

## What Research Tells Us About the Intersecting Streams of Homelessness and Foster Care

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This paper reviews mounting evidence linking foster care and homelessness and considers new approaches for intervention. Although there is no causal evidence that family homelessness leads to foster care or vice versa, the association no longer originates solely from samples of homeless people, but also from samples of people with childhood histories of foster care. Many programs work with families, children or youth based on their current living situations and limits imposed by funders. This results in discontinued services when the living situations change. Given the strong and consistent associations between homelessness and foster care, a better approach is to design programs that work with transient families regardless of their living situation. Parenting is key. Whether the parents are living with their children in homeless circumstances or are formerly homeless parents working to reunify with their children, coordinated, comprehensive, trauma-informed and family focused programs are needed to support parenting and family stability.

*Keywords:* homelessness, foster care, families, children, services

When administrators, policymakers, or providers discuss homeless populations, they usually focus on single adults. Homeless families and youth receive far less attention. Even federal agencies have used different definitions of homeless children. In 1992, the Department of Health and Human Services (DHHS) amended the Stewart B. McKinney Homeless Assistance Act and issued a program announcement under Section 340(s) for services specifically targeting homeless children. Their definition included children who lived in homeless shelters, the streets, abandoned buildings, cars, doubled-up situations where more than one family cohabitates in a residence because of financial necessity, and other temporary living situations *including* foster care (Public Law No. 101–645 Public Health Service Act of 1992, Section 340(s)-[Title VI of the Stewart B. McKinney Homeless Assistance Act amended], 1992). Conversely, the definition of homelessness used by the Department of Housing and Urban Development (HUD) has been restricted to “literally” homeless people living in shelters or on the streets (U.S. Department of Housing & Urban Development, 2007). These different definitions strongly influence the estimates on the numbers of homeless families.

This inequity in definitions remained until very recently, when in May 2009 the HEARTH (Homeless Emergency Assistance and Rapid Transition to Housing) Act was signed into law (Helping Families Save their Homes including the HEARTH Act, 2009). The HEARTH Act not only required that HUD modify their definition to more closely reflect the homelessness definitions of other federal agencies (that included unstably housed people and those about to lose their housing), but it also legislated a time

period for implementation and integration of this new definition into existing HUD-funded programs (Helping Families Save their Homes including The HEARTH Act, 2009).

The HEARTH Act's adoption of a single definition of homelessness will help repair the current amalgam of disjointed services. Still, labels and definitions make a difference. For example, a child who lived in a shelter was considered “homeless.” Nevertheless, if the child was removed and temporarily placed into foster care, the child was then labeled as in “foster care.” For many programs, the child will no longer qualify as homeless or be eligible for services funded for homeless children. However, the mounting evidence on the connection between foster care and homelessness throughout the life span compels us to reconsider our target population and our approach to service delivery. This review illustrates the overlap between homeless and foster care populations throughout the life span, describes the seminal role of parents, identifies existing services and policies, and suggests essential elements for a comprehensive service delivery approach that support the children and families that lapse into homelessness or have contact with the foster care system.

### Background Literature

#### *Homelessness and Foster Care: Families With Children*

Using a nationally representative sample, the National Survey of Homeless Assistance Providers and Clients (NSHAPC) noted that although only 20% of the homeless population consisted of families, 57% of homeless men and 76% of homeless women were parents of children under 18 years old (Burt, Aron, Douglas, Valente, Lee, & Iwen, 1999, p. 12.2). These findings demonstrated that the majority of children were living in foster care or other out-of-home placements; and only 15% of minor-aged children were living with their homeless parents (Burt et al., 1999, pp.

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12.1–12.3). Although many believed that it was the parents' substance abuse or mental illness that necessitated their children's entry into foster care, Cowal, Shinn, Weitzman, Stojanovic, and Labay (2002) challenged this explanation. They found that homelessness, rather than parental substance abuse or mental illness, was more strongly associated with child out-of-home placement (Cowal et al., 2002). Additional support for this finding has been presented in more recent studies, which indicated that only between 24–26% of children age 18 years old or younger who were not living with their homeless parents were in the foster care system (Park, Metraux, Brodbar, & Culhane, 2004; Zlotnick, Tam, & Bradley, 2007). Nevertheless, a 24% prevalence rate of childhood foster care among homeless children is more than 34 times the rate of same-aged U.S. children (~0.7%, 489,003 children age 18 or younger were in the U.S. foster care system in the 73,431,515 U.S. population of children of the same age) (Children's Bureau, 2005; Population Division-U.S. Census Bureau, 2008).

It is noteworthy that the above studies relied on sampling frames of homeless families. However, in a sampling frame consisting of a northern California County's foster care system, 48.7% of the randomly selected foster care children had histories of being removed from "homeless" parents (Zlotnick, Kronstadt, & Klee, 1998). Because this study only categorized birth parents as homeless if the words "homeless" or "undomiciled" were documented in either the original child abuse report or court report, it is likely that the prevalence rate of formerly homeless children in foster care is an underestimate. Consequently, the evidence of the relationship between homelessness and foster care is strong and bidirectional.

#### *Homelessness and Foster Care: Teens or Youth*

The relationship between homelessness and foster care also has been found in older children or youth. Surprisingly, published estimates on homeless children and youth from more than 20 years ago to very recently have remained fairly consistent ranging between 1.5 to 1.7 million (Chelimsky, 1982; The National Center on Family Homelessness, 2009; Toro, Dvorsky, & Fowler, 2007). Although most youth return to their parents' homes, the most frequently mentioned alternative placements were foster or group homes (Chelimsky, 1982).

More than 10 years later, another study found that approximately 5.0% of a nationally representative sample of youth 12–17 years old experienced at least 1 day of homelessness; and at least one-fifth of formerly homeless youth had childhood histories of foster care or group home placements. Prevalence rates of foster care or group home histories among runaway, throw-away, and homeless youth ranged from a high of 62% in one shelter-based sample of homeless adolescents (Ensign & Santelli, 1998) to lower rates ranging between 11–33% among shelter and street youth (Greene, Ennett, & Ringwalt, 1999). Parenting and family problems were apparent among run-away, throw-away, and homeless youth, who attributed their homelessness to: being kicked out of the home; family fights; removal from their parents' home by child welfare or police; neglect and physical abuse; and problems resulting from parental substance abuse (Ringwalt, Greene, & Robertson, 1998).

There is a shortage of available foster family homes nationwide, and in particular, foster care families willing to care for older children (Hollinshed, 2001), which may contribute to the finding that one-third of older youth have lived in eight or more different foster care placements (Pecora et al., 2005, p. 26). Considered a last resort, many older children and youth wind up in group homes (Legal Advocates for Permanent Parenting, 2007). Among foster care children, youth 14 years or older are more than twice as likely as their younger counterparts to live in group homes (Wertheimer, 2002). For these reasons, it is unsurprising that youth growing up in group homes have poorer connections to family, and are more likely to transition out of foster care alone (Legal Advocates for Permanent Parenting, 2007).

The trauma of living in these unstable situations becomes evident in studies that have investigated outcomes among youth who were "aging out" or "emancipating from the foster care system." Between 15–22% of youth experienced homelessness within 1 year of aging-out of the foster care system (Kushel, Yen, Gee, & Courtney, 2007; Pecora et al., 2006). Living in a homeless shelter is an extreme situation. Many other emancipating foster care youth, whereas not staying in homeless shelters, were unstably housed, and moving from one place to another. In one Midwestern United States' sample, a staggering 53% of foster youth were characterized as either homeless or unstably housed within 18 months of emancipating from foster care (Kushel et al., 2007). Again, these studies indicate a consistent and strong association between homelessness and foster care for youth.

#### *Homelessness and Foster Care: Adults*

Of all homeless subgroups, single adults have received the most attention. A large number of descriptive studies have demonstrated the high prevalence rates of substance abuse, mental health problems, and childhood histories of sexual and physical abuse in homeless adults. In addition, evidence of a childhood history of foster care in homeless adults has emerged: 10.2% in a Los Angeles sample of a high density area of homeless adults (Koegel, Melamid, & Burnam, 1995); almost 25% in a New York City shelter sample (Susser, Lin, Conover, & Struening, 1991); 19.6% in a shelter sample in Worcester, MA (Bassuk, Buckner, et al., 1997); 38.6% in a Minnesota City sample (Piliavin, Sosin, Westerfelt, & Matsueda, 1993); 32.9% in a county-wide sample in Northern California (Zlotnick, Robertson, & Wright, 1999); 26.0% in a nationally representative sample of U.S. homeless clients (Burt et al., 1999); and most recently, 30% in a sample drawn from New York City's database on homeless shelter residents (Park, Metraux, & Culhane, 2005) (see Figure 1).

Although many studies have examined histories of childhood foster care in homeless adults, few researchers have conducted longitudinal studies on former foster care children to measure adult psychosocial outcomes such as homelessness. One exception is a British study that followed a sample of 16,567 infants from England, Scotland, Wales, and Northern Ireland over 30 years (Viner & Taylor, 2005). They found that, compared to others, fewer males with histories of childhood foster care completed high school, more were permanently expelled or excluded from school, and more had criminal histories. Similar findings were documented among females who were followed in this study. Additionally, Viner and Taylor (2005) reported that among the males followed

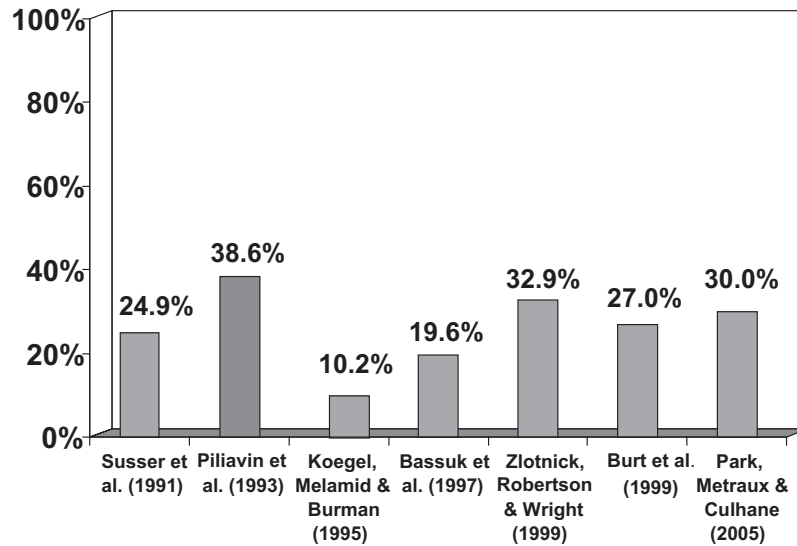


Figure 1. Homeless adults with histories of childhood foster care.

into adulthood, those with histories of childhood foster care also were significantly more likely to exhibit adulthood psychosocial problems such as mental illness, substance abuse problems, and homelessness.

#### Central Role of Parents and Parenting

Although there is no causal evidence that family homelessness leads to child placement into foster care or that a child's or youth's entry into the foster care system leads to homelessness, there is a consistent and strong connection throughout the life span demonstrated by the following: (a) Many formerly homeless children are living in foster care homes; (b) disproportionately large numbers of homeless youth have histories of living in foster care or group homes; and (c) large numbers of homeless adults have histories of childhood foster care.

The cycle linking homelessness and foster care begins with homeless parents, usually single female-heads-of-households, who have suffered from childhood sexual and physical abuse, and adulthood trauma (Bassuk, Dawson, Perloff, & Weinreb, 2001; Bassuk, Buckner, et al., 1997; Zlotnick, Robertson, et al., 1999; Zlotnick et al., 2007). Homelessness becomes more likely as parents struggle to maintain their families while battling mental illness and substance abuse problems (Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk, Weinreb, Dawson, Perloff, & Buckner, 1997; Becker, Jordan, & Larsen, 2006; Buckner & Bassuk, 1997; Garland, Landsverk, Hough, & Ellis-MacLeod, 1996; Grella, Hser, & Huang, 2006; Lindsay, Kurtz, Jarvis, Williams, & Nackerud, 2000; Zima, Wells, & Freeman, 1994; Zlotnick, Kronstadt, & Klee, 1998; Zlotnick, Tam, & Robertson, 2003). This cycle is apparent when parents with these concerns come under the scrutiny of many agencies and providers, and children assessed to be at risk of neglect or abuse, are removed from their parents and placed into the foster care system.

This cluster of problems (e.g., childhood trauma, sexual and physical abuse, and later adulthood mental illness and substance abuse) is consistent with the multiple studies that have demon-

strated that adults with childhood histories of trauma, physical, and sexual abuse are much more likely than others to suffer from both mental illness and substance abuse (Medrano, Zule, Hatch, & Desmond, 1999; Nyamathi, Longshore, Keenan, Lesser, & Leake, 2001; Tam, Zlotnick, & Robertson, 2003; Wilsnack, Vogelanz, Klassen, & Harris, 1997; Zlotnick et al., 2007). In fact, there is evidence of a dose-response relationship in which an accumulation of adverse childhood events such as psychological, physical, or sexual abuse and family dysfunction are related to mental illness and an increasingly high prevalence rate of risky adulthood behaviors such as substance abuse (Felitti et al., 1998).

Although some may blame homeless parents for their inability to care for their children because of substance abuse and mental illness, others reflect on the cycle of trauma and subsequent emotional problems, and recognize a legacy that may be passed onto their children. This link was suggested by a qualitative study that presented narratives in which several homeless mothers reported that the absence of good parenting role models in both their birth and foster care parents resulted in their lack of knowledge on parenting, which in turn resulted in poor parenting skills, and eventually contributed to their children's removal and placement into foster care (Roman & Wolfe, 1995).

Trauma, poverty, mental health, and substance abuse are common themes in the cycle of homelessness. Another common theme is the glaringly evident ethnic or racial disparity found in both homeless and foster care populations. Although only 12% of the U.S. population is Black, more than 40% of the homeless population (Burt et al., 1999) and 32% of foster children are Black (Children's Bureau, 2005). Unfortunately, the racial and ethnic disparities also have been noted in other areas of the child welfare system. White and Latino children are far more likely than Black children are to successfully reunify with birth parents (Children's Bureau, 2005; Westat Inc. and Chapin Hall Center for Children, 2001). This inequity also is apparent in the allocation of resources and services to both youth and families in foster care (Courtney et al., 1996; Garland et al., 2000).

## Existing Services, Interventions, and Policies

### *Current Interventions*

Many organizations target their services to specific populations. Organizations serving homeless families are not likely to provide services to children in foster care. Funding streams support this behavior. However, this unifocal approach is problematic when a child is moved from their birth parents that are living in homeless situations to foster care. With this new status as a “foster child,” the child and birth parents, who may have been receiving one set of services as a homeless family, are now entitled to another set of services. If they are reunified and live as a family, they may be entitled to yet another set of services. Agencies and providers may completely change with each new status, even if the type of service is the same.

Because children entering a homeless shelter or foster care placement have multiple needs for services, they are more likely to come under public scrutiny than children living in other more typical living situations are. Even with a single request for assistance, the family may be referred to more than one agency, and as a result, encounter many “helping professionals” including case managers, public aid workers, child welfare workers, school teachers and officials, health care providers, and social workers. The more agencies involved, the greater are the chances of finding issues of concern including mental health concerns or substance abuse problems. The issue is particularly salient for families with children living in shelters where they are under the constant scrutiny of fellow parents and shelter workers who make requests and give suggestions (Friedman, 2000). With this intense scrutiny, individuals living in poverty are much more likely than middle- and higher-income individuals to gain the interest of public officials, including child protective services.

This attention has both advantages and disadvantages. The advantages are more obvious. Families are offered a wide array of expertise and services that could help the child, the parents, or the entire family. The disadvantages may be less apparent. With multiple providers, there are disagreements on the needs and the type of services needed as well as who should provide the services. Consequently, service dissemination can become confusing, duplicative, disjointed, fragmented, or forgotten. Moreover, because many children living in homeless or foster care situations move frequently, services received in one location may be terminated when they move to another, and there can be delays or problems initiating services at the new location.

Fractured and severed relationships are a common legacy of transiency, both in foster care and homelessness. Thus, in addition to the instability of the home lives of homeless and foster care children and their families, the service provider connections are equally fragmented and unstable. In addition, as the child and/or family moves, there is the need to recite one’s troubling and often traumatic history repeatedly to every new provider at every new location. Equally frustrating is the provider who is unaware of or who makes assumptions about the child and family based on their current living situation.

### *Foster Care Children and Family Services*

Foster care providers, policymakers, and administrators have recognized that foster parents and child welfare workers need to

update their knowledge on existing services as well as to enhance their skills, and as a result, Title IV-E funds are available to support continuing education services for those who have contact with children in the foster care system (Administration for Children Youth & Families, 2000). However, there are no requirements for the workers or providers to attend or use the information presented. Child Welfare workers charged with assessing foster care placements, ensuring the welfare, and protecting the safety of foster care children, have large caseloads, a limited reservoir of resources, and many regulations by which they must abide. As a result, it is not uncommon for children in the foster care system to suffer the additional trauma of living in several placements. Multiple placements translate into multiple moves with different families, schools, and social environments. Needs or resources identified for children in one location with one family may be forgotten, inaccessible, or unavailable in another. As a result, children fall through this fragile safety net.

At least two strong federally funded programs, the Chaffee Foster Care Independence Program (CFCIP) and the Transitional Living Program, provide education, employment, and training on basic living skills with the goal of supporting foster youth to become independent and successful adults (Foster Care Independence Act of 1999-H.R. 3443 (Public Law 106-169), 1999). Unfortunately, funding is limited so opportunities are not always available for eligible youth.

### *Homeless Children and Family Services*

Homeless families have other federally funded programs that provide health and social services. For example, the Runaway, Homeless and Missing Children Protection Act has allocated approximately \$43,000,000 to more than 300 agencies across the nation to provide basic services including food; clothing; medical care; individual, group, and family counseling; recreation programs; and outreach to youth and agencies that work with youth and families (Administration for Children & Families, 2008). There also are health centers in the U.S. providing services to homeless individuals, children, and families, including children who are temporarily in foster care. In 2007, approximately 740,000 people received these services; however, only 13.3% (or less than 100,000) of them were homeless youth and children under 18 years (U.S. Department of Health and Human Services-HRSA/BPHC, 2007).

For the past decade (before the HEARTH Act), funding has emphasized chronic homelessness (Federal Register Vol. 68, No. 17). As the definition of a chronically homeless person was an “unaccompanied homeless individual” who has a disabling condition and who has been continuously homeless for either a year or more OR has had at least four episodes of homelessness in the past 3 years, it is apparent that the emphasis is on adults. Children who lived with homeless birth parents did not qualify since they were not “unaccompanied” individuals. Youth who ran away and lived on the streets also were unlikely to qualify because of the chronicity criteria and their young age. For example, youth aged 16 would only qualify if they had four homeless episodes since age 13 or had evidence of living on the streets, continuously for a full year, without interruption since age 15.

## Discussion

Foster care and homelessness are categorizations of people based on their temporary and transient living situations so when children classified as “homeless” enter foster care, they are reclassified as “foster care children.” With this overlap between homeless and foster care populations, it is not surprising to discover that the needs of homeless and foster care children are similar. However, often because of funding streams and federal eligibility criteria, few programs currently work with transient families or youth no matter what their living situation is. A new approach is needed in which agencies work with transitional families or youth, whether they are living in homeless situations or have had contact with the child welfare system.

The existing literature from foster care and homeless populations provides insights on the optimal services and service characteristics for agencies who would work with transitional families. The first insight is the duration of care. Long-term follow-up is vital for transitional families and youth; especially because often their lives are comprised of a series of fractured and severed relationships. In addition, their life situations and challenges are complex and filled with trauma, which has resulted in foster care placement or homelessness. Many parents are struggling with mental health and substance abuse problems while trying to parent and retain custody of their children. Such situations require substantial support from various services.

Another finding widely reported in the literature on homeless and foster care families, as well as in studies on substance abuse, is the importance and utility of a single provider who is the focal point and coordinator of care (Huber, Sarrazin, Vaughn, & Hall, 2003; Morgenstern et al., 2006; Zlotnick, Kronstadt, & Klee, 1999; Zlotnick & Marks, 2002). This individual, often called a case manager, engages, develops a relationship, and identifies goals, strengths, and challenges of the youth or family. The case manager understands the complex needs of families in these situations, and is an advocate for the family, child, or youth’s needs (Werrbach, 1994). With a central person, the youth or family receives support and help with negotiating large bureaucratic systems such as public housing and health care, and there is less need to repeat one’s history to each new helper or agency that enters the youths’ or families’ lives.

The case manager is particularly effective for transitional families with heads-of-households who are struggling with mental illness or substance abuse, many of whom have suffered from childhood and adulthood trauma, which are frequently evident in parents who are homeless or who have children in foster care. The case manager needs to have the education, skills, and experience to successfully engage parents who are struggling with these problems, and are living in homeless situations or are at risk of having their children removed. The goal is to provide them with the support that they need to stabilize their families and protect their children. This latter role is particularly important since both mental health and substance abuse problems have been identified as leading causes for children reentering foster care once they were reunified with their birth parents (Festinger, 1996). Not only are case managers aiding parents with their roles as advocates and protectors of their children; but they also are a consistent presence in families’ lives and therefore have the ability to recognize when there is a need to intervene for the parents’ or children’s protection.

Traditional types of mental health services may not be appropriate. An increasing body of literature is demonstrating the benefits of trauma-informed mental health services. These approaches adjust to the complex lives of this population and are designed for vulnerable, ethnically or racially diverse, populations including those in foster care and homeless living situations (National Child Traumatic Stress Network, 2008).

Research findings indicate that services need to begin early when a family first arrives at a shelter or the child first enters foster care, particularly since early intervention for young children can reduce the magnitude of trauma and subsequent problems later in life (Dozier, Higley, Albus, & Nutter, 2002; Orfirer & Rian, 2008). The focus of the first meeting is to build a relationship, and understand a family’s strengths, goals and challenges (Festinger, 1996). Services must include physical and psychosocial assessments for the child, youth, and family. However, assessments are not the replacement for treatment, and an assessment made of children who recently experienced trauma or were removed from their parents, may not represent their status once their living situation stabilized.

The need for early intervention also is crucial for youth in long-term foster care or group homes. Recent studies have demonstrated that waiting until the year before they age-out of foster care or group homes to provide one-on-one therapy, support groups, assistance with education and employment readiness, and mentorship, is too late. These services need to begin earlier, to be extended to all eligible children in foster care, and to remain available until former foster care youth have attained stability as young adults (Kushel et al., 2007; Pecora et al., 2006).

The studies on homeless and foster care populations have indicated that, at the very least, a shift in the service delivery approach needs to take place, in which there is the recognition that transient populations overlap. There is a cycle of homelessness that includes both homeless and foster care situations. In both situations, the parents’ health and well-being as well as their central role in their children’s lives must be acknowledged and considered, even if: (a) the parent has mental health concerns and/or substance abuse problems; or (b) the parent has had contact with the child welfare system and temporarily may or may not be living with their children. Long-term problems require long-term interventions and follow-up that:

- Identify parents with mental health concerns and substance abuse problems who are living in homeless situations or whose children are temporarily in the Child Welfare System;
- Help find stable living situations for families;
- Provide long-term mental health and/or substance abuse treatment emphasizing their role as parents, and recognizing the impact that mental health and substance abuse issues have on their parenting abilities and subsequently on their children;
- Assist parents with parenting skills that support the growth and development of their children while living in transient situations;
- Ensure follow-up by a case manager or social service provider who establishes a relationship with the child, youth and family; and
- Extend health insurance and educational, employment, substance abuse, and other assistance to emancipating foster care youth so they have access to services until 25 years old.

In light of the mounting research demonstrating the connection between homelessness and foster care, we may want to revisit our current population labels and categorizations, whether they come in contact with homeless shelters or the child welfare system and foster care. Services must be comprehensive, long-term, trauma-informed, and family focused. They need to include assistance with parenting and life skills, as well as mental health and substance abuse treatment with the goal of promoting safety and family stability.

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