopper 1992).

Most of the emphasis within psychology is on micro-level models, but there are macro-level models that adopt an ecological approach derived from Bronfenbrenner's (1979) work. These models take into account environment-centered factors such as poverty, neighborhood and community characteristics, and service system characteristics (Shinn, 2007; Toro et al., 1991) and are examples of the more balanced causal models emerging to account for both individual and structural factors interacting to create at-risk populations and homelessness (Sommer, 2001).

The most promising theoretical models that demonstrate how psychology can better address homelessness are the trauma model (Goodman et al., 1991), the risk amplification model (Whitbeck & Hoyt, 1999), and the ecological model (Toro et al., 1991).

TRAUMA MODEL

Building on basic research on the harmful effects of trauma, Goodman et al. (1991) and van der Kolk (1987) proposed that homelessness typically involves a series of traumatic events that put people at risk for PTSD, depression, substance abuse, and other negative outcomes. A number of studies support this view, documenting high levels of stressful events and victimization, depression and PTSD, and substance abuse among all subgroups of homeless people (as documented in this report).

ECOLOGICAL MODEL

The ecological model frames homelessness within the context of person-centered factors (e.g., resources of and barriers for homeless people) and environmental factors (e.g., external resources) and specifically posits that homelessness results from a lack of resources (Toro et al., 1991). This model was expanded to include developmental factors such as family bonds and relationships to examine homelessness among children and adolescents (Haber & Toro, 2004) and has served as an explicit or implicit guide for a number of policy analyses on homelessness (Shinn, 1992, 2007; Toro & Warren, 1999).

RISK AMPLIFICATION MODEL

The risk amplification model (RAM) explains how adolescents become homeless by focusing on negative life events and negative developmental trajectories to argue that most homeless adolescents come from disorganized family environments characterized by conflict, neglect, violence, and parental substance abuse (Paradise et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck, Hoyt, & Yoder, 1999). These adolescents leave home, link with other homeless adolescents, and become embedded in deviant social networks that amplify the risk of engaging in high-risk behaviors such as sex work, substance abuse, and criminal activity (Cauce et al., 2000; DeRosa et al., 2001; Rice, Milburn, Rotheram-Borus, Mallett, & Rosenthal, 2005; Tyler, Hoyt, & Whitbeck, 2000). RAM provides a solid explanation for the problems of homeless adolescents and their continued homelessness (Haber & Toro, 2004; Milburn et al., 2009).

NEW MODELS AND FUTURE RESEARCH

Researchers are testing new models, such as the risk amplification and abatement models (RAAM; Milburn

et al., 2009) that complement and build upon RAM to determine how adolescents emerge from homelessness. Assuming that socializing agents influence homeless adolescents across multiple levels of social organization—specifically, family, peers, social services, and formal institutions—RAAM examines how positive and negative experiences across these socializing agents can amplify or abate homelessness. RAAM builds upon RAM by supporting the assertion that negative contact with socializing agents amplifies risk, but it adds another assertion that positive contact abates risk. RAAM further extends the work of RAM by incorporating an ecological perspective, which links person-centered factors (e.g., family relationships) to environmental factors (e.g., social institutions) (Haber & Toro, 2004). RAAM is supported by longitudinal findings. For example, homeless adolescents who had connections to positive socializing agents such as family (e.g., maternal support), peers (e.g., prosocial peers who were in school and got along with their families), and social institutions (e.g., attending school) were more likely to exit homelessness over 2 years (Milburn et al., 2009).

Future research must address the limitations of these theoretical models. Most were developed for specific subpopulations of homeless people—for example, the trauma model was developed for homeless adults, primarily women (Goodman et al., 1991), and the RAM was developed for homeless adolescents (Whitbeck & Hoyt, 1999). Yet some of these models, such as the ecological model, hold promise for understanding homelessness among the full range of homeless subgroups (Haber & Toro, 2004; Toro et al., 1991).

Traditionally, theory development pertaining to homelessness was based on observed associations between homelessness and other factors. This work is generally correlational rather than causal. Since the late 1980s, however, there has been more emphasis on systematic analyses (Sommer, 2001), and longitudinal work has emerged in the research literature (Ahmed & Toro, 2004; Cauce et al., 1994; Fowler et al., 2006; Milburn et al., 2006, 2007, 2009; Pollio, Thompson, Tobias, Reid, & Spitznagel, 2006; Rosenthal, Mallett, Gurrin, Milburn, & Rotheram-Borus, 2007; Roy et al., 2003, 2004; Shinn et al., 1991, 1998; Toro et al., 1999).

There continue to be challenges to assessing the viability of theories because of differences in methodology between various studies, modeling errors, and other weaknesses, but enumeration techniques for determining the prevalence of homelessness have improved over time (Sommer, 2001). Homelessness is not well explained by any one theoretical paradigm, as the circumstances of those who are homeless are so diverse (Peressini, 1995).

CONCEPTUALIZATION OF THE SURVEY

INTRODUCTION

In order to document psychologists' current views and activities related to homelessness, we designed and conducted a Web-based survey through the APA Public Interest Directorate in coordination with APA's Center for Workforce Studies. Requests to participate in the survey were sent to a sample of APA's membership (including 4,000 members and 4,000 student members). Potential participants were contacted via e-mail and were assured that their responses would be confidential. Four hundred eleven individuals responded to the survey (the response rate of 5.1% is similar to that obtained in other recent member surveys conducted by APA).

The survey asked participants to identify activities in which they participate that benefit homeless people, including therapy, research, service administration, and fundraising. In addition, participants were asked how much time they spent on those activities and whether they performed these functions as part of their professional work or in a volunteer capacity.

Identification of the ways in which psychologists work on behalf of homeless people is central to understanding how well the discipline is addressing this important social issue. It is equally important, however, to understand what would help psychologists become more involved in this work. Participants were asked if certain things would increase their willingness to work with this population, including options such as more training, more time, and access to funding. Finally, the general attitudes and compassion of respondents toward people who are homeless were assessed on the basis of six items used in recent national and international surveys (Tompsett, Toro, Guzicki, Manrique, & Zatakia, 2006; Toro et al., 2007).

RESULTS AND DISCUSSION

Here we present preliminary results from the member survey (more complete analyses will be available through various reports produced during 2010). The range of activities relevant to homelessness as reported by the 411 respondents is shown in Table 1. By far the most common activity was the donation of money, food, and other items. This activity has also been reported as common among the general public (Toro & McDonell, 1992). However, respondents also reported engaging in activities typically associated with psychologists: 24% reported doing therapy and/or counseling with homeless people, and 20% reported doing assessments. Only 28.5% of respondents reported doing nothing regarding homeless people in the prior year.

TABLE 1
Activities Performed (in Past Year)
in Relation to Homelessness ($N = 411$)

Activity	<i>N</i>	%
Assessments	82	20.0
Therapy/counseling	100	24.2
Research	49	11.9
Grant writing	13	3.2
Psychologist training	26	6.3
Other staff training	33	8.0
Speaking to community groups	30	7.3
Interviews with media	5	1.2
Member of organization advisory group	35	8.5
Donate money, food, clothes, etc.	232	56.4
Participate in fundraising events	63	15.3
None of the above	117	28.5

TABLE 2
Capacity in Which Work Was Done

Capacity	<i>N</i>	% ^a
As part of my job	58	19.5
As a volunteer	147	49.3
Both as part of my job and as a volunteer	93	31.2

^a Out of 298 valid.

On the whole, the information in Table 1 suggests that psychologists are already significantly involved in a wide range of activities in relation to people who are homeless.

About half of psychologists reporting activity involving homeless people did it as part of their job (19.5%) or as part of their job and volunteer work (31.2%; see Table 2). The remaining half did the reported activities solely as part of volunteer work (49%). It was surprising that so many psychologists reported being involved (at least in part) with homelessness in connection with work activities, given that funding for such involvement is so scarce (see Table 5 on barriers to becoming involved with homeless people).

While Tables 1 and 2 suggest that psychologists are significantly involved with assisting people who are homeless, Table 3 shows that the total amount of time they devote is rather small, with 30% of all 411 respondents reporting only a few hours per year and another 22% reporting only a few hours per month. However, while a majority (52%) shows limited involvement or no involvement (29%), there are a significant number of psychologists who work with those who are homeless for a few hours per week (8%) or 10 or more hours per week (11%).

Examination of analyses in which the information on time spent was cross-tabulated with the types of activities listed in Table 1 revealed that the large numbers engaging in the donation of food or clothing tended to spend little time on this type of activity (78% of those who did this spent a few hours per month or less), whereas the small numbers engaging in several other activities spent much more time doing them (e.g., grant writing, research, and psychologist and other staff training). Regardless of the types of activities that psychologists engage in, most spent at least a few hours per week on the activities. Those who engaged in traditional clinical activities (i.e., assessments and therapy/counseling) tended to spend moderate amounts of time at these activities (e.g., 52% of those doing therapy/counseling did so for a few hours per week or more).

Psychologists work with a broad range of subgroups among the overall homeless population (see Table 4). The largest numbers work with individual adults (36%), those who abuse substances (26%), and those with mental illness (30%). However, significant numbers also work with families, adolescents, and veterans. The large emphasis on serving those who abuse substances and who have mental illness is consistent with the high rates of these disorders among the population of adults who experience homelessness.

Almost half of the participants (49%) reported that simply having “more time” could encourage them to get involved with people who are homeless (see Table 5). Simply being asked to assist those who are homeless would also appear to encourage many more to get involved (37% of respondents), as would more training in homelessness issues (30%) and easier access to those who are homeless (21%). Reimbursement for their time spent (20%) and more funding for research (16%) and services (24%) would also encourage some to become involved. Very few psychologists (only 10%) actively indicated that they wish not to become involved with people who are homeless. In summary, although they are generally willing to become involved, psychologist report many barriers that make it difficult to become involved with people who are homeless.

TABLE 3
Time Spent on Activities

Time spent	N	% ^a
No response (mainly due to no activity)	120	29.2
A few hours per year	124	30.2
A few hours per month	90	21.9
A few hours per week	33	8.0
10 or more hours per week	44	10.7

^a Out of 411 total.

TABLE 4
Subgroups Worked With (N = 411)

Subgroup	N	% ^a
Families and children	58	14.1
Adolescents	60	14.6
Individual adults	138	36.1
Families	80	19.5
Groups of adults	45	10.9
People with:		
Mental illness	123	29.9
Substance abuse/dependence	108	26.3
HIV/AIDS	49	11.9
Chronic health problems	64	15.6
Other disabilities	45	10.9
Veterans	54	13.1

^a Out of 411 total.

TABLE 5
What Would Help You Get Involved?

Item	N	% ^a
More training	124	30.2
Access to the people who are homeless	121	21.4
More time	202	49.1
Money for my time	82	20.0
Funding for research	67	16.3
Funding for services	97	23.6
Being asked to do something	152	37.0
I don't want to be involved	41	10.0

^a Out of 411 total.

TABLE 6
General Attitude and Comparison Items

Item	Strongly Agree	Agree	Disagree	Strongly Disagree
When you think about homeless people, do you feel sad and compassionate?	37.6% (38.3%)	58.7% (51.0%)	3.4% (7.0%)	0.2% (3.5%)
It makes you angry to think that so many people are homeless in a country as rich as ours.	50.1% (46.6%)	36.3% (34.8%)	12.1% (16.1%)	1.5% (2.6%)
You feel less compassion for homeless people than you used to.	1.7% (7.4%)	9.8% (15.1%)	52.4% (48.7%)	36.1% (28.8%)

	Very Willing	Somewhat Willing	Not Willing
Pay \$25 a year or more in taxes to reduce homelessness?	60.0% (32.9%)	29.6% (36.8%)	11.4% (30.3%)
Have housing for the homeless in your neighborhood?	37.3% (39.5%)	50.6% (35.0%)	12.0% (25.5%)
Have a shelter for the homeless located near your home?	33.1% (39.5%)	50.4% (36.9%)	16.5% (23.6%)

Note. Percentages are of valid responses ($N = 405-410$). Comparative results in parentheses are from a representative U.S. sample from 2001, $N = 435$ (see Tompsett et al., 2006).

Like most Americans (see Tompsett et al., 2006) and most citizens in other developed nations (see Toro et al., 2007), the psychologists and students responding to our survey were generally concerned and “compassionate” toward people who are homeless (see Table 6). For example, the vast majority of respondents (96%) agreed or strongly agreed that they are “sad and compassionate” when thinking about individuals without homes. On many items, it seems that psychologists are even more compassionate toward homeless people than is the general U.S. public. For example, 60% would be very willing to pay \$25 more in taxes to reduce homelessness (vs. 33% of the general public), and 88% would be very willing or somewhat willing to have housing for people who are homeless in their neighborhoods (vs. 75% of the U.S. public).

Additional analyses will compare the characteristics of this respondent sample of 411 to general characteristics of the APA membership to assure that the sample was not biased. It is important to note that the psychologists who were more likely to work with people who are homeless may have been more likely to respond to this survey. Analyses will also allow a statistical comparison of the above “compassion” items with the most recent national sample of the general public. Results will be submitted to the APA membership through reports (such as in the *Monitor on Psychology* and/or the *American Psychologist*).

REMEDICATION OF HOMELESSNESS

INTERVENTIONS FOR HOMELESSNESS

Efforts to remediate homelessness address individual factors, prevention measures, and public policy. Psychologists may play an important role in the remediation of homelessness at the individual level through the treatment of substance abuse and other mental health disorders and— at a more structural level—by using housing as an environmental strategy to meet basic needs.

INDIVIDUAL FACTORS

Efforts by psychologists to remediate homelessness at the individual level include involvement in providing housing and a range of supportive services, including addiction treatment, mental health services, medical treatment, and case management. These interventions address the factors that lead an individual or a family to homelessness or those factors that make it difficult to become and remain housed. The provision of housing is a leading intervention in the effort to end homelessness among members of low-income households (Shinn & Gillespie, 1994); however, providing housing without addressing the psychosocial factors that influence homelessness is insufficient to remediate the problem. A variety of housing models for people experiencing homelessness are described in the literature, all of which aim to facilitate stable housing among people with mental illness or substance abuse problems.

Other interventions relevant to psychologists, including the critical time intervention, intensive case management, assertive community treatment, and ecologically based

family therapy are promising tools for providing vital services to people who are homeless. There are, however, a limited number of studies documenting interventions aimed at families and adolescents. While the remediation of homelessness ultimately may depend mostly on improving the ratio between low-income households and increasing the number of affordable housing units (Shinn & Gillespie, 1994), psychologists can play a role in helping people with mental health and substance abuse problems get and keep such housing.

Providing housing without addressing the psychosocial factors that influence homelessness is insufficient to remediate the problem.

SUPPORTED HOUSING AND RESIDENTIAL CONTINUUM MODELS

The question of whether safe and affordable housing is sufficient to remediate homelessness has special significance for people with comorbid substance abuse and other mental and physical disorders. This question forms the basis for the evolution of two philosophically unique housing paradigms:

- *Housing first*, also called supported housing or rapid re-housing (for immediate housing of families from shelters).
- *Treatment first*, also referred to as linear, contingent, continuum-based, or residential continuum approaches.

Rog (2004) described treatment first as a range of housing options coupled with required service participation through which an individual's transition to independence is achieved over time. This is in contrast to housing first, which simply offers voluntary services to those receiving housing first. Such programs couple housing in the community with

supportive services, usually for addiction and/or other mental disorders, but they differ in their requirements to obtain and keep housing benefits. Whether housing is contingent on compliance with such services forms the basis of the difference.

In housing first, there are no contingencies or barriers to receiving housing. In treatment first, housing is either contingent on treatment compliance or completion of a part of the treatment program itself. Housing first is a way to implement a housing-first strategy for people who need intensive services or are nonresponsive to contingency-based housing entry paradigms. Services in housing first are voluntary, but residents have the opportunity to see a case manager regularly depending on their health status and stability. The services that a case manager makes available to them are voluntary. Within a housing-first philosophy, there are models that have intensive case-management services available. One of the new areas of research to look at is housing-first models and their effectiveness in improving health and recovery. Typically, housing-first models measure housing stability and only recently have started to evaluate health status and so forth.

Conversely, criticism of the contingency-based, or treatment-first, housing model is that people who are chronically homeless may find it difficult to engage in treatment without being housed first. They may be unable to meet or commit to the demands related to housing readiness (e.g., sobriety, basic living skills, personal hygiene, and commitment to engage in treatment) and ineligible for these types of housing resources. In contrast, the housing-first approach offers direct access to housing without drug abstinence or treatment participation requirements and voluntary participation in supportive services based on consumer choice. Homelessness or housing needs are considered first and foremost in housing-first programs, and many such programs actively target those unable to succeed in other structured settings.

Safe and affordable housing is associated with residential stability for formerly homeless adults with serious mental illness (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000). In addition, the majority of people with serious mental illness who are engaged in housing with supports available are less likely to experience hospitalization (Rog, 2004) and more likely to have improved quality of life (Sullivan, Burnam, Koegel, & Hollenberg, 2000). Compared with a matched group of individuals participating in the linear residential treatment model, 88% of housing-first

participants retained housing after 5 years, whereas only 47% of the comparison group did so (Tsemberis & Eisenberg, 2000). In another study of the housing-first approach, 84% of program participants with serious mental illness and often co-occurring substance use disorders remained enrolled in the program for at least one year, indicating housing success for people with chronic homelessness with histories of significant housing instability (Pearson, Montgomery, & Locke, 2009). In a 2-year experimental investigation of supported housing among homeless people in San Diego with chronic and severe mental illness, those who received Section 8 housing vouchers were much more likely to achieve independent housing (Hurlburt, Hough, & Wood, 1996).

Housing is also associated with HIV risk reduction. Aidala, Cross, Stall, Harre, and Sumartojo (2005) found in a sample of more than 2,000 people living with HIV/AIDS presenting for services that the odds of recent use of drugs, use of needles, and sex trading were as much as four times higher for the not-housed than for the housed clients. Follow-up data collected up to 9 months later showed that improvements in housing status resulted in significant reductions in needle use, drug use, and unprotected sex among the clients, whereas the odds of sex trading increased significantly for clients whose housing status worsened or who became homeless.

The first randomized experiment designed to compare the effectiveness of housing first and treatment first was conducted by Padgett, Gulcur, and Tsemberis (2006). The New York Housing Study was a longitudinal experiment contrasting a housing-first program (offering immediate permanent housing without requiring treatment compliance or abstinence) and treatment-first (standard care) programs to 225 adults with mental illness who were homeless in New York City. After 48 months, results showed no significant differences between housing-first and treatment-first programs in alcohol and drug use, but treatment-first participants were significantly more likely to use treatment services. This study and previous reports concluded that adults with homelessness “dual diagnoses” can remain stably housed (Tsemberis & Eisenberg, 2000) without increasing their substance use in a housing-first model. Thus, regarding housing-first and treatment-first programs, one is not necessarily better than the other. It may be that the two programs are not comparable, as they are designed to target different outcomes, and that matching the program to the needs of the person may be the best approach.

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In contrast to models that offer housing with no (or limited) strings attached, treatment-first (contingency-managed) housing is designed to engage and sustain homeless people in effective substance abuse programs that provide housing. It is an example of an effective intervention that offers safe housing to homeless people with substance use disorders, but on the condition that the person successfully engage in and respond to treatment services. Contingency-managed housing is more of a behavioral intervention (in which housing is used as a reward) than a housing program (in which program-provided housing is made contingent on abstinence from addictive drugs).

In Birmingham, AL, Milby et al. (1996) first used program-provided housing and work therapy as reinforcement for crack cocaine abstinence while encouraging participation in comprehensive day treatment as an intervention for drug addiction and homelessness. Milby and colleagues, under the sponsorship of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, developed this treatment-first intervention and have studied it over the past 2 decades. Homeless participants are initially exposed to furnished, rent-free housing to experience its reinforcing effect. While attending behavioral day treatment, participants continue to earn access to housing contingent on weekly drug-free toxicology tests. A positive drug test (indicating drug use) results in loss of housing, transportation to a local shelter, transportation to behavioral day treatment, and continued drug testing. Two consecutive drug-free tests earn access back into the program-provided housing.

Some treatment arms that were studied used contingency-managed work therapy in the same manner. This was the first of six programmatic contingency-managed housing and work therapy clinical trials and one cost-effectiveness study by these authors in Birmingham, Houston, and Ukraine (Kertesz et al., 2006, 2009; Milby et al., 2000, 2004, 2007, 2008, 2010; Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005; Schumacher, Mennemeyer, Milby, Wallace, & Nolan, 2002; Schumacher et al., 2003, 2007; Vuchinich et al., 2009).

A meta-analysis of contingency-managed housing/work therapy and behavioral day treatment interventions from the Birmingham Cocaine Treatment Studies (1990–2006) conducted by Schumacher and colleagues (2007) found that contingency management and behavioral day treatment consistently produced higher abstinence rates from drugs than no contingency management. People with cocaine dependence and co-occurring nonpsychotic mental illness had better housing and employment outcomes when

housing was offered as part of the behavioral treatment (Kertesz et al., 2006). Finally, consecutive weeks of abstinence during treatment predicted long-term housing and employment stability in Milby et al.'s (2010) most recent trial. Psychologists can play many roles in this type of treatment-first intervention in terms of assessment, diagnosis, goal setting, relapse prevention, and voucher reinforcement activities.

In sum, more than 350 communities in the United States are committed to ending chronic homelessness. Kertesz and colleagues (2009) reviewed studies of housing-first and more traditional rehabilitative (or treatment-first) recovery interventions, focusing on the outcomes obtained by both approaches for homeless people with addictive disorders. According to reviews of comparative trials and case series reports, housing-first reports document excellent housing retention, despite the limited amount of data pertaining to homeless clients with active and severe addiction. Several linear programs cite reductions in addiction severity but have shortcomings in long-term housing success and retention. They suggest that the current research data are not sufficient to identify an optimal housing and rehabilitation approach for all important homeless subgroups.

It is likely that the answer lies in the use of different modalities to meet the needs of different populations. For example, how will the housing approach cope with people with criminal records who may be restricted from government-subsidized housing, and to what extent could this undermine housing interventions for people with criminal records?

The research regarding housing-first and linear approaches can be strengthened in several ways, and policymakers should be cautious about generalizing the results of available housing-first studies to people with active addiction when

they enter housing programs. The work of the authors cited above not only represents rigorous approaches to measuring the outcomes of effective housing interventions but also highly practical clinical models for working

with people in homeless conditions. Details of their research offer strategies for outreach, screening, assessment, diagnosis, goal management, relapse prevention, HIV risk reduction, and other psychosocial roles for psychologists in this context.

Housing-first and treatment-first programs may actually be conceptualized as two different entities that are not easily compared. One is a housing program and the other is a treatment program. This may be the reason housing first has better housing outcomes and treatment first has better

Housing-first and treatment-first programs may actually be conceptualized as two different entities that are not easily compared.

treatment outcomes. In this schema, housing first represents a housing option for people with long-term homelessness who refuse to go to treatment or who have repeatedly failed in treatment. It may be that housing first and treatment first are not on the same continuum—rather, they are two different options for two different groups of people. Psychologists can contribute to matching people to programs in the most efficient way.

OTHER SUPPORT-BASED INTERVENTIONS

In addition to housing assistance, there are a number of other interventions documented in the research literature designed to address homelessness. These include intensive case management, assertive community treatment, critical time intervention, and ecologically based family therapy. These are effective for different groups of people without homes who have co-occurring addiction and mental and physical disorders, including adolescents, despite the dearth of data on interventions for homeless youth designed specifically to end homelessness.

Homeless youths are at high risk for substance abuse, mental illness, and blood-borne infections, such as hepatitis C (Nyamathi et al., 2005). Robertson and Toro (1999) found that 48% of these youths have alcohol disorders and 39% have other drug disorders. Adolescents experiencing homelessness face unique challenges and may benefit from interventions based on harm reduction (Nyamathi et al., 2005). Innovative youth-centered interventions may include service-based care, street outreach, case management, and motivational interviewing as well as integrated health services, such as hepatitis A/B vaccination, and mental health and substance abuse programs.

One empirically supported approach to the problem of substance abuse among runaway youths without homes is ecologically based family therapy (EBFT; Slesnick & Prestopnik, 2005). Compared with service as usual, EBFT reduced overall substance abuse in this population. It involves individual and family sessions and includes not only the adolescent and parents but also siblings and extended family members. Slesnick and colleagues (2005) proposed that future research may demonstrate that intervention with families whose relationships have not fully deteriorated might prevent future homelessness. A brief motivational intervention also demonstrated success in reducing substance use for adolescents without homes (Baer, Garret, Beadnell, Wells, & Peterson, 2007).

Case management is also successful in supporting the mental health needs of youths who are homeless. Cauce and colleagues (1994) demonstrated that adolescents engaged in case-management services had improved

outcomes. Participants in intensive mental health case management were also more likely to report satisfaction with life and lower levels of aggression (Cauce et al., 1994). Case management is a useful intervention for adults who are homeless as well. For those with mental illness, case management linked to other services is effective in improving psychiatric symptoms and results in greater decreases in substance use (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005).

Assertive community treatment (ACT) provides community-based mental health treatment and support to people with serious mental illness. This team-based approach is used extensively with people without homes and improves housing stability for people with mental illness (Nelson, Aubry, & Lafrance, 2007). It is effective in decreasing psychiatric hospitalizations and increasing outpatient contacts (Hwang et al., 2005). Drug abstinence is difficult to achieve and maintain, especially when people return to their pretreatment environment. Forging ties with formal social support networks in the community, such as religious organizations, may reinforce abstinent behaviors established during treatment among people without homes (Stahler et al., 2005). ACT offers advantages over standard case-management models in reducing homelessness and symptom severity in homeless persons with severe mental illness (Coldwell & Bender, 2007).

Critical time intervention (CTI) is a more recently published empirically supported model for preventing homelessness in high-risk groups. CTI is designed to prevent homelessness for people with severe mental disorders by intensifying the continuity of care during the transition from controlled to community environments through building problem-solving skills, motivational coaching, and advocacy with community agencies.

Herman and colleagues (2000) provided the background and rationale for this model, described the intervention, and illustrated how it was adapted for women's transition from shelters to living in independent housing. Draine and Herman (2007) described CTI as a promising model to provide support for reentry from prison for people with mental illness. K. Jones and colleagues (2003) investigated the cost-effectiveness of the CTI program and found that it is not only an effective method to reduce recurrent homelessness among people with severe mental illness but also represents a cost-effective alternative to the status quo. Kaspro and Rosenheck (2007) suggested that CTI can be successfully implemented in systems that have little past experience with the approach and yields improved housing and mental health outcomes (Herman, Conover, Felix, Nakagawa, & Mills, 2007; Susser et al., 1997). Susser and

colleagues (1997) suggested that strategies that focus on a critical time of transition may contribute to the prevention of recurrent homelessness among people with mental illness.

CLINICAL APPLICATIONS WITH HOMELESS PEOPLE

Clinical work with people living without homes requires the same strong commitment to assessment and case conceptualization used by psychologists in working with any individual or population. All clinical work with marginalized populations requires psychologists to exhibit multicultural competence as well as appropriate empathy and respect for the experiences of all people. Building strong therapeutic alliances with individuals is a critical component of success. Recognition of personal strengths as well as challenges underlies an authentic therapeutic relationship. The reality of living without homes is a critical component of a person's experience. Adjustment must be made by therapists to accommodate the needs of the people with whom they work. Treatment modalities as well as service settings must be responsive to the demands posed by experiences of homelessness. The following sections highlight practical applications of clinical work with people living without homes.

BUILDING TRUSTING RELATIONSHIPS

Many poor individuals do not trust psychologists. Based on prior experience or beliefs shared within marginalized communities of poor people, mistrust for all mental health providers is high. Although traditional clinical skills are essential in treating any individual, treating people with mental illness who also lack housing requires a specialized set of clinical skills as well as specific knowledge. Regardless of a provider's best intentions, skills acquired in the treatment of housed people may not be sufficient (Hoffman & Coffey, 2008). Clinicians must bring knowledge of the needs of homeless populations to their work.

WORKING AS PART OF A TEAM

Many psychologists work as part of a clinical team in a variety of professional settings. Interdisciplinary teamwork and collaboration are particularly salient to interventions directed to those without homes. The need for shelter, food, clean clothes, laundry, showers, social security and other benefits, legal services, and referrals for mental health care require access to a wide range of psychosocial services and providers with diverse formal training, expertise, life experience, and knowledge. No single provider can expect to

address this multiplicity of needs, nor is one need necessarily more dominant than another.

Psychologists do not necessarily need to serve as team leaders and must recognize the particular expertise of all team members. Among the necessary team members are people who operate and staff shelters, outreach workers on the street and in various community sites, housing program advocates, facilitators of drop-in centers, workers in food pantries, health care providers, and income benefit staff. Professional collaborations between mental health professionals and primary care or other medical providers is especially important (Health Care for the Homeless Clinicians' Network, 2000)

ASSISTING WITH WELFARE BENEFITS

Many people without homes are unemployed and dependent on government welfare benefits, sometimes called general assistance, for minimal sustenance and accommodations. To be eligible for the minimal welfare benefit, a person

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must have documentation of a recognized disability that interferes with sustained gainful employment. Such documentation must be completed by a health or mental health professional. The provider must include diagnosis of a physical disorder or mental health disorder listed in the fourth edition (text revision) of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) and an estimate of benefit duration.

A considerable number of physicians and psychologists are hesitant to provide authorization for this welfare benefit for various reasons. Some providers employ a "bootstrap" approach, believing all but the severely impaired should work. Others believe they are being manipulated or enabling a person's substance abuse. Others state that they are a "therapist" and not a social services provider. These providers demonstrate a sociopolitical philosophy that denies people with mental illness the most basic necessities: a minimal cash benefit, shelter, access to regular food, and access to health care.

Although there may be people who manipulate the system and falsify a renewal authorization or allow others to use their documentation to falsify authorization, life for a person without housing is a matter of survival, and at times psychologists will indeed be taken advantage of. A therapist's authorization of welfare benefits may be the access point to engage people in treatment, despite the risk of being manipulated. Psychologists who are not willing to authorize

these minimal benefits for people who are without homes and also experiencing mental illness should question their desire and ability to effectively work with this population.

SELF-CARE

Psychologists who work with populations of people living without homes may adopt different attitudes and values regarding clinical treatment than many of their colleagues. Work with this population may also involve clinical practice with people suffering from extensive trauma. Clinicians may encounter criticism or denigration of that work by colleagues. Clinicians may feel isolated and stressed and may suffer from burnout. It is important to seek appropriate supervision as well as to have a support system of coworkers and others who appreciate and value working with this population (Chafetz, 1992).

HANDS-ON TREATMENT

When working with people without homes, psychologists bring unique and useful skills and competency in evaluation (with or without psychological testing) and diagnosis of a wide range of mental health disorders. Being a consultant from a distance is usually a disservice to all involved. To be of maximum value to frontline workers, direct contact with clients is necessary.

Location is an important consideration when treating clients in this population. Many people with mental health or substance abuse disorders are reluctant to meet in a provider's office, and providing services on a homeless person's "turf" may provide the greatest chance for initial success (Morse et al., 1996). This hands-on approach enables a provider both to consult with frontline caregivers and to establish rapport with the homeless person.

One model for treating homeless clients is similar in many ways to disaster services known as "psychological first aid" (Schultz, Espinel, Galea, Shaw, & Miller, 2006) in which the provider obtains a brief snapshot of the person and provides reassurance and a treatment plan. The psychologist sees up to four people in 2 hours, establishing initial contact. With a structured model in mind, the psychologist is able to obtain a great deal of information in 30 minutes. Some homeless clients will require shorter initial contacts, but for others a longer session is necessary. When a homeless client has acute problems, a flexible psychologist can depart from the brief-contact model and provide necessary clinical services. Psychologists must realize, above all, that their credibility is constantly being judged by the homeless community. Establishing trust and credibility takes time and can be quickly lost.

DETECTING OTHER CONDITIONS

Clinical services that involve more extensive evaluation of clients have important implications for obtaining additional services or benefits that will enhance a person's life, meeting both immediate and long-term needs, such as substance abuse treatment. This requires patience and seeking differential diagnoses, an approach that has often never been taken with the homeless person (Buckner, Bassuk, Zima, 1993).

In addition to severe and persistent mental illness, there are some frequently occurring disorders, disabilities, and issues among the homeless population that can benefit from being recognized and addressed. These include developmental disabilities, reading and other learning disorders, fetal alcohol syndrome/effect, attention-deficit hyperactivity disorder, traumatic brain injury, subtle expression of mental illness, past physical/sexual abuse and other child maltreatment, separation from children and family, loss of employment, and history of criminal acts. There is often considerable shame surrounding these conditions, and individual and group therapy, with or without medication, can be effective treatment.

PREVENTION OF HOMELESSNESS

The existing literature devotes considerable attention to treatment-oriented approaches for dealing with the social problem of homelessness. Psychologists, other researchers, and policymakers have only recently begun to consider ways to prevent homelessness from occurring in the first place (Burt et al., 2007; Haber & Toro, 2004; Lindblom, 1996; Shinn & Baumohl, 1999; Toro et al., 2003, 2007). Although there are virtually no examples, to date, of empirically supported preventive interventions, recent publications have suggested a number of possible directions.

TARGETING THOSE AT RISK FOR HOMELESSNESS

There are many ways to identify people at risk of experiencing homelessness. The poor and people with histories of residential instability, prison/jail time, and foster care placements are some identifiable groups that could be targeted for preventive interventions and policies. Adolescents who are aging out of the foster care system at age 18 are particularly vulnerable to homelessness in the United States as well as in other developed nations. Studies show that 20–50% of adolescents/adults experiencing homelessness have a history of foster care placement (Firdion, 2004; Toro et al., 2007, 2008). Extending comprehensive interventions and/or support services to age 21 or older could assist youths in making the transition from foster care to independent adult life (Toro et al., 2007).

Teenage mothers with children are another at-risk group. R. L. Fischer (1997) targeted pregnant teens and provided pre- and postnatal care, educational assistance, job training, parent training, intervention aimed at preventing subsequent pregnancies, and services to strengthen support from the family of origin. Compared with a control group, girls who received intensive services showed more educational attainment, better health outcomes, fewer subsequent pregnancies, and more employment at an 18-month follow-up. Similarly, O'Sullivan and Jacobsen (1992) found that, compared with a control group, teenage mothers receiving intensive services showed a much reduced rate of repeat pregnancy. Such interventions, in addition to those noted previously, could also help prevent future homelessness.

In addition to identifying particular groups of people at risk for homelessness, identifying at-risk communities or neighborhoods may also be possible. On the basis of their analysis of prior addresses of families admitted to shelters in New York City and Philadelphia, Culhane, Lee, and Wachter (1996) found that people vulnerable to homelessness are heavily concentrated in certain neighborhoods. One recent intervention called HomeBase (<http://www.nyc.gov/html/dhs/html/atrisk/homebase.shtml>) provided case management, cash rental assistance, and other coordinated services to at-risk people in certain areas of high poverty in New York City (with other areas serving as comparison communities) and found that, with an average of \$2,900 in cash assistance provided to each family served, homelessness was prevented (families in comparison communities had a 10% higher usage of shelter services).

SCHOOL-BASED PROGRAMS

Early childhood intervention programs such as Head Start were effective in reducing the harmful developmental outcomes often associated with poverty (Committee on Child Psychiatry, 1999). Such programs, when applied to homeless children, could promote the secondary prevention of homelessness. However, to successfully accomplish secondary prevention for currently homeless children or primary prevention for housed children at risk for homelessness, such programs will need to do more than simply provide day care, educational stimulation, and nutritious meals; they will need to provide additional services targeted to parents (as some of the early Head Start programs did; see Schweinhart & Weikart, 1988). While the day care provider could serve a preventive function by helping the parent(s) maintain employment,

financial viability, and housing, other services such as case management, educational and employment assistance, and parent training could be even more important in preventing future homeless episodes.

School-based programs may also have potential for preventing homelessness among older children and adolescents. For example, Hendrickson and Omer (1995) discussed the "comprehensive service school" that provides adult education and career development, child care, economic and social services (e.g., helping families find housing, jobs, food assistance), family support services (e.g., parenting classes, support groups), transportation, legal services, health services, and mental health counseling.

Given the close connection between homelessness and poverty, it is reasonable to consider that school-based and other programs that reduce poverty and its harmful consequences have the potential to prevent homelessness in the long run.

Given the close connection between homelessness and poverty, it is reasonable to consider that school-based and other programs that reduce poverty and its harmful consequences have the potential to prevent homelessness in the long run.

POLICY

The task force recognizes safe and stable housing as a right to which every person is entitled. Disability of any kind or socioeconomic status does not negate the right to be housed in one's community. Homelessness arises out of a lack of housing. We support policies that seek a rapid return of all people to permanent community housing. Similarly, we recognize that many people, with and without homes, are in need of an array of services, including mental health treatment. Supportive housing and a continuum of mental health and other social services must be offered to all people in need. Whenever possible, such services should be community based. We furthermore recognize the ability to earn financial resources and to provide for oneself and one's family not as a privilege but as a right. Income and other resource disparity rests with a discrimination based on race, gender, age, cultural background, or sexual orientation and other factors. We support policies that enhance opportunities for education, job training, child care, and health care for all people. We recognize the need for psychologists to work across disciplines with others to eradicate social injustices that place certain people at greater risk for loss of housing than others.

RECOMMENDATIONS TO ADVANCE RESEARCH, TRAINING, PRACTICE, AND POLICY

Psychologists, in their roles as clinicians, researchers, and educators, have unique contributions to make to the remediation of homelessness. The task force endorses the following research, training, practice, and advocacy recommendations as vehicles by which the discipline of psychology can contribute to ending homelessness under the leadership of the American Psychological Association.

RESEARCH

To further address the causes, course, prevention and remediation of homelessness, social science researchers are encouraged to:

- Direct research efforts toward prevention of homelessness in marginalized and vulnerable populations.
- Design and disseminate evidenced-based interventions for work with those currently experiencing homelessness.
- Engage in program evaluation with a focus on mechanisms that support rapid return to permanent housing and methods for sustaining housing in vulnerable populations.
- Conduct research on service utilization among chronically and pervasively mentally ill populations at risk for homelessness.

- Investigate methods to promote resilience in at-risk populations, including children and youth.

TRAINING

To enhance the ability of psychologists to work effectively with populations at risk of homelessness or currently living without homes, the following education and training are recommended:

- Incorporate into graduate school curricula theoretical and applied perspectives of working with diverse and underserved populations at risk for homelessness.
- Develop practicum and internship placements that allow trainees opportunities to work with at-risk populations including sheltered families and adults, children in foster care placements, unaccompanied youth, individuals with chronic mental illness, and persons with substance and alcohol dependence.
- Create continuing education programs that encourage psychologists to engage in work with populations experiencing homelessness.
- Enlist psychologists to offer appropriate mental health education programs to service providers, charitable groups, community volunteers, and the public at large. The focus of such training should include better understanding of

psychosocial factors associated with both the entrance into and exit from homelessness. Educational program content should strive to dispel stigma associated with homelessness as well as pervasive mental illness and promote strength-based approaches to working with marginalized populations.

PRACTICE

In accordance with APA guidelines that encourage psychologists to provide clinical and other services to marginalized and underserved people, the task force recommends that psychologists:

- Provide strength-based clinical and assessment services to populations that are homeless or at risk of homelessness, including families involved with child welfare agencies, children in foster care placements, unaccompanied youth, persons experiencing alcohol or illegal substance dependence, and persons of all ages identified with pervasive and/or chronic mental illness.
- Maximize the utilization of clinical and assessment services by providing them in accessible settings and at times that reflect the needs of the populations served.
- Create meaningful collaborations between psychologists, social workers, case managers, nurses, physicians, teachers, and schools to best serve the multifaceted needs of individuals at risk of homelessness or those who currently are without stable housing.

ADVOCACY

To prevent an increase in homelessness, to better address the needs of those currently without housing, and to promote the rapid exit from homelessness where it currently exists, we encourage psychologists to advocate at the state, local, and federal levels as follows:

- Advocate for legislation that would fund supportive housing as well as safe low-income housing in urban, suburban, and rural areas.
- Advocate for legislation that would provide a range of needed services, including mental health services to at-risk families, unaccompanied youth, and children and adults with disabilities.
- Advocate for funding for targeted counseling services, education and job training opportunities for youth in foster care, and for transitional services for those returning to home placement and/or communities.
- Advocate for an increase in substance abuse and alcohol treatment programs, including services that promote the strengthening of families.

- Advocate for health care coverage for those without homes and those at risk of losing stable or permanent housing.
- Advocate for education and job training and after-school and day care programs to support poor families.
- Advocate for debt forgiveness programs for psychologists and others engaged in research on the prevention or amelioration of homelessness.
- Advocate on an individual basis for persons in need of services, including low-income housing, supplemental income, food, and benefits.

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