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Families Moving Forward: Homeless Women with Children Transitioning to Independent Living

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FAMILIES MOVING FORWARD: HOMELESS WOMEN WITH CHILDREN TRANSITIONING TO INDEPENDENT LIVING

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ABSTRACT

Family homelessness is one of the most profound and disturbing social problems of the 21st century and is projected to remain an ongoing issue for the United States in upcoming years. The fastest growing segment in the homeless population continues to be families, specifically single women with children. One intervention to the problem of homeless women with children is by providing them with transitional housing, a step beyond the familiar short-term emergency shelter. Transitional housing typically shelters families for up to 2 years. During this extended stay, women participate in programs designed to assist them with addiction, mental health, domestic violence, parenting skills, nutrition, employment, and gaining the independent skills necessary to transition their families to stable living.

The purpose of this grounded theory study was to explore the transition process by which formerly homeless women residing in a transitional shelter acquired stable housing. The aims of this study were to identify factors that impacted the transition, identify support structures, skills, and knowledge necessary during the transition, and to explore how this experience influenced their health.

Data were collected through semi-structured interviews with a sample of 29 women who participated in one shelter program within the past 3 years. Dimensional analysis, an approach to the generation of grounded theory, was used to guide the investigation of the transition process of formerly homeless women from shelter to stable housing.

Findings revealed a substantive explanation of how internal and external factors shape the transition process. A core dimension of *creating a better life* emerged as these

women moved through phases of homelessness toward independent living. Phases included a *turning* point-lifestyle and homelessness before the shelter (context), reality *check*- evaluating their lives and their decision to enter the shelter (conditions), *taking responsibility-working* the shelter program and making changes (processes/actions), and *taking the life* skills-leaving the shelter for independent living (consequences).

This study provides fundamental knowledge and an understanding of the transition process from the perspective of homeless women and identifies factors that influenced their ability to move to stable housing. Implications for future research, education, practice and policy are suggested.

DEDICATION

This study is dedicated to the 29 formerly homeless women who shared their experiences with me. They persevered through their tears, pain, and laughter while sharing their stories to make sure I understood both the hardships and joys experienced in their lives. They truly are an inspiration to me and I wish them much success as they continue to move forward with their lives.

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TABLE OF CONTENTS

LIST OF TABLES

PAGE

LIST OF FIGURES

PAGE

LIST OF APPENDICES

PAGE

CHAPTER 1

Introduction and Statement of the Problem

The increased number of homeless women with children has become a national concern in the United States (Burt, Aron, Lee, & Valente, 2001). Homeless families have been identified as the fastest growing segment of the homeless population since the 1980s (Bassuk & Weinreb, 1994; Burt, Aron, & Lee, 2001; Da Costa Nunez, 2004; U.S. Conference of Mayors, 2005). Current statistics maintain that single women head approximately 85% of families that are homeless; they are mothers to at least 1.35 million children (National Center on Family Homelessness, 2006).

The United States Conference of Mayors (2005), which publishes one of the few ongoing annual studies describing hunger and homelessness, reported that requests for shelter for homeless families increased in 63% of the 24 cities surveyed between November 2004 and November 2005, representing an increase of 8% from the previous year. Unfortunately, an average of 32% of the requests for shelter by homeless families was estimated to have gone unmet during that same year due to a lack of resources. The need for shelter reflects the growing enormity of the problem faced by homeless families.

The phenomenon of family homelessness has become a topic of contentious debate about poverty, welfare reform, and personal responsibility. Most of this debate can be divided on two ends of a continuum. On one end, family homelessness is believed to result exclusively from structural factors such as poverty, cuts in social welfare benefits, and a lack of affordable housing. At the other end, homeless families are largely held responsible for their current situation based on their individual characteristics.

Despite increasing interest in this area, the majority of research on family homelessness has focused on the front end of the experience--the causes or risk factors associated with becoming homeless--or has largely become descriptive in nature, asking, "Who are the homeless families and where are they found?" (Stojanovic, Weitzman, Shinn, Labay, & Williams, 1999). A paucity of research has examined the trajectory from homelessness to shelter to stable housing. Many homeless families enter the shelter system as a first step to addressing their housing problem; however, not all families successfully negotiate the transition from shelter to stable housing.

Purpose and Aims of the Study

The purpose of this qualitative study was to explore the experiences of formerly homeless women with children who participated in a transitional housing program and currently resided in stable housing. Specifically, what was the process by which homeless women with children moved from a transitional shelter into stable housing? The aims of this study were:

1. To discover factors that impacted the transition process;

2. To analyze what knowledge and skills were perceived to be important during this process;
3. To identify important support structures or individuals during the transition; and
4. To reveal how shelter living or stable housing impacted their physical and psychosocial health needs.

Background

The typical homeless family is headed by a single woman who is likely to be a minority group member in her late twenties with two or three children of preschool age (Bassuk, et al., 1997; Lindsey, 1996). While each family has a unique history, many report similar precipitating events leading to homelessness: fleeing an abusive relationship, eviction or inability to pay rent, job loss, and interpersonal conflict with family members or friends with whom they were living before becoming homeless (Bassuk et al., 1997; Weitzman, Knickman, & Shinn, 1994). Individual histories of alcohol/substance abuse and mental health problems have been reported as contributing factors precipitating homelessness.

One intervention to the problem of homeless women with children is the provision of transitional housing, a step beyond the familiar, short-term emergency shelter. Transitional housing typically shelters families for up to two years. During this extended stay, women participate in a program and have the opportunity to attend to their health and the health of their children, including problems with addiction, domestic violence, parenting skills, nutrition, employment, and gaining the independent living skills necessary to transition

themselves and their children into stable homes. Little is known, however, about how these women make the necessary changes in their lives in order to achieve stable housing.

Significance of the Study

The problem of homelessness reaches far beyond young, single women. Homeless women are also mothers with an average of 2.2 children, likely under the age of *5,* who are spending critical developmental years precariously housed (Bassuk, Buckner et al., 1997; Bassuk, Weinreb et al., 1996). Averages indicate that approximately 10% of women entering housing programs lived in a shelter as a child and another 30% grew up in foster care (Da Costa Nunez, 2004). In New York City alone, children make up 44% of the total shelter population, and for them it may be the only home they know. The effects of homelessness and transient living are potentially devastating and long-term for these individuals, families, and society.

The escalation of homelessness for young single women and their children must be confronted. Transitional housing programs offering shelter and the opportunity to develop skills leading to self-sufficiency and independence benefit not only the homeless women they serve, but also the future generation of children. Transitional housing programs seek to address this problem and make a positive impact on the cycle of homelessness faced by this at-risk group.

Method

Grounded theory was chosen for this study because its theoretical underpinnings of symbolic interactionism focus on meanings people give to their

experiences (Glaser & Strauss, 1967; Kools, McCarthy, Durham, & Robrecht, 1996; Strauss & Corbin, 1998). Grounded theory is particularly well suited to understanding complex social phenomena and their contextual variation (Strauss & Corbin, 1998). The goals of this study are consistent with symbolic interactionism; this study aimed to uncover the meanings inherent in the transition process for homeless women and to understand how they achieve housing stability. This theory reflects the perspective of the research participants, whom are understood to be experts in the phenomena as interpreted by the researcher, thereby giving voice to their stories (Mallory, 2001; Schatzman, 1991, Strauss & Corbin, 1998).

Grounded theory was an appropriate fit for this study with homeless women for several reasons. First, grounded theory is designed to reveal the human characteristic of change in response to, or anticipation of, various life circumstances (Strauss & Corbin, 1998). Secondly, because grounded theory is an inductive, analytical approach, it is particularly useful in situations that have not been previously studied, where existing research has left major gaps, and where a new perspective might be desirable to identify areas for nursing intervention (Schreiber & Milliken, 2001). Finally, transitional housing was initiated several decades ago; however, the literature in this area remains primarily descriptive. As the need for transitional housing increases, so does the need to research and develop a substantive theory to assist in the knowledge and formation of programs that may be more responsive to the needs of homeless women.

Philosophical Underpinnings

Symbolic interactionism. The role communication has in the development of self-concept has been studied within the communication and sociology disciplines for decades. Verbal and nonverbal symbols are used in human interactions, and in symbolic interaction theory, the reactions of others shape one' s self-view. Blumer (1969) developed the concept of symbolic interactionism and described communication as the most human and humanizing activity in which people can engage. The three core principles of symbolic interactionism are meaning, language, and thought. These principles lead to conclusions about the formation of self and socialization into a larger community (Blumer, 1969).

Meaning is the construction of social reality. The first principle is that humans act toward people or things on the basis of meanings they assign to those people or things. Meaning arises out of the "process of interaction between people or groups of people" (Blumer, 1969). It is this process of interaction that gives meaning to individuals or objects that otherwise have no inherent meaning. Once people define a situation, it is very real in its consequence (Charon, 1998). Meaning is dynamic and changing as a result of the interaction.

The second principle is that as human beings, we have the ability to name things. By talking with others we attach meaning to words and develop a universal language (Blumer, 1969). Language is the source of meaning. Meaning arises out of the social interaction people have with each other and is not inherent in objects; rather, it is negotiated through the use of language (Charon, 1998).

Symbolic naming is the basis for society--the extent of knowing is dependent on the extent of naming--and is the way we interpret the world.

The third principle relates to an individual's interpretation of symbols as modified by his or her own thought process (Blumer, 1969). Thought is the process of taking the role of another. Role-taking involves imagining the world from the perspective of another. As we imagine the other's perspective, so we act (Charon, 1998).

From a theoretical perspective, symbolic interactionism is particularly applicable to the transition process described by women in this study. The women in this study expressed a strong desire to change their self-perceptions as well as the judgments of others who viewed them as "homeless" or "addicts." For most of these women, taking on new roles and disconnecting from past friends, activities, and other attributes that rendered them "homeless" or "addicts" were crucial to the transition process that connected them to becoming independently housed.

In summary, symbolic interaction with others is not random, but is influenced by one's expectations of how others will act. It is a process that accompanies all human interaction, all symbolic communication, almost all human cooperation, much of how we learn, and much of how we influence others (Charon, 1998). This theoretical perspective guides research through understanding interactions and agreed-upon interpretations. Concepts are defined through symbolic interactionism and are grounded in experience (Blumer, 1969).

Current research continues to focus primarily on the antecedents of family homelessness and, while important and valuable, the studies have done little to describe

how these families manage to cope, utilize support networks, eventually improve their situation, and move forward from homelessness (Barrow & Zimmer, 1998; Winship, 2001). A greater understanding of how some families secure housing is needed for the development of effective interventions that will decrease future occurrences of homelessness. In this study, formerly homeless mothers were interviewed in an effort to address the research gap regarding the process of securing stable housing after residing in a transitional shelter.

CHAPTER 2

Literature Review

Definition of Homelessness

Rossi's studies (1989, 1994) on America's homeless are based on the following definition of the term *homeless persons,* which suggests that homelessness may be considered primarily a housing problem:

> [Homeless persons are]...those completely without shelter, those living in homeless shelters who would otherwise be without places in which to sleep... [those] doubled up with others or in inappropriate housing as at-risk populations. Those living in shelters or on the streets and in other public places are considered the "literal homeless." Persons living in conventional housing but either doubled up, tripled up, or on the verge of losing their housing are considered precariously housed. (p. 343)

The *Stewart B. McKinney Homeless Assistance Act* (Public Law 100-77) enacted in July 1987 defines homelessness thus:

> [the lack of]... a fixed, regular, and adequate nighttime residence, or the absence of-a primary nighttime residence that is (a) a supervised or publicly operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b)an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

This definition is applicable to individuals and homeless families (National Coalition for the Homeless, 2005b).

Patterns of homelessness are usually characterized in the following ways:

1. Temporary homelessness arises when people are displaced from their usual dwelling by natural or manmade calamities.
2. Episodically homeless people are those who frequently go in and out of homelessness and comprise the majority of homeless individuals today. They are primarily persons living in poverty whose month-to-month finances are precarious and whose short-term reversals of fortune result in episodes of homelessness in varying degrees of severity and duration. As long as there is a poverty population whose incomes put them on the economic edge with no social welfare system to protect them against short-term economic difficulties, there will be persons who fall into a state of homelessness. A large portion of this population consists of young, female-headed households in transition from one household to another, using shelters as a resting place until they can establish a home on their own, sometimes while waiting for governmental assistance.
3. Chronic homelessness occurs when people have spent more than a year on the streets without any intervening period of residential stability. These long-term homeless have disabilities of all types that severely affect their earning power, diminish their employment prospects, and reduce their acceptance by families and friends. This group is most affected by shortages in unskilled jobs, loss of

affordable housing, and by declines in the economic stability of their social networks (Rossi, 1989).

Numbers of Homeless

Varying estimates of the number of homeless exist, depending on how homelessness is defined (doubling up with others during hard times counts), when the data are collected (during the day versus night, or in the summer versus winter months), as well as where one looks for homeless individuals (in shelters or on the street; Burt, Aron, Lee, & Valente, 2001). The most recent count from the 2004 National Law Center on Homelessness and Poverty indicated 3.5 million adults (1% of the population) and 1.35 million children are likely to experience homelessness at some time in any given year (National Center on Family Homelessness, 2006). These figures were determined by those utilizing service providers; actual numbers are likely to be significantly higher, as not all homeless have contact with service providers. For the purpose of this study, the question of precisely how many homeless people exist is not of central importance because homelessness is not static; homeless women with children move in and out of a state of homelessness (Rossi, 1989).

Homeless Families

Homeless families have been identified as the fastest-growing segment of the homeless population since the 1980s (Bassuk & Weinreb, 1994; Burt, Aron, Lee, & Valente, 2001; Da Costa Nunez, 2004; U.S. Conf. of Mayors, 2005). Current statistics maintain that single women head approximately 85% of

homeless families, and they are mothers to at least 1.35 million children (National Center on Family Homelessness, 2006).

The United States Conference of Mayors (2005), which publishes one of the few ongoing annual studies describing hunger and homelessness, reported that shelter requests for homeless families increased in 63% of the 24 cities surveyed between November 2004 and November 2005, representing an 8% increase from the previous year. Unfortunately, an average of 32% of the requests for shelter by homeless families was estimated to have gone unmet during that same year due to a lack of resources.

Contributing Factors of Homelessness

There is rarely a single reason why one becomes homeless. A number of factors in combination probably precipitates most episodes of homelessness. According to Phelan and Link (1999), homelessness is conceptualized in the current body of literature through the perspective of two levels of influence:

> Individual-level issues and problems are represented by personal characteristics that contribute to vulnerability and the risk of homelessness [including] many psychosocial issues as adverse early childhood experiences, mental/emotional health, substance abuse, and domestic violence. Socio-demographic include factors such as gender, age, education level, and ethnicity. (p. 1335)

A study by the National Coalition for the Homeless (2005) reported that "structural issues occur at a societal level and contribute to the risk of homelessness... [These issues encompass] conditions of poverty, unemployment, lack of affordable housing, gender-related problems, insufficient income" for unskilled laborers and recipients of public assistance, "inadequate social services

and healthcare, and an increase of female-headed families" (NCH, 2005; Toro & Warren, 1999; U.S. Conference of Mayors, 2005). Homelessness appears to disproportionately affect underserved groups who have limited access to basic resources.

Individual Factors: Socio-demographic Characteristics

The *National Survey of Homeless Assistance Providers and Clients* (U.S. Census, 1999), is a landmark survey (n=2,947) conducted in 1996 to examine characteristics of a nationally representative sample of the homeless population in the United States. Demographics revealed that homeless families were most commonly headed by single African American mothers, aged 25-54, with 2.2 minor children. Specifically, families were represented by single females (84%), 60% of whom had children aged 0-17 years; 41% of those mothers had never been married. The survey revealed the diversity of homeless families: 38% White, 43% African American, 15% Hispanic, 3% Native American, and 1% other races. Although most of the women had less than a high school education (53%), 21% completed high school and 27% had some education beyond that level.

In general, ethnic representation varies among many studies and appears to be influenced by geographical location. Additional studies reflect the diversity of homeless women across the United States, which supports the theory that homeless women represent a heterogeneous group (Burt et al., 2001). Women who are homeless vary in age, ethnicity, marital and parental status, and educational and vocational background. Similarly, the reasons for homelessness are complex; there are clearly many different paths to homelessness.

Individual Factors: Adverse Childhood Experiences

Homeless women appear to have experienced more disruptions and losses in their family networks and support, both in their families of origin and as adults. According to the literature, many homeless women report serious disruptions early in their original family life. For some, this includes an unknown father, death of a parent, mental illness, alcoholism or drug abuse of a parent, or a violent family setting. Families of origin have critical influences on adult homelessness. The prevalence of adverse childhood experiences--including a combination of lack of care, foster care, physical abuse, and/or sexual abuse--has been explored in several diverse studies and was shown to dramatically increase the risk of adult homelessness (Anderson, 1996; Browne, 1993; Buckner, Bassuk, & Zima, 1993; Nyamathi, Stein, & Bayley, 2000). This kind of childhood environment has been seen as contributing to social isolation and lack of family support.

Individual Factors: Violence

Many women's paths to homelessness start with escaping violent home situations. Many studies successfully link domestic violence and homelessness among women with children (Browne, 1993; Browne & Bassuk 1997; Nyamathi, Leake, & Gelberg, 2000). One study found that "50% of homeless women with children were fleeing abuse" (National Coalition for the Homeless, 2005), and 46% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 2005).

When a woman experiences physical violence at the hands of a partner or spouse, she may have limited options and possibly nowhere to go. Although

shelters for battered women are more available than they were in the past, they are always temporary options. Women who experience adulthood physical abuse often must choose between the abusive relationship and homelessness (Browne, 1993; Browne & Bassuk 1997; NCH, 2005). Women that choose not to return to the setting of domestic violence may lack the financial options to establish an independent living situation.

Browne and Bassuk (1997) believe that "lack of affordable housing and long waiting lists for subsidized housing mean that many women are forced to choose between abuse and the streets" (p. 269). Frequently it is an episode of violence that causes a woman to take her children and leave, and thus homelessness becomes a direct result of leaving an abusive situation (Fogel, 1997). Furthermore, violence may also contribute to social isolation among women, and that isolation, particularly among poor women, makes them vulnerable to becoming homeless (Nyamathi, et al., 2001).

Individual Factors: Health, Mental Health, and Substance Abuse Health

Homeless women face a unique set of barriers to accessing healthcare. While they are poor and largely uninsured, simply making healthcare services available to them at low or no cost is no guarantee that they will access services (Lewis, Andersen, & Gelberg, 2003). Barriers frequently encountered include transportation issues, competing needs (e.g., food and shelter), difficulties making appointments or receiving follow-up information due to transience and lack of telephones, cultural and language barriers, and care received from providers not trained to deal with the homeless (Lewis et al., 2003; Gelberg, Browner, Lejano,

& Arangua, 2004). In a qualitative study by Hatton (1997), homeless women described profound isolation from support systems and revealed they managed mental and physical health problems by overcoming them alone.

Comparison studies of mothers supported by Aid to Families with Dependent Children (AFDC) indicated that pregnancy and recent childbirth were independent predictors of their shelter seeking (Shinn, Knickman, & Weitzman, 1991; Wetizman, 1989). Compared to poor housed mothers, pregnant young mothers seeking shelter were less likely to have been primary tenants or to have other independent living arrangements, but are more likely to have given birth before age 18 and to have experienced serious family disruptions that resulted in out-of-home care (Shinn, Knickman, & Weitzman, 1991).

Explanations for increased shelter use by young pregnant women or young mothers with children under one year of age include mounting stress from having to adjust to the needs of infants and young children in already crowded or strained living arrangements (McChesney, 1990; Weitzman, 1989). Other explanations include access to social services such as Women, Infant & Children (WIC) benefits and priority placement in transitional housing for pregnant women and women with very young children. The shelter also offers young mothers an escape from street life or worries about nutrition.

Mental Health

Housing status has also been found to affect mental health status. Bassuk (1995) documented a higher lifetime prevalence of specific mental health issues for homeless mothers when compared to low-income housed mothers and the

general female population. The prevalence of mental health issues varies in the literature, but it can be estimated that 20-50% of the homeless population experience mental health issues (Burt et al., 2001).

Although depression has been cited as a common problem in the homeless, it is unclear whether it serves as a precursor or consequence to this stressful situation (Bassuk et al., 1996, Caton, Basin, & Shrout, 2000; Nyamathi, Flaskerud, & Leake, 1997; Nyamathi et al., 2000). Findings of qualitative studies indicate that homelessness and shelter living are stressors in themselves (Banyard & Graham-Bermann, 1998; Fogel 1997; Thrasher & Mowbray, 1995).

Homeless women who have serious mental illnesses are at much greater risk for continued violent victimization such as rape and physical battery (Goodman, Dutton & Harris, 1995; Nyamathi, Wenzel, Keenan, Leake, & Gelberg, 2001). Homelessness has a severe impact on the health and well-being of the entire family.

Substance Abuse

Generally, the homeless report a high prevalence of substance abuse and/or addiction. Substance abuse often includes a combination of alcohol and illegal drugs, incorporates both current usage and lifetime problems, and generallyaffects 37% to 75% of people (Burt et al., 2001; Caton et al., 2000; Weinreb, Goldberg, & Perloff, 1998).

There is a common belief that most homeless persons abuse drugs or alcohol and end up homeless because of this abuse, but research does not consistently support this belief. Although often cited as the reason for

homelessness, substance abuse is not the sole reason. Research does not make clear whether the tendency toward substance abuse is a form of self-medication, a way of facing the realities of life on the streets, or a cause of becoming homeless (Caton et al., 2000; Weinreb et al., 1998).

Access to housing and supportive services has been shown to increase compliance with medical treatment, reduce arrest and incarceration, and reduce costly visits to local emergency rooms (Health Care for the Homeless Council, 2001).

Structural Factors: Services/Support

Social support is an essential component of services provided to the homeless and can serve as a structural resource, as part of a program, or as an individual resource (McChesney, 1993). Social support is believed to enhance a person's sense of well-being, to moderate the negative effects of stress and to facilitate positive coping. Homeless women have few resources with little to no significant support person or system (Bassuk, Browne, & Buckner, 1996; Nyamathi, Leake, & Gelberg, 2000; Nyamathi, Stein, & Bayley, 2000). The lack of social and familial support may increase the likelihood of vulnerable persons becoming homeless. In fact, many homeless women report social isolation, few if any friends, and difficulty trusting others (Bassuk, et al 1997, Nyamathi, Leake, Keenan et al, 2000).

Additionally, the type of social network is an important aspect. Homeless mothers may be more likely to name their minor children as members of their social network due to strained, fragile relationships with many of the adults in

their lives (Bassuk & Rosenberg, 1988). Other studies that evaluated housed mothers or homeless mothers revealed that homeless women were more likely to name a parent or other family members as sources of social support (Bassuk & Rosenberg, 1988; Letiecq, Anderson, & Koblinsky, 1996). Lastly, they may have fewer members in their social network as a result of wearing out their welcome (Shinn, Knickman, & Weitzman, 1991).

The significance of support networks in the lives of children, especially those who experienced adverse circumstances, indicated that early support systems could have critical effects during adulthood. In a qualitative study of families of origin of homeless women and those who had never been homeless, Anderson and Irnle (2001) found that support networks of children, especially those who encountered adverse experiences, were significant. These early support systems were found to buffer the effects on the negative outcome of adulthood homelessness.

Individual Factors: Education and Employment

Brooks and Buckner (1996) identified that 60% of poor housed women either had a GED or high school diploma, compared with *50%* of parents without homes; homeless heads of households who worked during the five years prior to shelter use were employed in entry-level or service jobs; those then currently employed or who had worked during the last three years were older at the time of their first pregnancy and had fewer children than those who had never worked; and the latter were more than twice as likely to have been in foster care than those currently or recently employed. Working women also were much more likely than

women who had never worked to have grown up in homes where the primary female caretaker worked. These findings suggest that increased education and parental employment were highly predictive of future employment. Barriers to employment included a limited supply of affordable childcare and limited education (Brooks & Buckner, 1996).

In addition to socio-demographic factors that influence individual-level factors related to homelessness, the most commonly cited issues in the literature included adverse childhood experiences, interpersonal violence, mental/emotional disorders, and substance abuse. These significant problems frequently occurred in combination with each other as well as with other structural- level factors that contributed to the state of homelessness.

Structural Factors: Poverty

Research literature seems to be in agreement that persistent poverty contributes significantly to homelessness (Bamouhl, 1996). Poverty has been identified as a primary cause of homelessness in the United States and is affected by numerous factors that impact income levels (National Coalition of the Homeless, 2005; U.S. Conference of Mayors, 2005). While poverty is not all there is to homelessness, there is very little homelessness without it.

The lack of adequate financial resources, adequately paying jobs, or public assistance can easily lead to homelessness. In the last 25 years, women have made up an increasing proportion of the poor. This is referred to as the *feminization of poverty* and includes structural and demographic factors. Structural factors include labor market influence such as gender differences in wages and women

concentrated in low paying jobs with little room for advancement, adequacy of governmental benefits; policies that did not adequately promote economic equality, such as equal pay legislation and affirmative action. Demographic factors included rates of divorce, decline of household formation rates, rising teen birth rates, and young women living alone longer due to later marriage.

The homeless, especially women, have annual incomes well under the federal poverty level and rely on support from a variety of government sources such as Temporary Aid to Needy Families (TANF) and the WIC programs (Bassuk et al., 1996; Weinreb et al., 1998). While some homeless women are employed on a full- or part-time basis, the income generated is still too little to afford housing (NCH, 2005).

Women face many social and economic hardships during their lifetimes that contribute to their risk for homelessness. Economic problems are further aggravated by gender-related workplace biases that contribute to low income levels, the effects of single parenthood, lack of adequate and enforceable child support laws, difficulties in finding safe and affordable housing, and inadequate federal and state government aid (Bassuk, 1993; Brooks & Buckner, 1996; Kneipp, 2000; McChesney, 1993; Toro & Warren, 1999).

Structural Factors: Housing

The current housing crisis for low-income Americans has been identified as another significant and primary cause for homelessness and is increasing due to lack of affordable housing and a limited amount of programs for housing assistance (NCH, 2005). The U.S. Conference of Mayors (2005) reported that

" requests for assisted housing by low-income families and individuals increased" by 63% from the previous year and, on the average, a waiting period of 20 months existed for all applicants for public housing.

These factors ensured an increase in requests for emergency housing. Families requesting emergency shelter increased by 12% in urban areas from 1997 to 1999 (U.S. Census Bureau, 1999). Most recently, the 2006 U.S. Conference of Mayors reported that requests for shelter for homeless families increased in 63% of the 24 cities surveyed between November 2004 and November 2005, representing an 8% increase from the previous year. Unfortunately, an average of 32% of the requests for shelter by homeless families was estimated to have gone unmet during that same year due to a lack of resources (U.S. Conference of Mayors, 2005).

Between 1970 and 1995, the gap between income and affordable housing for low income renters grew substantially. In 1970, low income renters exceeded available units of low income housing by 300,000; and in 1998, low income renters exceeded available low income rental units by 4.4 rnillion-"the largest shortage on record" (Daskal, 1998). Federal retreat from housing production during the last three decades added to the lack of low income housing. Although the number of housing subsidies increased during the 1990s, this increase could not offset the growth in the number of poor renters eligible for such subsidies. Poor renters living in unsubsidized housing spent as much as 75% of their income on housing (Daskal, 1998).

Approximately 500,000 low rent units continue to be lost each year to gentrification, condominium conversion, arson, abandonment, or demolition. This contributes to the increasing eviction rates for low income families. Furthermore, some homeless have reported they have lost their apartments because of fire or other dangerous conditions that caused authorities to condemn their buildings (Styron, Janoff-Bulman, & Davidson, 2000).

Because of the affordable housing shortage, homeless families often resorted to other means before seeking shelter services. Studies showed that doubled-up housing, the practice of moving in temporarily with friends or family after a loss of housing with nowhere else to go, was a common precursor to homelessness (Bassuk et al., 1997; Shinn et al., 1998).

Researchers have found that "contrary to popular opinion, welfare does not provide relief from poverty" nor protect a family from becoming homeless (Shinn et al, 1998, p. 1651). An increasing number of former welfare families experience homelessness. In the past, the program giving the largest cash assistance for these families was the Aid to Families with Dependent Children (AFOC) program. On August 22, 1996, the *Personal Responsibility and Work Opportunity Reconciliation Act* changed the nation's welfare system by repealing the AFOC program and replacing it with the TANF block grant. TANF requires, with some exceptions, recipients to find work as soon as possible, no longer than two years after receiving benefits in exchange for time-limited assistance (NCH, 2005; U.S. Department of Health and Human Services, [U.S. DHHS]).

In 2005, 459,095 families received TANF benefits in California (U.S. DHHS, 2007). Families who receive TANF benefits and Food Stamps combined "still live below the poverty level in every state"; for example, the median TANF benefit for three-member family is "approximately one-third of the poverty level" (NCH 2004). While the TANF and Food Stamps safety net provides vital income for poor families, it is not sufficient to prevent homelessness among all families (McChesney, 1990). Researchers (Wood, Valdez, Hayashi, & Shen, 1991) conducted interviews with single homeless mothers in Los Angeles and found that prior to becoming homeless, 82% of these women had income below the poverty level, including their federal entitlement benefits, and they spent 67% of their income on rent.

Public housing or government subsidized housing is typically the only affordable housing option for families receiving TANF assistance. However, nationwide, fewer than 1 in 4 families receiving TANF assistance live in public housing or receive a housing voucher to help them rent a private unit because of long waiting lists and limited availability (NCH, 2005). Applying for a Section 8 voucher involves getting on a waiting list in most U.S. cities, which is also true for the city of San Diego. Affordable housing assistance in San Diego lags far behind demand. There are an estimated 400,000 San Diego families who could qualify for some kind of housing assistance, and yet, there are only 12,000 available vouchers. San Diego's Rental Assistance Program currently has a waiting list of 37,000 families and individuals. The wait time for a Section 8 voucher is approximately 5-7 years.

Section 8 certificates and vouchers provide rent subsidies for low income households so they can rent privately owned housing units managed by landlords who agree to participate in the program. Section 8 vouchers are administered through the Local Housing Authorities and Urban Development to pay landlords the difference between 30% of the households adjusted income and a fair market renters cap (U.S. Department of Housing and Urban Development, 2000 [HUD]).

According to a report by the National Coalition of the Homeless, "housing costs in the San Diego region have escalated dramatically over the past few years. San Diego's lower income families and individuals are struggling more than ever to find safe and decent affordable housing" (2005). In addition to Section 8 vouchers, public housing is also an avenue for low income families. Public housing consists of apartments owned by the city or county housing agency. The City of San Diego's Housing Commission owns and manages 1,746 rental housing units scattered throughout the City. These small apartment buildings (most have fewer than 25 units) provide affordable housing for only a handful of low income families, seniors, and disabled persons. For profit and not-for-profit agencies also own affordable housing that is available for families meeting the criteria. Other programs in San Diego are available and eligibility for housing programs depends on income, location, and any adjustments in income limits as required by HUD.

Because studies of causes of homelessness are conducted with participants who are already homeless or have been homeless, it is not clear from the literature whether the variety of contributing factors discussed here might, to some extent,

be the result of the homeless experience or be exacerbated by homelessness. Regardless, homelessness clearly is not due to just one factor. It appears that a combination of factors occurring at a critical period can precipitate homelessness.

Structural Factors: Policies

The 1980s saw a shift in the homeless population from single men and women to homeless families, specifically young, single women with small children. As a result, new policies were instituted. Political influences on homelessness are reflected through many policies at all levels of government. At the federal level, the Stewart McKinney Act/P.L. 100-77 (U.S. Dept. of Housing and Urban Development [HUD], 2000) serves as the federal government's response to the issue. Enacted in 1987, this legislation was meant to assist homeless families and individuals through a broad base of six programs that support partnerships and collaborative efforts with individual states, community agencies, and organizations in a cost effective way. One of these six programs is the Supportive Housing Demonstration, which regulates transitional housing and shelter plus programs. Other supportive housing under Title IV of the Stewart McKinney Act include emergency shelter grant programs and Section 8 that provides permanent housing for previously homeless tenants (HUD, 2000).

The Stuart McKinney Act made funds available to develop programs designed to meet the complex needs of this population and other diverse homeless populations (Barrow & Zimmer, 1998). These funds allowed community based non-profit agencies to take an increasing role in creating housing programs designed to provide a stable environment to young mothers and their children

while offering the opportunity to work on self-sufficiency and economic independence. Since the concept of fostering "housing readiness" was new, most of these programs were created from the ground up, with few existing models for guidelines. The researchers report that transitional housing now encompasses a wide variety of models "..including target populations, physical structure, service intensity, admission thresholds, and conditions and duration of tenure" (Barrow & Zimmer, 1998).

Data from the 1996 *National Survey of Homeless Assistance Providers and Clients* estimated that about 21,000 service locations throughout the United States operated 40,000 homeless assistance programs. Food pantries were "the most numerous type of program, numbering 9,000." Emergency shelters were next with "about 5,700 programs, followed closely by 4,400 transitional housing programs," of which approximately 1,900 were permanent housing shelters with a large percentage serving families (Burt et al., 2001). The remaining services were soup kitchens, outreach programs, and voucher distribution centers. The total number represented a dramatic increase from a 1989 HUD survey that revealed a total shelter count of 5,400. As a result, a variety of housing-related interventions have been developed and delivered over the past several decades (Fischer, 2000).

Transitional Housing Programs

Beginning in the 1980s, homeless shelters noticed they were serving increasing numbers of homeless families. As homeless populations shifted from single men and women to families with children, emergency shelters saw the need to address increasingly complex issues. Families stayed longer and required more

services than did the single populations previously served. This demographic shift in the homeless population prompted both government and community responses (Barrow & Zimmer, 1998).

In 1992, the U.S. Department of Housing and Urban Development (HUD) was tasked with coordinating a new plan for the homeless. In its 1994 report, *Priority: Home! The Federal Plan to Break the Cycle of Homelessness,* the Interagency Council on the Homeless recommended "implementing the continuum of care concept to support individuals and families as they moved from homelessness to housing stability" (Barrow & Zimmer, 1998). The priority of the continuum of care concept was to help homeless persons find affordable permanent housing, encourage coordination and cooperation among local housing agencies, and create jobs for low-income adults. This report named transitional housing as "one of the necessary components of a comprehensive response to homelessness."

Often the first stop for homeless families is the emergency shelter. This "crisis" stage housing provides a bed and meals while a family begins to stabilize. Typically, emergency shelters have a stipulated length of stay, usually 30 days to several months. It is assumed during this time that a family will obtain housing and employment (McChesney, 1990). However, emergency shelters often lack support services to assist families in accessing services. For women with children, this deadline is especially hard to meet. They are often forced to return to living with relatives or friends in overcrowded situations or worse, return to abusive relationships to avoid becoming homeless again

Transitional housing was developed as a bridge between crisis or emergency housing and permanent housing. It differed from emergency shelters in offering smaller facilities, more privacy, and more intensive services. Sometimes called second-stage housing, it usually included social support services, required contracts that directed clients to work toward specific goals, and provided housing for longer periods than did the emergency shelters (Barrow & Zimmer, 1998; Fischer, 2000; Fogel & Dunlap, 1998; Women's Institute for Housing and Development, 1990).

Programs were tailored to help residents define goals and achieve independence, but varied in numerous ways, from target populations and admission requirements to physical structure and service intensity. Program approaches were diverse as well, ranging along a continuum from low-demand models (flexible criteria and optional services) to high-demand programs (structured, service-intensive; Fischer, 2000, Winship 2001).

Services were designed to promote housing readiness by equipping residents with the skills necessary to acquire and keep housing. However, Barrow and Zimmer reported that "the specific ingredients of housing readiness were contingent on what was required to obtain permanent housing" for a specific population in a given location as well as "the program's judgment about what experience and skills were needed" to maintain housing once obtained. As a result, there was "some variation in how transitional housing programs defined and approached housing readiness at various points in the process of moving from homelessness to housing" (Barrow & Zimmer, 1998).

Transitional Housing Models

Transitional housing structure can be divided into two areas: physical layout and program design. These areas often overlap, as program policies need to reflect the characteristics of a particular housing site or model. Facilities using a congregate or shared living approach require different policies and management style than programs housing women in individual apartments (Sprague, 1991; The Women's Institute, 1990). For this study, factors that impacted the transition process may have included a combination of the program structure and physical layout of the shelter. The purpose of this study was not to evaluate the program structure or physical layout of the shelter. However, literature searches revealed varied descriptions of the physical layout of transitional shelters and a handful of qualitative studies documenting the program structure as experienced by the women who utilized the shelter.

Physical Layout

Sprague (1991), an architect and developer of supportive housing, explains the connection between the physical structure of transitional housing and program design and policies. As an example, programs offering independent apartments with private kitchen facilities may foster independence while housing designed with communal living spaces and shared kitchen facilities may encourage social development and provide the opportunity for more intensive support. However, Sprague contends that this congregate living design also requires additional policies to insure shared responsibility for maintenance and upkeep of the facility. Sprague offers several designs for building transitional

housing and rationales for each but does not discuss the success or failure of each model in women securing stable housing.

As community based non-profit agencies took an increased role in sheltering homeless families, shelters were smaller in size than the emergency facilities operated by the government and they incorporated many other services designed to assist women reach goals of acquiring stable housing and/or employment.

Program Structure

Approximately 40% of the individuals served by transitional housing programs succeed in obtaining housing and a source of income upon leaving the program. The proportion rises to 57% if only those that complete or graduate from the program are counted (Barrow & Zimmer, 1998). These statistics suggest that the services provided by transitional housing programs are helpful in moving women from homelessness to stable housing. Many programs build services into the program structure and require clients to use these services to gain skills necessary to move forward and also set goals for housing and/or employment. Little research is available on which of these supportive services are most valuable to women during this transition process.

Life skills and goal setting. Although programs vary considerably, typical services include parenting classes, education and job training, employment services, budgeting classes, counseling and goal planning. Most programs require clients to sign a formal contract establishing written goals and insuring some type of progress on these goals. Additionally, many programs mandate attendance at

classes, workshops, or counseling sessions (Fogel, 1997; Barrows & Zimmer, 1998; The Women's Institute, 1990).

Washington's (2002) study of a transitional housing program in Memphis, Tennessee, did not specifically address program structure, but did identify life skills, classes, financial counseling, school enrollment, job training, counseling, case management, and service planning as program requirements for clients. Interviews with ten successful graduates of the program described these services to be of significance as they moved to stable housing. The positive affirmation of these services led Washington to conclude there is a positive correlation between program structure and program success. However, only successful graduates who were stably housed and employed were interviewed and no negative aspects of the program structure were addressed in this article.

Operational structure. Women move into transitional housing from a variety of circumstances. Some come from jail, rehabilitation centers, or sub standard housing; others are fleeing abusive relationships or have left doubled-up situations, and others come from the street. Still others are corning from emergency shelters or welfare hotels. By the time women with children get to the shelter, they may be traumatized and in a state of shock resulting from events they have experienced. Friedman (2000) contends that residing in a shelter should not add to that trauma. She argues that the quality of that shelter experience matters greatly and that a positive shelter experience can help family members recover from the losses and events they have suffered.

The Women's Institute housing manual (1990) declares that a good set of house rules is a necessary ingredient of any successful transitional housing program. These documents should provide a set of guidelines specific to the needs of the physical space and resident population it serves and should be clarified with residents upon admission. It is also suggested that policies be set in place for obvious reasons of safety and living arrangements to ensure communal spaces are shared with minimal conflict and confusion. Program structure and policies must accommodate a wide variety of needs, habits, cultures, and expectations.

Staff support. Rules are necessary for maintaining safety, order, and predictability for women living in a communal setting. Friedman (2000) suggests that rules can be helpful in taking the surprise out of day-to-day interactions, and reduce the ways in which women and staff have to negotiate with each other to work out each person's role in these interactions. A study by Fogel (1997) describes the efforts of staff to "maintain harmony through a variety of organizational structures" (p.122). However, Friedman (2000) interviewed mothers who felt humiliated by demeaning practices and interactions with staff. The researcher reported programs that run with paternalistic views and deficit-oriented approaches seemed to add to the stigmatization, humiliation, and lack of respect these women already had experienced prior to entering the shelter. When staff used power to maintain order, rules were met with direct confrontation and indirect forms of resistance. In her observation of other programs where staff members took the time to ask rather than assume, listen rather than direct, and

respect rather than judge, they encouraged independence by helping women build self-esteem (Friedman, 2000).

Friedman reports that women in her study identified staff as one of their major sources of strength. Caseworkers helped the residents set and meet goals and spent time with them individually. The researcher contends that when mothers are supported in realizing their dreams, programs can be successful in moving women from homelessness to self-sufficiency. It is evident that staff members play an integral role in developing and enforcing policies that respect the resilience, strength, and unique needs of the women they serve.

Criticism of Transitional Housing

Evidence both supports and criticizes the positive effects of long-term transitional housing. Designing longer term programs may seem the answer to improved educational opportunities and job stability, but the negative effects of sheltered living may cancel the benefits if longer term stays create enabling behavior rather than empowerment. Fogel (1997) suggests that the effects of sheltered living--low self-esteem, loss of will, and little interest in self-improvement--increase over time in shelter environments and that may foster a lack of motivation leading to increased shelter stays.

Internal and external forces influence shelter living. Lack of decent employment and affordable housing create obstacles that may often seem insurmountable. As women remain unsuccessful in acquiring stable housing and continue to stay for longer periods of time, depression levels elevate and success is harder to accomplish (Bogard et al, 1999). Other compounding issues include

the public stigma of homelessness and welfare dependency (Barrow & Zimmer, 1998). The language of 'disability' is commonly referred term used by policy makers and society when discussing this population (Bogard et al., 1999).

Other internal forces adding to the public stigma includes issues of mental health that are occasionally a shelter prerequisite. Some program requirements such as parenting and counseling classes may label a homeless mother unfairly and equate homelessness with poor parenting skills or mental health problems (Bogard, 1999; Weinreb & Rossi, 1995).

Upon entering the shelter system with their children, many mothers describe the experience as stressful and report feelings of depression and hopelessness. Meadows-Oliver (2002) conducted a quantitative meta-analysis of 18 studies describing the experience of mothers caring for their children in a shelter. The studies had varied sample sizes (ranging from 3 to 64 mothers), which were heterogeneous with respect to mothers' ages and ethnicities. With respect to shelter life, Meadows-Oliver found that women spoke frequently of (a) loss of privacy because of the communal setting, (b) loss of freedom to engage in a variety of activities because of restrictive shelter rules, and (c) loss of parental authority because shelter staff frequently undermined their parental role. She also found that mothers were concerned about the safety of their children. For this reason, it was not uncommon for homeless mothers to leave their children with relatives or friends when they entered the shelter system.

In some cases, adolescent children are split from the rest of the family due to the regulations of the shelter and the function of the family is disrupted. Many

shelters will not house males over the age of 12 with women and children. So these adolescents end up living with family members if available, or in shelters for runaway youth or homeless men. There are other shelters that will not take women with more than two children. Their accommodations will not allow large families to move in, even on a temporary basis (Bassuk, 1993a).

Veness (1994) describes a trend toward smaller, more service-oriented programs targeting those segments of the population most likely to be mainstreamed. She states that "designer shelters" have become models of middle-class home life and select clients whose attitudes and activities most closely conform to normative values. Critics of transitional housing argue that programs should meet the needs of a more diverse population, because funds diverted from permanent housing should not be focused on these women who would most likely succeed anyway (Veness, 1994, Weinreb & Rossi, 1995).

While some critics question the positive aspects of long-term shelter stays, more adamant criticism challenges the need for any transitional programs. Transitional housing critics suggest using transitional money to build more affordable permanent housing (Barrow & Zimmer, 1998). Several models are available using permanent housing with intensive case management as a shorter road to self-sufficiency. Although this may be one way to independence, this topic is beyond the scope of this research to address.

Program Evaluation and Gaps in the Literature

Barrow and Zimmer (1998) posit that providers have accumulated "considerable experience in developing and operating transitional housing for

homeless families" in the last several years, and that "individual agencies have used this experience to inform their ongoing program development." Program descriptions and technical assistance manuals provided a rich variety of program approaches and practices that varied according to the population served. However, this literature often presented sharply contrasting perspectives on the effectiveness of the program components (Barrow & Zimmer, 1998; Winship, 2001).

Although many program models exist, few statistics have been gathered on how the program structure affects the successful transition to becoming stably housed. Even less has been published on participant satisfaction or the ability of programs to retain their participants until the completion of mutually established re-housing goals. The few completed evaluations of HUD' s Transitional Housing Programs (as reported by the U.S. General Accounting Office [GAO], 1991) encompassed the first published research on services for homeless families, and indicated that single female-headed households accounted for approximately 29% of the families served. With regard to outcome, 40% of individuals served found housing and a source of income by the time they left the program. Unavailable from the GAO was data on the long-term effects of housing on those utilizing transitional housing programs. Shlay (1993) contends that "frequently, evaluation efforts have focused solely on in-program outcomes and the families' status at exit" (p. 460).

The most recent government report regarding transitional housing statistics was an update to the GAO report of 1995. The final report on *Westat's National Evaluation of the Supportive Housing Program* indicated that overall,

56% of participants went on to stable housing after completing the shelter program, and income and employment both increased. The findings from this study were based on existing program records and again, follow up data was unavailable (Barrow & Zimmer, 1998).

Barrow and Zimmer argued that descriptions of specific transitional programs and the findings that 40% to 60% of HUD Transitional Housing Programs residents moved on to permanent housing suggested that "transitional housing could be effective in helping families accomplish an exit from homelessness." The researchers did caution, however, that "individuals and family members with substance abuse and mental health problems were less successful than other groups" (Barrow & Zimmer, 1998).

In perhaps the largest evaluation of its kind, the work by Rog, Holupka, and Mccombs-Thornton (1995) and Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka (1995) on the 5-year demonstration of the Homeless Families Program provided data on 1,670 homeless families served in 9 cities. The researchers reported:

> [there is] considerable housing stability over time using Section 8 (housing) vouchers with 91% using the vouchers after 12 months and 75% using them after 30 months. The research showed little difference in families' increased self-sufficiency but did highlight the complexity of the difficulties facing these families. (p. 519)

Descriptive accounts of transitional housing programs, as individual accounts, may be found in annual reports, program brochures, conference presentations, journal articles, or popular media. Although seemingly abundant, they remain largely outside the published literature. Finally, according to Barrow

& Zimmer (1998), when they did enter the published literature, well-designed studies of their effectiveness were uncommon.

Patterns of Shelter Exits and Transitions Out of Homelessness

Unfortunately, for many homeless families, transitioning "from the shelter system into conventional housing is often temporary and succeeded by further spells of homelessness and dependence on federal entitlement income" (Sosin, Piliavin, & Westerfelt, 1990, p. 159). Studies suggest that among those families that do exit the shelter system, more than half will become homeless a second time.

Piliavin, Wright, Mare, and Westerfelt (1996) gathered longitudinal data on 113 "recently homeless" adults drawn from social agencies in downtown Minneapolis to explore transitions between homeless and domiciled states. The sample consisted of predominantly White males in their early thirties who lived alone. Thirty-four percent of participants reported being married at some point in their lives, but marital status at the time of interview was not reported. The researchers (Piliavin, Wright, et al., 1996) defined an "exit" from homelessness as a departure from the streets to conventional housing, such as an apartment, house, or hotel for at least 30 days. At follow up, approximately 48% of the participants exited to conventional housing arrangements, another 48% to shared living arrangements such as with family or friends. The remaining participants exited to board and care facilities. Results indicated that among those adults *(n* = 83) who exited to conventional housing between the first and second interviews, roughly one-third had subsequently returned to the streets before the second interview.

The median exit duration from homelessness among these male individuals was 56 days (Piliavin et al, 1996).

Dunlap and Fogel (1998) conducted a qualitative longitudinal study of 9 formerly homeless families to examine the first 2 years of their relocation process after exiting a 60-day transitional shelter. At 1-year follow-up, 8 of 9 families were stably housed; however, all families received public assistance to meet their basic needs. The same 9 families were interviewed again a year later to determine the long-term impact of shelter services. All but 1 adult family member was employed full time and 7 families had purchased a car. At this time, 8 of 9 families were housed and 1 family was staying in a motel. However, Dunlap and Fogel found that families could only afford housing in poor urban areas with high rates of crime and drug abuse. Safety was cited as a common concern; 3 families were crime victims and all 9 families reported "seeing murders, shootings, violent crimes and active drug dealing near their apartments" (Dunlap & Fogel, 1998, p. 183).

Several studies point to the important role of subsidized housing in homeless families' abilities to achieve residential stability. For example, Stojanovic et al. (1999) conducted a longitudinal study of the housing patterns of 233 homeless families who exited New York City shelters. The sample included homeless mothers with at least one child and pregnant mothers who received welfare and who entered the shelter for the first time. The mothers were on average 27 years old, predominantly African American and Latina and had a high school diploma or GED.

For their study, Stojanovic et al. (1999) categorized housing outcome in two categories-subsidized and unsubsidized. A "subsidized, own apartment" referred to New York City Authority apartments (i.e., projects), apartments with rent subsidized by Section 8 certificates, and properties in a subsidized landlord program. "Unsubsidized" referred to a residence in which the participant was the primary tenant in his/her own unsubsidized apartment, living doubled-up with family or friends, living on the streets, other public place or in an institution such as jail or drug rehabilitation. About 50% of families *(n* = 114) moved into subsidized housing after first exiting a shelter and 15% returned to the shelter within the next 5 years. In significant contrast, of the 119 families who found unsubsidized housing, 43% returned to the shelter at some point within the next 5 years. Only 11 of these 119 families remained consistently housed in their own apartment at a 5-year follow up. Unsubsidized housing often meant living doubled-up with family or friends (34% of families exited a shelter for this arrangement). Families reported several reasons for leaving doubled up arrangements and returning to the shelter, including problems with the "host" resident, severe building problems or neighborhood safety, and overcrowding (e.g., 43% indicated more than three or more persons per bedroom; Stojanovic et al., 1999).The authors did not find significant differences among mothers who obtained subsidized housing and those who did not with respect to individual-level characteristics (e.g., ethnicity, education, employment history, mental illness, substance use or health problems).

Stretch and Krueger (1992) investigated the housing patterns of 875 families who resided in a 60-day family shelter in St. Louis between 1983 and 1987 (*M* length of stay = 33 days). Approximately half (46%) exited to permanent housing arrangements, including Section 8, public housing, private rentals/purchase, or doubled up with friends. The other families (54%) exited either to temporary living arrangements such as transitional programs and other shelters or left the shelter without specifying a location.

In 1989, the authors interviewed 201 of those families who had subsequently exited the shelter to permanent housing arrangements. On average, families were away from the shelter for 3.5 years. At that time, 64% resided in Section 8 housing, 17% resided in private or purchased units, 2% resided in shelters, and the remaining families resided in other public assistance settings. Stretch and Krueger (1992) examined indicators of residential stability and found that families had moved an average of 2.3 times since exiting the shelter and the average family maintained their residence for 24 months. One in six families reported becoming homeless again. Those families who received Section 8 placement upon leaving the shelter were less likely to report additional episodes of homelessness than those families who did not receive Section 8 placement (6% vs. 33%, respectively). Although the authors tracked homeless families after they exited the shelter, their analysis did not ascertain what characteristics enables these families to secure and maintain their permanent housing arrangements.

Currently, there are only a few consistencies in the findings of research on transitional housing. Research on housing outcomes has been largely descriptive,

so we know a good deal about where families go upon exiting a shelter and their rates of placement in various housing arrangements but less is known about the reasons why some families are more successful at exiting the shelter system and procuring housing than others. Some exceptions include a handful of studies that used multivariate analyses to examine predictors of shelter exits and housing outcome. These limited studies are briefly reviewed.

Zlotnick, Robertson, and Lahiff (1999) conducted a longitudinal study over a 15-month period of 397 homeless adults recruited from emergency shelters, meal programs, and drop in centers in Northern California. The majority of the participants were African American males. Among female participants, only 9% had their children with them.

Zlotnick et al. (1999) defined a residential exit from homelessness as a minimum of 30 consecutive days in the same apartment, house, or room. Most of the participants (about 80%) exited into a residential setting during the 15 month follow up period. However, patterns of residential exits differed significantly by household composition. Women with children obtained a residential exit earlier over the follow up period than single women and single men (2 months versus 3 months and 3 months, respectively). Also, women with children had the highest rate of securing stable housing; 27% obtained stable housing (i.e., remained housed in their first exit location throughout the entire 15 month follow up period) compared to 13% of single women and 15% of single men (Zlotnick et al., 1999). Logistic regression analysis was performed to identify variables associated with obtaining stable housing. Results indicated that a shorter history of homelessness

(less than one year), having some type of entitlement benefit income, and government subsidized housing were the three most important predictors associated with obtaining stable housing.

Rocha, Johnson, McChesney, and Butterfield (1996) analyzed 10 years of data on 1,156 families to ascertain where families resided after they exited the shelter system. The only data available to the authors were families' case records so analysis was limited to demographic characteristics. Seven demographic characteristics in all were included in their analysis: number of children, age of children, age of mother, educational status of the head of household, ethnicity of the head of household, and household income. Logistic regression was used to analyze a multivariate mode regressing permanent versus temporary housing on these demographic characteristics.

The majority of families were headed by African American females with two children. During the 10 year period, about 60% of families obtained permanent housing arrangements in public housing or private rental units. Twenty-one percent exited to another shelter transitional housing program, and about 16% exited to shared housing arrangements with friends or family (Rocha et al., 1996).

Rocha et al. (1996) found that two family characteristics were significant predictors of permanent housing placement--family size and ethnicity of head of household. Larger family sizes and African American families were less likely to find permanent housing placement. That is, for each additional child, the likelihood of finding permanent housing decreased and White families were

almost two times more likely to find permanent housing than their African American counterparts. It should be noted, however, that the authors concluded it was not " methodologically sound to assess race as a predictor of permanent housing" because of the lack of ethnic variation in their sample (p.54).

Shinn et al. (1998) conducted a longitudinal study of 266 first time homeless families to examine predictors of shelter entry and subsequent housing stability. Predictor variables included various demographic factors (age, education) and individual-level characteristics including mental illness, substance abuse, health problems, incarceration, and social ties. At follow up about 5 years later, 79% of former shelter users were living in their own residences, 17% were doubled up, and only 4% were in a shelter. Approximately, 60% were described as stably housed, living in their own residences for at least one year with no moves. These families had maintained their residence for an average of three years. Shinn and colleagues found that the only predictor of housing stability after exiting a shelter was receipt of subsidized housing, which increased the odds of stability roughly 20 times.

In conclusion, researchers have only recently begun investigating patterns of shelter exits and predictors of housing outcome among homeless families. Studies are needed to develop more informed approaches to aid the transition from homelessness to housing. To date, these studies are limited in that most do not consider the role of individual-level related variables. Long-term follow up studies are essential in order to understand what combinations of shelter service programs and housing may help sustain housing stability over time for homeless

women and children. Relatively few studies have explored the transition process of shelter living to stable housing from homeless women's perspectives. The current study addressed this shortfall by interviewing formerly homeless women and identifying factors that impacted their move to stable housing.

CHAPTER 3

Method

The purpose of this study was to provide an in-depth investigation of formerly homeless women who participated in a transitional housing program and to identify their pathways to stable living. Such programs greatly affect the experiences of homeless women as they move from crisis to stabilization. Various factors must be examined in order to fully understand the changes that occur in the family during this transition, such as the structure provided by housing, the needs of mothers, and community support.

This research focused on the following questions: What was the experience of women who have participated in transitional shelters? What factors impacted the transition process? What knowledge and skills were helpful during this process? What support structures or individuals prior to, during, and after becoming stably housed proved important? How did the shelter experience or independent living affect physical or mental health needs?

Qualitative approaches are ideally suited for this type of research. Although this study did not evaluate the program itself, it did evaluate the experiences of those who participated in a transitional housing program. Qualitative methods such as grounded theory allow the researcher to draw from

the individual experiences within the program and use these as a means of evaluation. Denzin and Lincoln (2005) note this type of "thick" description (Lincoln & Guba, 1985) captures and records the voices of lived experience.

Grounded theory finds its roots in the tradition of the Chicago School of Sociology and the social psychology of symbolic interaction (Blumer, 1969). Symbolic interactionism is a social psychological theory of human action that emerged from the work of Herbert Blumer in the late 1960s. According to Blumer, three premises are central to symbolic interactionism, and these premises guide the conceptualization of human behavior in the context of social interactions. Consequently, they guide conceptual approaches to understanding how homeless women experience the transition process of moving to stable housing and the nature of social interaction within the context of moving forward with their lives.

The three central premises of symbolic interactionism stipulate that human beings (1) act toward social objects based on (2) meanings they attribute to them and (3) a complex interpretative (i.e., self-interaction) process. For the purpose of this study, those premises translate into a study of homeless women transitioning out of homelessness (social object of inquiry).

Design

This study used a qualitative approach informed by the grounded theory methods of Strauss and Corbin (1998) to develop a substantive explanation describing the transition process encountered by homeless women as they moved from a transitional shelter to stable housing. Traditional methods of data

collection through semi-structured interviews, field notes, and memos were utilized. Dimensional analysis as described by Schatzman (1991) was used to guide data analysis.

In keeping with grounded theory methodology, the researcher chose to conduct individual interviews because this is a way to obtain information from participants about potentially sensitive topics. Participants may be more willing to provide information about their perceptions, perspectives, and views regarding their transition experiences if interviewed one-on-one. Individual interviews may also yield responses that are more rational and may give the researcher the ability to assess participants' emotional dimensions (Denzin & Lincoln, 2005). As is customary with grounded theory, interviews were carried out until data saturation was achieved (Strauss & Corbin, 1998). Dimensional analysis was utilized as a way to organize and analyze the data collected during this study.

Grounded theory was an appropriate fit for this study with homeless women for several reasons. First, grounded theory is designed to reveal the human characteristic of change in response to, or anticipation of, various life circumstances (Strauss & Corbin, 1998). Secondly, because grounded theory is an inductive, analytical approach, it is particularly useful for research in situations that have not been previously studied, where existing research has left major gaps, and where a new perspective might be desirable to identify areas for nursing intervention (Schreiber & Milliken, 2001). Finally, transitional housing was initiated several decades ago; however, the literature in this area remains primarily descriptive. As the need for transitional housing increases, so does the

need to research and develop a substantive theory to assist in the knowledge and formation of programs that may be more responsive to the needs of homeless women.

Dimensional Analysis

Schatzman's method of dimensional analysis (1991) was selected for analysis of data collected from formerly homeless women. Dimensional analysis is rooted in the core ideas and principles of grounded theory, and has its own "procedures, epistemological assumptions, and logic" (p. 303). This method of analysis was selected because it emphasizes the meaning of interactions within a given context and provides a useful model that frames the investigative processes of grounded theory research. As in grounded theory, dimensional analysis finds its intellectual roots in symbolic interactionism.

The dimensional analysis explanatory matrix is a framework for the analytic processes of grounded theory research that is used to answer the question, "What all is involved here?" (Schatzman, 1991, p. 305). The explanatory matrix offers a procedural and a structural framework for analysis by organizing the perspective, context (e.g., the situation or environment), conditions (e.g., main dimensions influencing interactions), processes (e.g., intentional or unintentional responses prompted by specific conditions), and consequences (e.g., the outcomes of actions or processes) of a complex problem (Caron & Bowers, 2000; Kools et al., 1996; Schatzman, 1991; see Figure 1).

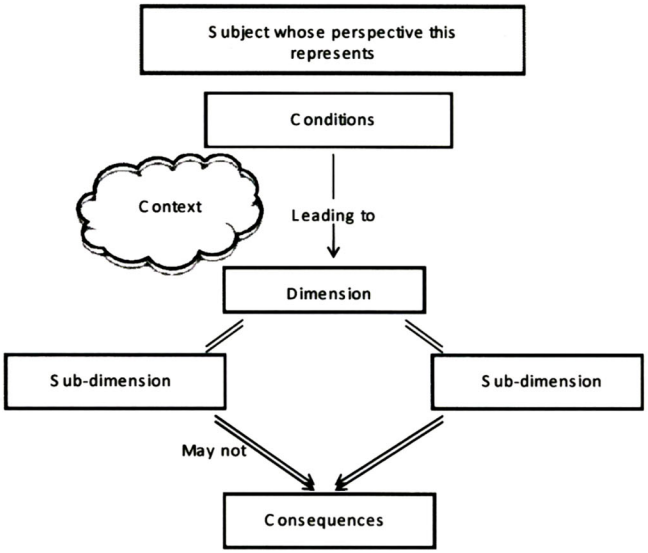

Figure 1. Dimensional Analysis Matrix
Adapted from Caron & Bowers, 2000; Schatzman, 1991

Dimensional analysis is based on a theory of natural analysis in which researchers draw on past experiences and knowledge as cumulative and integral parts of their thinking (Caron & Bowers, 2000; Kools et al., 1996; Robrecht, 1995). Just as human behavior is symbolically interactive within this philosophical paradigm, so too the researcher interacts symbolically with the data. Natural analysis and dimensionality are important tenets of dimensional analysis.

Dimensional analysis consists of three phases: designation, differentiation, and integration (Kools, et al., 1996; Schatzman, 1991). During the designation phase, dimensions are generated from the initial data. The purpose of dimensionalizing is to identify and label dimensions and properties noted during

data collection and to expand data by asking the question, "What all is involved here?" A collection of dimensions is assembled and assessed during this phase. In the differentiation phase, data is limited and analysis becomes more direct and focused. An explanatory matrix is used to reconstruct and explain participant viewpoints of the phenomenon. A central dimension is selected and other dimensions are arranged on the explanatory matrix. The central dimension provides purposeful orientation for subsequent inquiry and guides the remaining data analysis. During the integration phase, limited data are collected through theoretical sampling and analyzed as a means of verifying the validity of the emerging theory. When sufficient data saturation and depth of conceptual linkage have been reached and described, theory generation is complete. The final explanatory matrix tells the theoretical story of the phenomenon under investigation (Caron & Bowers, 2000; Kools, et al., 1996; Schaztman, 1991).

Setting

A private, non-profit, non-denominational transitional housing program in San Diego County, California was selected for this study. This shelter offers numerous support services for women and children, including access to healthcare, transportation, and childcare. Individual and group counseling for women focuses on mental health issues, domestic violence, substance abuse problems, parenting, personal development, and general homelessness issues. Staff members coordinate education, employment training, and job readiness programs for residents.

This transitional program offers five years of comprehensive services to its clients. The first part includes two years of intensive case management, certified substance abuse treatment, individual and group therapy, and 15 classes ranging in topic from life skills to employment skills. The women reside in separate group homes, prepare their own food, take care of their children, and attend work, school, or drug recovery programs during the day. During the three-year aftercare program, clients and their children may extend their stay to five years if needed, provided they are eligible to move into one of the single-family apartments available. Additionally, clients can receive counseling, rental assistance, and help with independent living once they have left the shelter.

Within a typical year, this program serves over *55* families with 76 children. The average age of single (or pregnant) mothers is 29 and the average age of children in the program is just under 3 years. More than 80% report a history of domestic violence. This program has vast experience in providing housing services and programs to homeless and/or battered women and their children; it collaborates with 25 non-profit health and governmental agencies to help these families move toward self-sufficiency.

More than 80% of women who did not have a GED upon entry to this program earned one within a year, and 83% who had previously received a GED enrolled in a community college or vocational program. More than 60% of clients found employment within the first year. Some jobs attained included car salesperson, advertising solicitor, medical assistant, nutrition assistant, and computer technician.

In summary, this transitional shelter provides a stable residence and assists with other basic needs in order that women may focus on their recovery from homelessness and develop skills needed for self-sufficiency. The director of this program indicated her support for this research in writing. The letter, forwarded to the University of San Diego Institutional Review Board, is attached as Appendix H.

Participants and Inclusion

The researcher recruited 29 women from a convenience sample for this study, all of whom were past shelter residents, were in stable housing, and had successfully completed the program provided by this specific shelter. Twenty-three of the women were living independently at the time of their interviews and six had completed the program but remained in transitional housing connected with the shelter. The women were required to converse in English and be willing to meet with the researcher for 60-90 minutes, sign a consent form, and allow the interview to be audio recorded. Women who had been living independently for three or more years after their shelter stay were not included. None of the participants meeting the inclusion criteria were excluded; in fact, while data saturation was achieved at approximately 20 interviews, the remaining nine women were interviewed and included for several reasons. Collectively, they had been independently housed longer than the first 20 participants. Additionally, the researcher had established contact and made a commitment to interview them, so this was honored. Finally, the researcher felt that their experiences might provide

new data because they had more experience living independently. Their stories enhanced and provided added strength to the findings.

Recruitment

Contact with shelter staff was necessary to explain the proposed research and receive assistance in locating past shelter residents. Recruitment occurred via flyers (see Appendix E) distributed in the shelter, through staff referral, and direct contact between the researcher and clients during regular aftercare meetings intended to establish rapport with past shelter residents. Additional participants joined because of a snowball effect from those already a part of the study.

This researcher has had several years of research experience with homeless women as a research assistant working on an NIH-funded study. Additional experience as a nurse practitioner with a focus on women's health has provided this researcher a level of entree and insight with homeless women.

Data Collection Procedure

This study explored the experiences of previously homeless women through interviews and discussion. The 29 interviews were conducted between January 8, 2007 and March 30, 2007. All interviews were face-to-face and audio recorded. Data was transcribed immediately after the interviews. The researcher transcribed the first three interviews and remaining data were transcribed by a professional transcriptionist who signed a pledge of confidentiality (see Appendix D).

Consent Procedures and Demographic Form

Following positive identification as a current or past shelter resident, interested potential participants were privately approached. After the purpose of the research was described and the eligibility of the participant ascertained, women were invited to participate in the study. Participants completed a consent form (see Appendix C) upon agreement to participate, and each received a copy of this form for their reference. Demographic information (see Appendix A) was obtained after consent.

To maintain confidentiality, participants' names did not appear on any forms, notes, or audio recordings; instead, all data referenced various code numbers, and some participants either chose their own pseudonyms or were provided with one. After each interview, all completed forms were stored in a locked file cabinet accessible only to the researcher. All study information will be kept for five years before being destroyed.

Interview Process and Questions

To promote confidentiality, individual interviews were conducted in a private area of the shelter or at a place and time chosen by the participant. Locations varied for each woman; some elected to meet at the shelter, while others invited the researcher to their homes or places of employment. Several of the interviews took place in local coffee shops or in participants' vehicles. Each woman was interviewed once; any necessary additional data was obtained from later informal phone conversations.

Semi-structured, in-depth interviews guided by open-ended questions were conducted with each woman using an interview guide, included in Appendix B. Questions were designed to elicit the information described in the aims of this study. For example, one initial question was, "Tell me about your life or things that led up to your shelter stay." The researcher explored each question in detail, asking for examples or more information as needed, and gave the women full opportunity to share their stories while maintaining lines of inquiry.

In order to ensure that participants responded to similar questions and to maximize the accuracy of data collection, questions were taken from an interview guide and participants received the questions in written form for their own reference. Questions were typed on 8½ x 11-inch laminated paper so participants could refer to them as needed.

Interviews lasted 60-90 minutes, depending on several factors. Each woman had a personal story of life before the shelter that was important for her to share; some had multiple histories of homelessness. A few women did not have childcare available during the interview and needed to be available for their children's needs. Occasionally, a woman would be tearful and wish to have a moment to re-group before continuing with the interview. With all women, contingencies were made for the interview to be stopped and resumed at a later date if needed; however, this was not necessary with any of the participants.

Ethical Considerations

Protection of Human Subjects

Approval for this study was obtained from the University of San Diego Institutional Review Board on December 27, 2006 (see Appendix F for letter of approval). Because the participants are former residents of a transitional shelter and some were still affiliated with the shelter, approval and support was obtained from that agency (see Appendix H). The researcher met all ethical standards and assured all participants of confidentiality during individual interviews according to the Human Participant Protection Education for Research Guidelines and guidelines established by the University of San Diego (see Appendix I). The researcher ensured that all ethical considerations for this study were addressed and explained to participants that if instances of domestic violence or abuse were disclosed during the interview, the researcher would need to take appropriate action. This was verbally discussed and included in the written consent form (see Appendix C). No such actions were necessary.

Participants were informed that conversations were held in strictest confidence and would not be communicated to the shelter staff. Further, they were assured that their consent to participate (or not) during the interview process had no impact on their current or future shelter needs. Women were reminded that their participation was voluntary, and that if they became uncomfortable with the process at any time or did not want to answer questions, the interview would be stopped at their request. This did not occur. Further, if this research is published, identities of shelter location and participants will be concealed.

Risks. Potential risks to the participants were considered and planned for with the allowance that should a participant experience any untoward discomfort, anxiety, or other emotional need during or after the interview, she would be provided with a phone number on her consent form for assistance. To this researcher's knowledge, referral for counseling or follow up was not necessary at the completion of all participant interviews. In fact, all women were eager, open, and willing to share their stories. One very emotional interview involved a woman detailing her history of domestic violence and while she was quite tearful, she shared that the interview was particularly helpful and added that it was a positive reinforcement of the new life she was living.

Benefits. The benefits of this study outweighed the potential harm to individual participants, and included adding to the body of nursing knowledge and knowledge for homeless women regarding their transitional experiences. Sharing their stories seemed to provide them with a time for reflection and opportunity to describe their personal growth in achieving stable housing. Their stories were described as a way of giving to and supporting other homeless women who follow them.

Remuneration. In appreciation of and respect for the participants' time in the study, each received either a $25 gift certificate redeemable for merchandise at a local store or $25 cash. If interviews occurred around meal times, participants and their children were offered food in an effort to ensure uninterrupted dialogue.

Data Analysis

Interview data were audio recorded and transcribed verbatim. Field notes and transcripts were coded line by line and analyzed using the grounded theory methods of Strauss and Corbin (1998) and dimensional analysis as described by Schatzman (1991). Data collection and interviews were concurrent during the coding and analysis processes. Important dimensions were identified as data was coded and its salience identified. Memos provided an additional method of organizing the data.

As the interviews proceeded, minor changes in the interview guide were utilized to confirm, differentiate, and organize the data. Continued data analysis led to the development of a specific framework or matrix. As various dimensions proved theoretically relevant, these dimensions were pursued with future participants to further differentiate the data. Eventually, sufficient data saturation and depth of conceptual linkage was reached, described, and became grounded in the data and theoretically relevant. From this matrix analysis, a substantive explanation of the transition process from shelter to stable living for these women emerged.

Research Standards

Research standards were an important component of the research process. The rigor of the design is the degree to which research methods are thoroughly and conscientiously carried out in order to distinguish important influences that occur during a study (Denzin & Lincoln, 2005). Research standards were

considered to ensure rigor during the research process, especially during data collection and analysis.

Establishing Trustworthiness of the Data

Based on the work of Lincoln and Guba (1985), constructs of credibility, transferability, dependability, and confirmability were used to examine the trustworthiness of data generalized in this study. Trustworthiness is essential during the research process to assure the reader that the researcher's findings can be read with trust and that his or her stated findings are the actual findings.

Credibility. The goal of credibility is to demonstrate that the study was performed in a way that ensures the subject of interest was accurately identified and described. In qualitative informed research, credibility is obtained by verification of the collected data. Participants were given the opportunity to confirm or add to emerging themes during their interviews. The researcher had the opportunity to verify written data with two of the women. The women that did review the transcripts of their interviews agreed that what they had said and meant had been accurately captured in the transcript. Credibility was established in this study by checking the accuracy of the audio recorded interviews against the written data text. Credibility was also assured by basing findings on the data rather than on the researcher's bias.

Transferability. Transferability is the applicability of findings to another context or place. Lincoln and Guba (1985) purported that a "thick" description of the event creates the possibility of transferability; however, the researchers did not specify what they meant in a delineated fashion by the term "thick." The data

should provide the widest range of information possible. Sampling should continue until no new information can be obtained in the interviewing process. Depending on the researcher's judgment and experience, the findings may be applicable in another setting or population. However, caution and weakness in such application cannot be ignored. Transferability was achieved in this study by inviting colleagues familiar with vulnerable populations and transition processes to make connections between elements of these research findings and their own experiences to other theories and disciplines.

Dependability. The dependability of a study occurs in the accountability of the researcher to explain changing conditions in the setting or research design. The ability of the research to provide rational, clear definition of steps taken in the study is important to the possibility of future replication of the study. The steps taken in this study are detailed in this chapter to facilitate replication of the study by other researchers. Dependability was also ensured by creating concise observational, theoretical, and methodological notes.

Confirmability. The objectivity of research is reflected in the construct of confirmability. The inherent characteristics of the researcher must not intrude on the data, and the researcher's objectivity must be preserved. The data should evolve and be interpreted on its own strength, and this was assured through an expert-reviewed audit trail of the data and analysis that could be traced back to original data sources.

Reflexivity/Reflectivity. Reflexivity and reflectivity were both utilized in this study. Reflexivity addresses issues related to the researchers' values, beliefs,

and ideas as potential influences on the study (Lincoln & Guba, 1985). Those assumptions were made explicit to the participants prior to the study. Reflectivity concerns thoughts and/or opinions of the researcher resulting from an idea or consideration (Denzin & Lincoln, 2005). The researcher met periodically with her dissertation advisor and peer reviewers to discuss data collection and analysis to ensure reflexivity and reflectivity.

In summary, a study is considered trustworthy if it meets the previously discussed credibility, dependability, transferability, and confirmability standards (Lincoln & Guba, 1985). The challenge in this research was to avoid bias and to allow the participants' voices to be heard. This study effectively avoided bias and succeeded in upholding research standards.

This chapter discussed the grounded theory method and focused on the methodology of the study, including the shelter program, participant selection, solicitation of consent, and maintenance of research standards. Data was gathered through interviews that were audio recorded, transcribed verbatim, read, and analyzed using dimensional analysis. The findings of this study are presented in Chapter 4.

CHAPTER 4

Findings

This chapter presents the findings of a qualitative study that explored the process by which homeless mothers residing in a shelter achieve stable housing. This research focused on the following questions: What was the experience of women who have participated in transitional shelters? What factors impacted the transition process? What knowledge and skills were helpful during this process? What support structures or individuals were important to the women? How did the shelter experience or independent living impact their physical or mental health needs?

The Transition Process

In-depth interviews with 29 formerly homeless women revealed similar experiences in their personal journeys from living in a transitional shelter to stable housing. Their stories revealed the processes by which they were able to make the transition from previous experiences of homelessness, addiction, and/or domestic violence to one of creating a better life and stable housing.

A homeless woman's transition from shelter to stable living was a process directly related with her efforts to change difficult lifestyle patterns and habits (mostly associated with drug abuse, domestic violence, or mental illness) and

create a better life. Typical events included the woman's decision to get help, her sense of benefiting from the shelter's social support and services, and her ability to identify goals for herself and her children and be willing to work toward achieving these goals. Several phases of the transition process were identified as (a) *turning point--a* time of reflection, evaluation, and a readiness for change; (b) *reality* check--finding a way to the shelter and accepting help; (c) *taking responsibility--leaving* the past, creating new beginnings and working the program; and (d) *taking the life* skills--moving forward to stable housing.

Key dimensions that emerged through these phases were similar for this group of women interviewed; however, it is significant to note that these phases did not occur at the same time or last the same duration for each woman. For some, phases such as turning point and reality check occurred simultaneously. Some events and experiences between phases revealed that personal experiences may render a woman in more than one phase at a time. Additionally, the duration and movement through the transition process varied significantly depending on unique personal circumstances.

A few women shared that they moved back and forth several times through the first phases until a sense of readiness pushed them forward to the next phase. Several experienced this process multiple times before becoming independently housed; in fact, twenty-one women in this study (69%) had previous shelter stays. Many lived without a home of their own and experienced repeated episodes of doubling up with friends and family, sleeping in cars, living on the streets, and other general homelessness issues.

Through their personal journeys and shared stories of life before, during, and after the shelter, a salient dimension of "creating a better life" emerged. The data will be described in order of the chronological events experienced by these women as they worked to create a better life for themselves and their children.

One of the requirements for admission into the shelter referenced in this study was that women were mothers and had one or more of their children living with them--or that they were in the process of reunification with them. Children over the age of 12 years were not permitted to reside in the shelter. Should a mother with teen children wish to participate in the shelter program, alternate living arrangements were necessary for her older children. For this study, all women in the shelter were mothers; therefore, the terms *mothers* and *women* are used interchangeably in this text.

The Participants

Twenty-nine formerly homeless women who lived in a transitional shelter and successfully completed the program requirements were interviewed face-to-face for 60-90 minutes. In some cases, incomplete financial data (income and expenses) necessitated a phone follow-up conversation. Participants were asked whether they wished to review written transcripts for accuracy. Two of the women met with the researcher on a separate occasion to review their interview transcript; both responded that they had nothing to add or delete from the original conversation, and read it as an accurate description of their stories.

The overall demographic characteristics of the women at the time of the interview are presented in Table 1 and Table 2. The women ranged in age from

23-50 years; the average age was 31 years. Nineteen (66%) women were Caucasian, *5* (17%) were Hispanic, 4 (14%) were African-American, and 1 (3%) was Pacific Islander. Fourteen of the women (49%) were single, 8 (27%) were divorced, 6 (21%) were separated, and 1 (3%) was married.

All women were mothers with 1 to *5* children, averaging 2.55 children per mother. One woman was pregnant and had additional children. The mean age of the children was 8.2 years; the range was 8 months to 30 years. Most of the children in all of the families had different fathers with the exception of 4 mothers (14%) who reported the same father for their children. Six (21%) of the mothers reported receiving child support from the fathers.

Seven (24%) women reported having less than a high school education, *5* (17%) had high school equivalency diplomas (obtained while in the shelter program), and 17 women (59%) graduated from high school. At the time of interview, 14 (49%) of the women had some education beyond high school, and *5* (17%) of the women had obtained a college degree.

Eleven (40%) participants reported they had been abused as children and 3 (10%) had been raised in foster care. A past history of gang affiliation was described by *5* (17%) participants in this sample.

Twenty-three (80%) women stated that the primary reason for this shelter stay was to get help with their recovery from substance dependence, and several indicated more than one addiction. Several reported that the loss of housing was directly related to their substance dependence and while several had past criminal records, two were expected to complete this program as part of their sentence.

Four (14%) women cited domestic violence in their current living situation as a factor for seeking shelter, yet 23 (79%) suffered intimate partner violence at some time prior to their shelter stays. One woman who had been a drug dealer for years sought help with her inability to break free of the addiction she lived with. Lastly, one woman sought shelter assistance for mental health reasons.

Fourteen (48%) participants reported a prior history of jail or prison time. Among those with a history of incarceration, 5 (35%) of the 14 women reported felony convictions. During their stay in the shelter, 14 (48%) women reported the need for legal assistance. The shelter provided the women with resources to address legal issues ranging from restraining orders and divorce proceedings to child custody and support issues, taking care of past convictions, misdemeanors, and utilizing the local homeless court. The homeless court provided an avenue for these women to have past misdemeanors and infractions resolved in a non-threatening, timely, and cost-effective manner.

The average length of shelter stay was 16 months; the range was 6-30 months. At the time of interviews, 22 of the women were independently housed, 4 remained in transitional housing through the shelter, and one resided with her father. In reviewing the number of prior episodes of homelessness and shelter stays, 8 women (31%) reported this was their first shelter experience, 12 women (41%) indicated this was their second time in a shelter; 4 (14%) had three stays, and 2 (8%) indicated more than 5 previous shelter stays.

At the time of interview, 19 (65%) of the formerly homeless women were employed; 17 (59%) were receiving Temporary Assistance for Needy Families

(TANF), and 3 (10%) were receiving Supplemental Security Income (SSI) for physical or mental health disability. Most families (22/29, 76%) continued to receive food stamps and 7 (24%) with small children received support from the Women, Infants, and Children program (WIC).

Table 1

Demographics of Participants

N=29	Number	Percentage
Age (mean, range)	31.03 (23-50)	
Education (n, %)		
< High School	7	24%
High School/GED	22	76%
Vocational School	10	34%
Some College	14	48%
College Degree	5	17%
# Children (avg, range)	2.55 (1-5)	
Average age (range) of children living with mom (Mothers not living at shelter)	5.78 (8 mos-18yrs)	
Marital Status (n, %)		
Never Married	14	48%
Married		3%
Separated	6	21%
Divorced	8	28%
Race/Ethnicity (n, %)		
White/Non-Hispanic	20	69%
African-American	4	14%
Hispanic	4	14%
Pacific Islander		3%

*percentages are rounded

Table 2

Personal History

N=29	Number	Percentage
Reason for recent shelter stay (n, %)		
Homelessness and:		
Drug Abuse	23	80%
Domestic Violence	4	14%
Mental Illness	1	3%
Other	1	3%
History of:		
(some with> 1) (n, %)		
Substance abuse	24	83%
Alcohol abuse	12	41%
Gambling addiction	3	10%
Drug dealing	4	14%
Intimate partner violence	23	79%
Gang affiliation	*5*	17%
Child abuse/molestation	11	40%
Foster care as child	3	10%
History of Incarceration (n, %)		
Prison/Jail	14	48%
Felony convictions	*5*	35%
Required Legal Assistance during Shelter stay (n, %)	14	48%
History of previous times homeless	Average4	Range: 1-10 or >
History of previous# shelter stays (n, %) N =26		
1 shelter stay	8	31%
2 shelter stay	12	41%
3 shelter stay	4	14%
4 shelter stay	1	4%
> *5* shelter stay	I	4%

* percentages are rounded

Table 3
Life after Shelter Program

Number of Participants=29	
Length of time living at shelter (# months: average, range)	16 months, (6-30 months)
Length of time in stable housing at time of interview (# months: average, range)	13 months (2-36 months)

	Number	Percentage
Living Situation (n, %)		
Transitional housing	6	21%
Low income/HUD	18	62%
Regular Housing	4	14%
Other	1	3%
Employment (n, %)		
Currently employed	19	66%
Income Assistance (n, %)		
TANF	17	59%
SSI	3	10%
Unemployment	1	3%
Food Stamps	22	76%
WIC	7	24%
Child support	6	21%
Education (n, %)		
Enrolled in college or vocational program	11	38%
Transportation (n, %)		
Own vehicle	24	83%
*Clean and Sober (n, %)		
(24/25 applicable, %)	24	96%
Participation in recovery program (n, %)		
*Connected with shelter aftercare Or other program	21	75%
*Attends NA/AA meetings or has Sponsor (as applicable)	14	48%

*self-reported

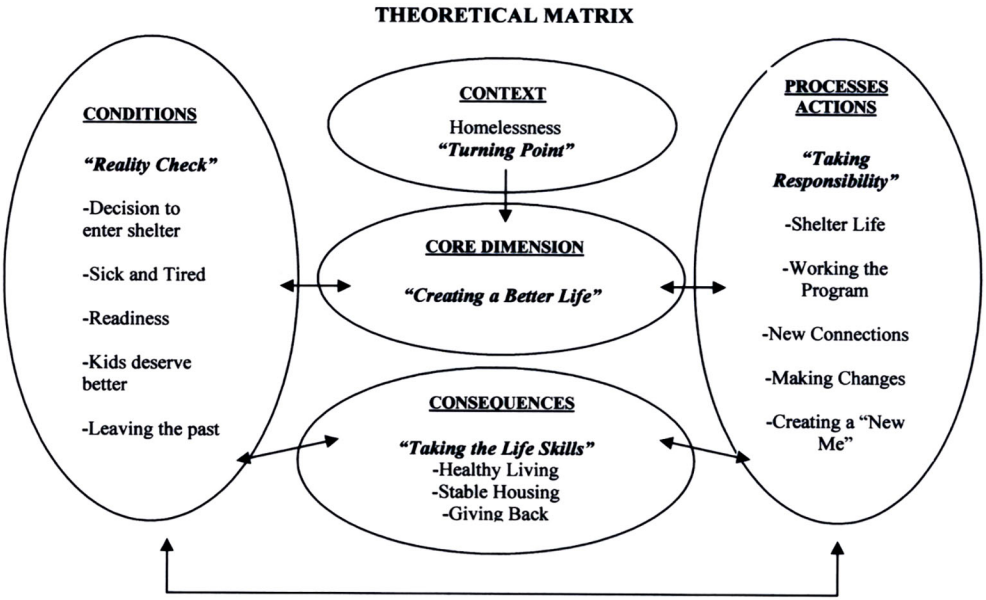

Figure 2. Perspective of formerly homeless women moving from homelessness to stable living.

Figure 2 utilizes the women's words and stories to describe the phases they experienced during this process. The remainder of this chapter will describe each phase of the transition process, all aimed at creating a better life.

Turning Point

Before women made the decision to enter the shelter, many lived under very difficult situations and experienced more than the general challenges of homelessness. Women described drug addiction, domestic violence, mental illness, periods of incarceration, isolation and/or separation from family and social support as stressors, and they lived with these stressors for varying amounts of time ranging from several weeks to many years.

Prior to making the decision to create a better life, women were living in very difficult and often high stress environments. Challenges to daily living included: poverty, domestic violence, homelessness, substance abuse, incarceration, physical and/or mental health instability, isolation from family, and for some, the threat of temporary or permanent separation from children. The context of a turning point helps to set the stage for the core dimension of creating a better life and journeying toward stable housing. A woman facing these situations lived with: (a) high risk, (b) unpredictable living conditions, and (c) the need to rely on herself for survival. Some early descriptions of turning points included themes such as unstable street life, living with stressors, drug addiction, domestic violence, gangs, burning bridges, feelings of isolation, and the need to leave the past.

Street Life is Crazy

Several mothers reported that their substance dependence forced them to live on the streets. During these times, described as "crazy" or "out of control," women lived without stable housing anywhere from several days or months to several years; one woman lived through more than 20 years of daily unpredictable and sometimes dangerous situations. In more than one instance, participants shared they had survival sex and resorted to stealing in order to support their drug habits and street lives. Others with severe addictions left their children in the care of family members or friends as they continued to risk their homes, health, and sanity in order to stay high. Surviving on the street left many with a sense of shame, loss, and a desire to change. Two women described street life thus:

(a) My life was so scary when I was high. There were times that I woke up in strange places, didn't even know who I had been with or where I was from the night before. One morning, I will never forget, I woke up, mostly undressed, in a room with three guys-I didn't even remember their names ..... I was so scared, it was so creepy. I did things I am so ashamed of.... this was no life for me or my kids... at least they were with my mom. It was time to get help.

(b) I spent from 1990-1999 in prison, and when I got out, the street became my home again. I was able to scrape enough money together to buy a car and that was my home ... bouncing around from place to place trying to find a place I could park-near a school for my son, it was just a mess. I ended up selling all kinds of drugs (and using some) just to survive and stay one step ahead. One last time I was caught and landed in prison again. No one survives on the street for very long.

Living with Stressors

One woman spoke to the instability and uncertainty she lived with on a daily basis:

> I lived a life that was extremely confusing, chaotic. Um, basically, my life ran me. I wasn't in control of my own life. There was so much baggage I brought from another relationship. My new boyfriend ended up being two different people. The moment I had my own mind, he would have a fit and basically, I lived with nothing but stress. I walked on eggshells every day.

Drug addiction. As previously discussed, 24 (83%) of the women stated that their housing and parenting problems related to drug dependency and that they wanted help. The drug of choice for most was crystal methamphetamines, but other drugs played a role in their addictions as well:

> I started doing drugs really early, probably drinking in the 6th grade and smoking pot in 7th grade. I maintained during the week and partied on the weekends. When I went to continuation school, I started with crystal meth. Eventually, it was cocaine, ecstasy, pretty much anything I could get my hands on. I was a full-blown addict by the time I was 20.

Homelessness. Many respondents shared stories of sleeping on the streets, in cars, or in parks. Almost all described instances of doubling up with friends, family or even strangers:

(a) When I got back to the area, I stayed at a friend's house. And he wasn't really a friend; it was a friend of a friend. It was only a day. Then it was all about what am I gonna do now? So, I found this girl that used to live with my neighbor and she says, "I have an extra room, come stay with me-you can help with the kids." She had twins. So I stayed there for six months and worked at night too. I still hadn't saved enough money to get my own place. Then once I got pregnant, she kicked me out and said, "My sister is corning to live with me now."

(b) My life was just pure madness. It was crazy. I mean what am I doing living in a house where there's no food and I can't even get my daughter to school, I don't know anybody around me where I'm living. My mom won't talk to me. I have no phone. It was just crazy. I just had to get drugs. I spent my whole welfare check on drugs and traded my food stamps for drugs...! was sick and tired...

Domestic violence. Domestic violence was one of the precipitating factors in several of the women becoming homeless. One woman shared a traumatic experience that was her sign to leave and never return:

(a) One night when he was corning home from work and it was so hot in the apartment. So humid that I was sitting on like the balcony in the front of our apartment. And when he walked up, he was so angry with me because I was not inside of the apartment. He felt that you know, there might've been guys that would've tried to come onto me or something. And there was no guys in sight. You know, I mean, there were no people down in front, but I'm way upstairs. I'm on my patio you know, just trying to cool off. And I'm like, "Do you know how hot it is in there?" And he's like, "That's not the point." And he was loud; it was embarrassing. He dragged me by my hair into the apartment. My kids immediately--when they realized that he was gonna basically go crazy--my kids immediately ran out to my neighbor's house and they called the cops. But by the time the cops got there, I was beaten from head to toe and he was nowhere in sight. I was carried away on a stretcher to the hospital. I had bruises, my face was unrecognizable. I had bruises all over--some were red, some were purplish. Um, he knocked out my two front teeth, like he wanted to say that, "If I can't have you, no one else can."

Another woman also had issues with violence:

(b) Yeah, I've been with many men who have never hit a woman till they met me because I know how to push them to the point, and I make them hit me, because I like to fight.

Mental illness. Many of the mothers described conditions of depression and bipolar disorder, but none recalled this as the primary reason for entering the shelter:

(a) I had never lived on my own, anywhere. Maybe with a friend for a month or two, that's all. Always with my mom, but her manic depression was getting worse and it was time for me to go-it wasn't a good atmosphere for my daughter. I knew this was no place to raise her. The shelter said they would help me find a job and housing if l went through the program. I really didn't have any place to go.

(b) I chose to be out there on the street. Because I was so into my drug addiction. I was so into just having to be with somebody. I had really bad depression. I was hospitalized for it. And um, being homeless was a decision I made. I chose to live out of the car. I didn't have to. I chose to run the streets late at night and just be out there, so...

Burning Bridges and Isolation

Mothers spoke of damaging relationships with family, friends and others who had made multiple attempts to help them in the past:

(a) I couldn't call no one, I had burned all my bridges and then some. I knew that there was nowhere else to tum to. When you have used up everything you have, there is nothing else to do. I had been given so many golden opportunities by my friends and family-I just burned 'em up, one by one. I just couldn't call one more time. I knew what the answer would be. Never before was I so alone.

(b) I mean I was walking up and down the street over here with my two children in the summertime cause it was hot and I had no place to go. Luckily, I did have a cell phone but I had burned all my bridges with people. Nobody wanted to give me and my children a ride anywhere or anything like that so I had $1.75 in my pocket. We took a

> bus to my dad's and because he was in his addiction and moving out, we all slept outside like we were camping. That is what I remember telling my kids... we're just camping out for a few days. Thank God four days later we got into the shelter.

God and Survival.

Many women stated that they were grateful to God for their survival of street life, drug abuse, or domestic violence. They felt they had been given a second chance. Two women explained their beliefs that God had a reason to keep them alive:

> (a) [It is] only through the grace of God I am here. I was selling, using, over-dosing, involved with gangs and my home boy. I should not be here because of what I have been through, unbelievable.
>
> (b) God had me in the palm of His hand, I held onto my daughter for the life of me. Before the shelter, I was homeless, using drugs, in and out of danger with a boyfriend who beat me. I was rescued for a reason.

Gang Affiliation

One woman described how difficult it was for her to break free from her past affiliation with a gang:

> I was doing so good; I had stayed clean and sober for at least a year after my first baby. See, I had to move away to stay with my aunt. When I came home and lived with my parents, [I] had a real good job, bought a Jeep Cherokee, and things were going good. Then I started meeting up again with my homeboys. I started getting stoned again, little by little, hanging out with them. Eventually doing more drugs and when my homeboy ended up getting locked up, I started picking up his business and doing a lot of transporting drugs for him. Of course, I was doing more drugs and just couldn't walk away from my homeboy. I loved him. My son was with my mom and my life was just running amuck. It took another year of hard drugs to want to get clean again--my homeboy was going to be in [prison] for a long time and so I had to leave the area again, but this time my mom wouldn't let me take my son.

Leaving the Past

Many of the women who had experienced issues with gang affiliation, abuse, or domestic violence shared their stories of disconnecting from the past:

> (a) I didn't make time to be afraid. I told myself that if he ever tried to hurt me--'cause he put me in the hospital twice with early labor, because he would try to grab me, wouldn't let me leave. So they had to stop my labor twice. Finally, one night when he was asleep, I took the kids and drove around till morning. I went to the shelter that my friends told me about. They knew I was leaving. I wasn't allowed to have contact with him and I didn't want him to know where I was going. It needed to be a fresh start.
>
> (b) Most of my friends were using and I didn't want that life and I came to the shelter to get away from it. I knew that I needed to move far away from my old friends; I had to move far enough away than just another town because I would go right back to the same old, same old. Not being able to take a five-minute car ride and hang with my friends was a must. I had to disappear and leave the past behind.

Reality Check

Most women recalled a time of evaluating their options--a reality check--before deciding to enter the shelter. Taking personal inventories led them to consider alternatives to situations they no longer found tolerable. They were fed up with the unpredictable, dangerous, and often shameful lifestyles they were living.

Sick and Tired

Several of the women used the words "sick and tired" to characterize the state they were in as they considered leaving the street life or their current situations:

> At first, the high was more important. At some point it got old and cold. There was no privacy--couldn't even keep clean. I got sick and tired of not being able to wash my behind when I wanted to... really, sleeping in the

> back of buildings on filthy dirty mattress pads and never taking a shower--just for the high--I needed the drug that bad. It was my choice to be out there but then I realized I was just tired of that. A good hot shower is the thing that makes me happy today.

Substance Abuse

Surprisingly, although several women reported living in situations of domestic violence, problems with drug abuse were most the significant reasons for seeking shelter. Some of the women struggled with gambling addiction, one with sexual addiction, and yet another described her addiction to selling drugs as a primary reason for her recovery:

> See, I never used drugs. It was my husband that did. I was always good with business stuff and so one day he said, "I can help you make a lot of money if you want to just sell a little on the side." Before I knew it, I was selling to everyone. I made so much money and my kids never wanted for nothing--we had the best of everything. I think I really knew how bad it was when other kids would come knocking on my door, looking for their mom and she would be getting high in my apartment. They would cry. The moms gave me all kinds of stuff--jewelry, food stamps, cash, anything for their fix. The kids had to know; they were so sad because they saw what it was doing to their moms. I felt so bad. I wanted to quit selling before my kids found out and before I was arrested. But I needed help...all I ever knew was my own high of selling drugs and the money I made.

Another spoke of her addiction:

> Crystal meth was the worst 'cause every day; it was like non-stop. It got to be where I was selling the drugs, using the drugs, a lot of drugs... and it got to the point where I was miserable, I was out of control. My kids were seeing things they shouldn't have seen as far as drug addiction and using. They would walk in on me high--while I was getting high. By this time, I knew I had made up my mind to stay clean and sober. It was so hard; nobody wants to help someone that's in addiction.

Isolation

Quite often, the women felt isolated from their friends and families and tended to keep to themselves. One shared an interaction with her mother, who encouraged her to seek shelter:

> My mother came to visit me week after week. I was so ashamed to be in my addiction that I wouldn't even see or speak to her. I would hide. One day, I did see her, and she just put her arms around me and hugged me and we cried. It was the touch I needed. I knew that she cared and was willing to help me through this. She drove me to the shelter for my intake interview and two days after that, she helped pack me up and drove me and my four kids all the way to the shelter. She knew exactly what it was like--she is a recovered heroin addict.

Crisis Event

Several women described specific events that influenced their desire to initiate change. Some had hit "rock bottom," but also shared in their stories that a positive or a negative event was seen as a *reality check* moment:

(a) The only thing I had to stay in was my car. It was supposed to be repossessed any day. I was living in my car and telling myself it was all going to be ok. I didn't want to bother my friends again--so I drove off. It wasn't until about six weeks later that I had to be realistic--being seven months pregnant and living in a car. I couldn't fool myself any longer... I was getting too big. That was when I knew; I am really going to have a baby and I need to do something now. I finally had to take a good look at my life. The prenatal clinic referred me for help.

(b) We had been having issues for so many years. I even left him after one beating--got a restraining order and everything. I will never understand why I went back. But the last time I did, he kept using and wanted to bring me down with him. I was so mad and angry at the world, you know; so unfair--why did I have to be in this life? Why can't he be a good person? I would wake up in a bad mood and start the day like that. I will never forget the day he made me coffee, which he did sometimes. I drank about a half cup and took my son to school. About 30 minutes later, I was driving and singing--happy, in a good mood--and then it hit me a little later on that day...he put crystal meth

> in my coffee. I couldn't eat, my heart was racing, my mind was spinning. I didn't want to believe he would be so sick [as] to force drugs on me. After we had a huge fight, he beat me up one last time. As soon as he left, I took the kids and we were out of there so fast. We had to hide in motels every couple [of] days and use a different name until we got into a safe shelter. I have never been so scared in my life. I was so humiliated because I had to explain to the shelter why I would have a positive drug screen. I knew he would come after me if he saw my car.

Kids Deserve Better and Fear of Losing Them

Many of the mothers shared that they did not want their children to be in dangerous situations. One mother, living on the street with a newborn baby girl, knew it was time to go to the shelter:

> (a) I knew I had to do something, and quick. I had been able to stay on the streets and live under freeway passes or in parks, but to have a new baby--no way. I remember thinking how crazy this is, [that] I had no clean diapers for my baby. She was getting rashes and a raw bottom from dirty diapers. She did not deserve this. I could take care of myself on the street but not her; no, no, she didn't ask to be brought into this and doesn't deserve a life like this.

Fear of losing children to Child Protective Services (CPS) was a motivating factor for many of the women:

> (b) And because I had no prenatal care with him, they were mandated to call CPS. So I had voluntary CPS case for a while, and I stayed clean. I knew if I didn't stay clean, they would take both my kids away.

Getting children back was another powerful motivator:

> I knew the only way to get my case cleared and keep my children was to get in a program. I had already been warned by CPS. They were gonna take my kids if I tested positive one more time and if they came back and their father was here. The police had been called too many times. Nothing was worth risking my kids being taken away. I lived in foster care and I didn't want that kind of life for them.

Living in Recovery

Most women assumed that staying at the shelter could help them stay drug-free. Several stated that one of the key reasons they chose to stay at the shelter was because they realized they could not stay in recovery on their own. For example, one woman moved out of her situation and into another with the hopes of staying drug-free and eventually going back to school. She had been in recovery, but her roommate situation became intolerable. She was not alone in finding her new situation challenging:

> It just doesn't work to live with people who are using when you're trying your best to stay sober. The temptation is too much. People who are actively using don't understand... until they try it. Finally, one day, I came home while everyone was partying and I said, "I need to get out now." That's when I called the shelter.
>
> You've got to be with people who are like you, it is too hard to go it alone, there is too much at stake to relapse. I had one more chance to prove to CPS I could be clean and sober.

Recovery after Jail

One woman was incarcerated multiple times before her stay at the shelter. When released, she immediately returned to the only lifestyle she had known. It wasn't long before she violated her terms of probation and landed in front of a judge once again:

> See, I am standing in front of the judge and they are all talking about where to send me, and finally, I started banging my cuffs on the table and said, "Excuse me, excuse me." The judge was kinda cool because he said, "What is it you want to say?" I told him honestly that if he put me in a six-month program without my son, I would run. I told him I wanted to do a two-year program (I already knew about the shelter) that would allow me to have my son with me. So that is how I ended up here. I couldn't believe it when he said, "Well, I guess you've done your homework and it sounds like that would be a good place for you."

Readiness

Many women shared a readiness to enter the shelter and initiate change "this time":

> Actually there was a time before when I was gonna go into the shelter, when I was first pregnant with my little girl. And I went through the process of applying but I didn't go. Finally, after living month after month in different motels, moving around with different people, I was ready. I was just finally... was, "I need to change my life around, I've got a little girl now, I can't live like this no more."

In summary, during the reality check phase of the transition process, women described experiences of personal evaluation and deliberation when their stressors became intolerable. This phase was really a process of self-assessment--a time of reflection of what track their lives were on and where they were headed. All women wanted to create a better life for themselves. They felt that their decision to enter the shelter was not impulsive, but made after considerable reflection and with readiness to create a better life.

The Decision to Enter the Shelter

The sources by which the women came to know about the shelter were significant. Several spoke of hearing about it from family members or friends of friends who had participated in the shelter. Some heard about the shelter while they were in emergency or temporary shelters. One woman heard from the prenatal staff of a medical facility. Some were referred by CPS caseworkers. One heard about the program while she was incarcerated, through staff members affiliated with religious services and an in-jail recovery program. Another mother learned of the shelter from the Internet. This type of information sharing demonstrates the importance of social connectivity in the transition process.

These links connected the women to vital services and for some, provided emotional or spiritual support while attempting major lifestyle changes.

One woman had been trying to stay in recovery for several years. She was impressed by the progress her friend had made:

> My friend was like a new person. At first, I didn't think she would make it, but she did. After I saw the changes in her life and how happy she was, staying clean and sober, working and having her own place, I knew it would be a good start for me. I tried so many other programs, in and out, six months here and there, but nothing worked. I was so scared for my intake interview--! remember that I had to get high to do it. The case manager took one look into my eyes and touched my hand and said it was going to be all right.

All women decided to enter the shelter--some with more desperation than others--because they desired a different life. They felt that the shelter offered them safety, structure, and hope.

The Shelter

The transitional shelter provided housing and an array of comprehensive support services to assist the women with ending the cycle of homelessness and/or abuse. The two-year program provided safe housing (group homes), food, 12-step programs to aid in drug rehabilitation and relapse prevention, therapy for mothers and children, daycare, legal assistance, education, career guidance, and employment strategies. All participants attended weekly life skills classes focusing on health care, safety, parenting, nutrition, domestic violence and child abuse prevention education, budgeting and financial management, decision making, anger management, coping strategies, spirituality, and art therapy.

The women in this study participated in three phases of the shelter program. Phase one provided time for them to focus solely on recovery from

whatever situation precipitated their homelessness. Employment was not permitted during this phase. Phase two began after program requirements were completed and the women were considered "graduates" of the program. They were expected to obtain employment and/or return to school as needed to complete a GED, enroll in vocational/trade school, or attend a local college if education was a goal. In "after care," the final phase of the program, women were encouraged to keep in contact with the shelter once they became independently housed. For some, this required housing assistance.

Although the structure and rules of shelters vary, this shelter followed basic regulations that served as surveillance and control mechanisms for the women. A curfew imposed during the week enforced all women to be home before 8p.m. nightly and 10:00p.m. on Saturday night. Chores were assigned to each woman and a house supervisor ensured these tasks were completed. Shelter rules mandated sober living and prohibited active use of any substance on the premises. Residents recognized for substance dependence or a history of substance abuse were required to attend a daily NN/AA program, submit mandatory random drug testing, and work toward Step 4 of recovery (see Appendix I for description of recovery steps).

Shelter Program

Phase one. During the first phase, homeless women and their children were provided with the security of a safe house (group home), where they lived with other women and children. Each mother was given one private room to share with her children; other areas of the house were communal. Families were

provided with food as needed and assisted with daily transportation via shuttle van to the central program and to and from medical or legal appointments. If the mother arrived without personal items--clothing, toiletries, or diapers for her child--these were supplied in the form of care packages. Furniture, bedding, toys, and other items were donated as needed to the families. Depending on their situations, mothers received vouchers for future purchase of additional items at a local thrift store.

Women were expected to attend the program daily from early morning until mid-afternoon while their children attended daycare or school. The shelter provided a daycare for infants and preschool-aged children. Women were not allowed to be employed during Phase one, as it was reserved for recovery, personal reflection, and learning life skills. They were instead expected to work toward a "graduation day" when they had successfully completed the program and could be proudly referred to as a "graduate."

Completion of this phase involved many accomplishments, including attending over 640 hours of life skills and drug recovery classes, working on reaching Step 4 of NA/AA**,** meeting goals mutually set by clients and case managers, establishing a savings or escrow account, and finally, receiving a recommendation from staff and clinical team review. Very few participants graduated in fewer than 6 months; the average time to completion was 8-10 months. Some went through the program more slowly and required 12-14 months to complete. If clients had violated rules or been placed on contract, time spent in this first phase might have been extended.

Graduation day was marked by a huge celebration and a ceremony dedicated entirely to the graduates. The shelter director shared words of hope and encouragement, the case manager spoke of the accomplishments achieved, and current roommates, friends, and family all shared in the success of the graduate's efforts to move forward and create a new life. Several women commented that this was the best day of their lives.

Phase two. During the second phase of the program, women were expected to obtain employment or work on job skills. Some needed to complete their GED while others enrolled in local colleges or vocational programs to increase their opportunities for higher paying jobs. Rent was required of all residents (30% of their total income), and they purchased their own food, secured their own transportation, and worked toward financial stability. A minimum of $50 per month was placed in an escrow account that would provide a future first and last month's rent deposit. The women became active participants in their search to secure future stable housing as they continued to work on themselves and become self-sufficient. Additionally, they were required to maintain sobriety and comply with random drug testing. Upon graduation, the women were allowed a weekend overnight visit with family or friends, although during the week they were still required to comply with curfew times and complete assigned household chores.

The transitional shelter provided a maximum shelter stay of two years--and even though women had "graduated" from the program, rules and curfew were still enforced and attendance at select meetings was required while they

resided at the shelter. Not all of the women took the full two years before moving out on their own; many were ready to move forward soon after completion of the program.

Phase three. The final phase of the program was referred to as "after care," and occurred when a resident moved into independent housing. Women maintained contact with their case managers, continued to work on goals, and returned to the shelter once a week for a voluntary drug screening and to maintain contact with others in recovery--sharing their experiences of "living life on life's terms" and putting into practice the newly acquired life skills. This venue provided an opportunity for the women to problem-solve with one another and vent frustrations of life's trials.

Women were encouraged to participate in this phase for a minimum of one year after leaving the program, though not all graduates did. They were eligible to reside in after care for up to three years, and some remained in order to give back by helping those who were new to the very same process they had experienced. If women remained connected to the shelter during after care, some of their needs continued to be met; for example, during the holiday season, community volunteers adopted mothers and their children and provided wish list items for them to ensure a special holiday and to help ease financial burdens. One mother shared how she used the shelter staff for job references and another asked her case manager to write a letter of support for educational scholarship opportunities. Case managers were always available to help problem-solve. Many women shared relief that help and counsel were just a phone call away.

Life at the Shelter

Adjusting to shelter life. As the following women attested, living in the shelter required toleration of different personalities and adjusting to shared living spaces--kitchens, bathrooms, living room--preparing communal meals:

> (a) Wow, it could be really tough depending on which home you were in. We had a great group and everyone worked together but man, I tell you some of the homes were just a mess. They set up chores and rules that you gotta follow, you have to work the program for a long time before they cut you some slack. Kind of reminded me at first of being back in jail, but really, it eases up once they know you.
>
> (b) I had to learn patience here. Sharing bathrooms, kitchens, even the one TV in the family room. I was thankful for so much they provided but it wasn't what I was used to. I came from my own home, left everything behind except the clothes on my back and my kids. It was a real shocker.

Different personalities. Women described various reactions to shelter life and its dynamics:

> (a) Sometimes I deal in here with what I was dealing with out there. Different staff, because of the way I talk, look at me funny, and residents do too. Everybody is judgmental. And I know at times, I'm judgmental...but it's rough; that's just how people are. I am realizing that I can't change somebody [else] but I can change myself.
>
> (b) I've always been a really clean person. I had to tell someone that they had bad body odor, it was so embarrassing but it had to be done. When you live with someone, you have to make it work.

Comparing themselves to others. Several women reported that it was difficult living with others who did not share the same commitment to recovery. One expressed her frustration with those just using the shelter as a place to stay:

> You can tell very early on why someone is here at the shelter. I know of some, even today, that are here because it is a safe place to stay, a roof over their head, and a way for them to save money while their boyfriend is in jail. They are using the program, not working it to get better. Mark my

> words, when their boyfriend is out of jail, they will be right back in the same situation. It is frustrating to see this situation taken for granted.

Another woman, drug-free for several years, had a different reaction to those perceived as not serious about the program. For her, looking at these women was like looking at her past:

> *[Interviewer: Is it sometimes frustrating for you?]*
>
> I am not going to judge anyone, hell, it took me more than one time around. Because I am older, I see so much of me in them and I wish I could help them understand that we don't get this time back and if they could grasp this opportunity now...

One woman expressed the challenge she faced in accepting her need for individual therapy:

> I am one of those people that unless medication is a dire need, I won't do it. I wasn't diagnosed until therapy and then I clinically had depression. When I look back at me being depressed, it was a, a symptom of my living environment. Now, I am so happy where I am going, I'm so like, "I'm gonna do this and I'm gonna beat it, and I'm gonna win"... it doesn't matter how far down you are, you can make it to the top. I want to be an example to my children and therapy taught me that.

Another woman felt that she had tried to be a responsible parent, unlike others she observed in the shelter:

> I don't think women make children as important as they are. I saw a lot of women put themselves before their children and that was hard for me to see. I'm very opinionated about things but I want the betterment for people, you see...it was hard for me to see a mother and she's not doing what she should be doing for her kids. Sometimes we have to sacrifice ourselves for our children.

One woman, who had no substance abuse history but fled an abusive relationship, had this assessment of others' situations:

> I couldn't have imagined a worse situation for me but when I listened to other stories and the past history that we all have, I can only be thankful for how my life turned around since being in the shelter. I had so much to

> learn about myself, my self-esteem totally changed from being in the program. I can see how the program worked not just for me, but for my roommates too. We all came with similar situations but working together in small groups and dealing with saying no to abuse made a difference for all of us.

Shelter help. Women felt that the shelter connected them with helpful resources connected with the program and other service agencies. Participants shared:

> (a) The shelter helped me deal with my legal troubles. I had so many tickets and things that I had let go for years-they just added up. I was having trouble moving forward because of my past. They connected me to the homeless court and I took care of all my legal responsibilities. Now I am free and clear.

> (b) The shelter provided lots of things in the beginning that I knew I needed help with. For the first month here, I didn't even attend the program. I was so beat up and embarrassed not to have any front teeth that they helped me with getting my mouth fixed, [and getting] medical appointments for the kids so they could enroll in school..and the help was always there when I needed it. They let me start the program once I got my new front teeth. I had to learn how to talk again.

Lack of transportation. As shelter residents, the women were provided transportation to and from program meetings, medical or legal appointments, and school or daycare needs for their children. Once they left the shelter, transportation service was no longer an option. Of the 29 formerly homeless women interviewed, 24 owned a functioning car. This was not necessarily the case when they first came to the shelter. Most of the women entered the shelter without a vehicle and it was only through living in the shelter and saving a small amount of money or using a yearly tax refund that they were able to purchase a used vehicle. Without transportation, many of these mothers indicated their home

finding efforts were severely hampered. Many also indicated that they did not have money for bus fare every time they wanted to look at rental apartments. Without a car, these mothers' search options were restricted. Additionally, public transportation in some areas did not readily provide access to such basic things as shopping for groceries or taking their children to necessary medical appointments.

> I had to rely on the shelter for all my transportation needs at first [because] my child has so many disabilities. Eventually, I was able to save enough money to buy a car to take her to appointments. Before I had a car, I would have to take three buses to get to her appointment.
> It is harder because you have your kid and you have to go to work and you have to take the bus and... that's anywhere, though. I mean, it can be done but if you don't have the motivation to want to do it, then you are going to go backwards.

One woman shared what it was like for her not having a car while she lived in the shelter:

> I kept to myself pretty much. I'd be out there with the other girls but I was usually in my room or I'm out walking around 'cause at the time, I didn't have a car. I'd walk around. On the weekends, I'd take the bus to see my brother.

Another shared how she was able to help other women with transportation:

> At first, I was the only one in our house with a car. I would be the responsible one to take people where they needed to go. I just couldn't see saying no when they had something important to do. I didn't really mind, but I was relieved when my roommates got their cars. I had more time to work on my things.

The lack of transportation was serious barrier to this woman's achieving and maintaining stability in another very important aspect, namely, access to a job:

> I have been let go from three good paying jobs because I didn't have a car. You know, my son with ADHD has special needs. Sometimes I would

have to leave work to go to the school right away [but] I had to take the bus. You can' t get to and from a job quickly taking public transportation. If I had a car, things would have been different.

Gratitude and dislike. Most homeless women expressed a mixture of gratitude to the shelters for providing a roof over their heads and a dislike for some aspects of the communal living arrangements, staff interference, and shelter rules:

(a) It helped me set boundaries. I never had a voice in my relationships. They taught me how to love myself. There's just so many things about the shelter. I mean, it's like the entire program. I think I was ready for it; I was really ready to change my life. I am so thankful for the new me. I learned it there.

(b) They [shelter staff] help people that want to help themselves, not someone who just wants to be taken care of. They don't make it easy for them here. When they first come in, yeah, they help you, they give you the basics; but eventually, they start weaning you off, and you know, after you graduate, you're on your own. I couldn't have made a fresh start without their help.

(c) I remember the first night I was there, it was awful. I was scared to be in a house with different people from all kinds of backgrounds--! always kept a clean house. I remember going into the kitchen at night and seeing roaches and screaming. Some of the girls came out to see what was wrong. I didn't like it at all. I was not used to this but eventually the problem was taken care of. I found out later that the girls were taking bets on if I would stay in the program or not. I told myself, I can get rid of these roaches just like the poison from my past. And that is what happened.

(d) I graduated the program, but I left sooner than I really wanted to. I couldn't handle all the rules and curfews. I was ready to be on my own and I didn't like being told what to do. I still work the program, but in my own way.

(e) Some of the women in my house made it unbearable for me to stay there. I didn't like how they were raising their kids and didn't want that influence for mine. Five women living together under one roof was too much for me. It was chaotic at times with all the kids out of control. It was time for me to have my own place.

(f) At first, it was really hard. I was an emotional wreck. You know it was very scary because you are like, in a house with other people, and you really have to take care of yourself. You have to get up and function every day. There is nowhere to hide or isolate. You have to work the program every day. Others were counting on me to be there unless I was physically sick.

Shelter staff. Almost all the women had favorable comments about the shelter staff, citing the staff's availability and sincere interest in helping women succeed. Some women found it encouraging that the shelter employed program aides who had been former shelter residents:

(a) They have been there too. They have been down the same road of recovery and it felt so good to know that they could relate to what I was going through-they really helped me to be who I am today and let me know I need to be who I am.

(b) When I first came to the shelter, I only had the clothes on my back, and they provided me with vouchers to get clothes from the thrift store. They gave me a whole bag of toiletries for me and my kids so we had a toothbrush, soap, and shampoo our first night. Now that was special because nobody ever did anything like that for me. When I came back with clothes for me and my kids, they took the time to let me show them off. And they were there for me to share my gratitude. That made me really feel a part of something, like I mattered.

One woman gave a specific example of how her case manager was teaching her how to get the most out of her NA meetings and individual therapy:

> She did everything to encourage me, was continually supporting me in my effort to stay sober. Her door was always open and she had time for me to open up and let her know how scared I was. She always knew the right thing to say--that it would be alright.

Many women expressed gratitude to the shelter staff for helping them begin a new life:

> As far as my shelter stay, I was so grateful to be there. They have saved my life more than once. The reason why I wanted and needed to be there

> is because I knew I could build a foundation and build a routine of doing the right things. Staying clean and sober one day at a time. The staff kept me conscious and focused on what I was supposed to be doing to stay in recovery.

Taking Responsibility

The key dimension of *process/strategies* was identified as the *taking responsibility* phase. Homeless mothers in the shelter accepted their positions of needing help in order to change and took on necessary responsibilities to be in control of the changes.

After entering the shelter, women reported a variety of reactions to living with each other, following the program, working on goals, and planning for the future. For many, the shelter environment and daily routine offered welcome structure, social support, and amenities nonexistent on the street. For some of the women, living with others could be conflicting and challenging, but was still considered worth the effort. Women used the terms *acceptance* and *surrender,* the first two steps of Bill Wilson's 12-Step AA program (Diamond, 2000) to conceptualize their readiness to change more than their addiction: they wished to become better prepared for life outside the shelter. As the women felt stronger both physically and spiritually, they described the need to become more independent in their recovery and parenting and the need to establish housing. Renewed with hope and new support networks, they took responsibility for necessary footwork and emotional growth. The women cited exercises of following rules, listening and sharing with others, and finding healthier ways to

cope with painful emotional issues, which enabled them to take advantage of shelter resources and maintain their recovery.

Acceptance and Surrender

"We admitted we were powerless over alcohol/drugs-that our lives had become unmanageable." The paradox of this first step of the AA/NA 12-step programs (see Appendix I) is that one must accept and surrender in order to gain control over one's life (Diamond, 2000). Women reported initial steps to change past behaviors, which involved taking personal responsibility for making necessary changes. This was possible after they surrendered to their addiction and also admitted they needed help from others. One mother explained how she was ready for assistance in the early part of her shelter stay:

> I didn't care. Tell me and I'll do it. I was desperate. I was spiritually bankrupted, emotionally drained, physically tired. So I just surrendered. I have to let somebody help me because I can't do it. Every time I try to do it, put my hand in it, it gets worse, so obviously I don't know; there's something I'm not doing right.
>
> I learned that it's better to ask for help than to try to force yourself to do something that you really are not capable of doing... so I'm going to go ahead and bow down, be powerless more or less, ok, which is one of the steps of being in NA and AA--be powerless--and go ahead and do. I got to buckle my pride, which is really hard for me, because I've always done it on my own.

Doing the Footwork

"Doing the footwork" and taking " baby steps" were phrases commonly used by women who lived at the shelter as they referred to doing some of the work of accomplishing goals on their own. Some reported that they received more acknowledgement and help from the shelter staff after they demonstrated their commitment to goals by doing some of the footwork:

(a) The case managers are always there to help. When I first got here, they showed me how to take baby steps and gave me everything. As time went on, they expected more and more of me. Funny thing, the more I did, the more they wanted to help. They are really supportive of those that try their best. They helped me to see how many things I could use for help.

(b) Today I am truly doing something and the staff knows that I am, and they tell me. And that's a difference of being in a shelter when you're working on something and being in the shelter when you just want to attend the program and get by... and that' s how I used to be back in the day, just in and out, in and out. That's why they got so many rules now because I understand that now, too... you can't be here forever, so you got to make something happen.

(c) They worked with me. They sent me to different places. They recommended me to different places for jobs, housing. And they were behind me because they saw that what I said I was following up on. I was working the program.

Mothers and Children

Women recounted their experiences of being mothers while in the shelter with varying degrees of sadness, hope, and even detachment. All wished to remain acknowledged as their children's mothers, despite past mistakes. Taking responsibility as a parent was not easy for many mothers who struggled with their own personal struggles of addiction recovery, history of domestic violence, depression, and/or court involvement.

Focus on myself. Although most women wished to be reunited with their children, many expressed the need for time to work on personal issues so they would be better prepared for parenting responsibilities. Some women said that this was the first time they had the opportunity to consider their own needs; others feared reuniting with their children prematurely only to lose them again if they weren't ready:

> I knew that I needed to get my act together. How could I possibly be a good mother to my children if I didn't take care of my own business first?

Worries. Women who did not have their children with them at the time of their shelter stay regretted that their children were in the care of others. Some women who reported histories of childhood abuse had very specific concerns about their children's vulnerabilities because they could not protect them.

> (a) Because... they think that part of some of my son's problems is from seeing a rape and from other things he experienced before coming here. Children from this shelter have been abused, molested or beaten themselves, or seen drugs. They can be so messed up when they come in and then they play with other kids who may not be messed up... their issues combine.

> (b) I'm scared, not for me, but for them because I'm not with them and I don't want them to go through what I went through at their age. They're with my mom, and she's doing the same things to them that she did to me -- that's poisoning their minds, except she poisoned my mind about my father, just [by being] negative. Now she is saying [to the kids], "Oh, your mom's sick. You won't be able to be with your mom until you're 18 years old"... and she hurts me when she does that, [but] she doesn't realize she's hurting them the most. I just got to give it to God every day. I can't worry about that all the time, it'll drive me crazy. I need to stay focused on the child I am raising now. I will keep trying to get my other children back, never give up.

Parental rights. Termination of parental rights and adoption of their children by others were consequences to be avoided, as one woman states:

> A lot of women have already lost their kids because of CPS involvement...I've seen what it's done to them because a lot of them go back out on the street--they don't care anymore. And they've got that pain now and that blows your recovery, and I've seen that happen to a lot of women.

Visitation. Frequency of contact with children not living with the mothers varied significantly, ranging from daily phone calls or weekly visits to no contact

for several years. In the following example, a mother was able to keep regular contact with two of her older children while she was a shelter resident:

> I still have primary custody, but while I was in and out of prison and then pregnant with my youngest, my grandmother had to get temporary custody in order to get cash aid for my children. Now they live 10 minutes away in walking distance from my new place. I see them almost every day. I didn't lose contact. I just missed a lot of things-birthdays, Christmases. I carry a lot of guilt with that too, because it's a form of neglect... And since I've been home, they've been doing a lot better in school and I guess with them just knowing I'm here and I'm okay and not out in the streets helps them too. I am still not ready to have all my kids together just yet.

The mother in the following example described frustration at having to separate her family when she entered the shelter:

> This was one of the hardest things I have ever done. I had to get clean and I needed help. I wasn't happy that I had to leave my son with my mom for two years. They wouldn't allow him to stay with me [at the shelter] or even visit on the weekends because he was over 12. I know my kids are big, but this was really frustrating. I worked hard to get on my own so I could have my family back together. We have a very good relationship because... ! would just call and say, "I'm coming over" and we would have quality time together. I know that it hurt him that he couldn't be with his other brothers and me during that time.

This mother, whose parental rights were terminated, spoke of what she learned too late, at a high personal cost:

> I had been living with my son at my mom and dad's on and off, still using drugs. I decided to get clean and sober but I had to go away. I went to stay with my aunt and then came back clean. It was good for a while-I started using and selling again. I had to do three days in jail and when I came out, they had temporary guardianship of my son. It went downhill from there. I was out of control. I even tried to kidnap him for a day and they put out an amber alert on me. There were cops everywhere. I remember my son was just singing in the back seat during the chase. They ended up adopting him and I have no parental rights. They won't let me have him back, even though I've been clean and sober 2 years. They hardly let me see him. I want him to know his younger brother and that I am ready to take care of him now.

This mother's words are representative of the experience of many mothers

in the shelter:

> All of us in the shelter are moms. We share that common bond and we can all say at the end of the day, we really want what is best for our kids. I am blessed to have all my kids here with my but I can see the pain and frustration from some of the others that have had their kids removed by CPS and they are not sure if they will ever have them back, it is so sad that they have cleaned up and still may not get their little ones back.

Parenting in the shelter. Most all mothers described the difficulties of parenting in the shelter and the impact it had on their children:

(a) I wanted to get out of the shelter as soon as possible. I didn't have the problem with drugs and so to have my kids hear about other women talking about their past with drugs, sex and just bad stuff... it was not the kind of thing for kids to be exposed to. I asked them not to swear and talk about it in front of them, but sometimes we would just have to go in our room and tum on the TV.

(b) Everybody parents differently and this was a really hard time. One mother might let her kids do something that I know I don't want my kid doing. It was a struggle if all morns weren't on the same page. The kids were seeing all kinds of bad behavior-from other kids and morns too.

Reaching Goals

Taking responsibility meant actively working to accomplish the goals mutually established by case manager and client to ensure that "baby steps" would build confidence. Women identified factors that played a role in facilitatinggoal attainment. To find out women's views on challenges and how they used strategies, the following questions were asked: What were some of the skills or knowledge you needed in order to become independent? What kinds of things were helpful or not? What helped you to manage?

Most women reported one or more of the life skills classes discussed in the *taking the life skills* section was beneficial, but these were not the only source

of help. Women staying in recovery, remaining focused, and being patient were some of the key factors that facilitated goal attainment. Additionally, for some women, new support networks and spirituality were important components relied on during the difficult times as they implemented their newly developed coping strategies.

Consequences and Responsibilities

Several women detailed daily struggles to stay drug-free and to face negative consequences for past behaviors.

> I learned how to be an adult while I was at the shelter. I didn't know how to do anything for myself except get high and live for the moment. I had a new baby to take care of. They helped me grow up and taught me how to be responsible. There was a consequence for things not done. The rules and curfew were actually a blessing for me.

Another woman's motivation to keep working toward goals was reinforced when she contemplated the alternative:

> I knew I never wanted to go back. The drug is always there for the taking, I had come so far and all I had to do was look at my kids and my new life for me to stay strong and know that life was history.

Keep going, keep busy. For some, the greatest challenge was to stay consistent in their efforts. Many reported that keeping busy and getting encouragement from others helped. These women also had the ability to use "self talk" to keep their resolve.

a) There were days in the shelter that I didn't feel like I was ready to leave...! was scared. There were lots of times I wondered, “Can I handle this?" I knew I had to just keep a positive attitude every day. I’d tell myself, "Just go to work; as long as you go to work and don't use, you'll be able to handle that"... one day at a time. And it all worked out.

b) The hardest part was believing in myself. My case manager was awesome--she was always there. No matter what time of day, her door was always open and she encouraged me every step of the way. I still go back to see her. What helped me was the encouragement from others and me telling myself over and over, "You can do this."

One woman found strength in putting her energy into gaining knowledge about addiction from others in recovery:

> I incorporated that [negative] energy into positive energy. That's what happens in recovery... you learn how to use your strengths and assets that you used negatively in your active addiction for positive things. Nobody sits down and teaches that to you. You learn that by listening to people, sharing their experiences with it. You learn it by reading. They share their experiences not only in groups but also in writings; these are all by recovering addicts. That's why I liked this program-people that came and talked to us and some of the staff are recovering. They have been down the same road.

Patience. Most women felt that having patience to wait for desired results was the most difficult part of reaching goals. Women in recovery observed that as addicts, they were not used to delaying gratification; now they had to wait. Prayer, sharing with others, and reciting, "Just for today," the slogan used at NA meetings, were also cited as helpful in developing this skill:

(a) When I first arrived at the shelter, I thought this was going to be a wave of a magic wand...I thought once I graduated the program, I would do the work, come out, and life would just resume as normal. Somebody would give me the keys and say, "Here's your place." I just thought it would cure all the problems I had made...I thought it would have been resolved more or less overnight. I have learned so much, to be patient. Things work out for a reason.

(b) The thing that stands out most for me is "Just for today." That's all I have. That's all [that any] of us have, just for today because we're not promised tomorrow ... and yesterday was history. So just for today, that's what I focus on. Whatever I have to do to be a productive member of society, and just live my life without the use of drugs, just for today. And when they kept saying that [in NA], that' s what got me. If I could just make it through the day, I'll be all right. Then I make it through the day. I pray about it and then I wake up the next day and I

> just ask God, "Just for today." And that's how I go, even today, and I have been sober 15 months.

Relying on a higher power. As discussed in the context of the turning point, spirituality was cited by many women as instrumental in their efforts to change. It was also described as a key source of guidance and support during difficult times. In fact, relying on a "higher power" is a keystone in recovery as stated in steps two and three of the 12 Steps of ANNA (Appendix G).

- Step 2: (We) Came to believe that a Power greater than ourselves could restore us to sanity.
- Step 3: (We) Made a decision to turn our will and our lives over to the care of God *as we understand Him.*

Some women spoke of the spirituality class offered once a week:

> (a) I grew up religiously in the church and at times I forgot about Him. But I was using and needy and in pain, rather than with gratitude being thankful for Him and praising Him. But now I'm able to use Him in all things and I was reminded of that during my spirituality class. It was an optional class, but I made sure I went every week when I was there. It made all the difference to me.

> (b) My relationship with my higher power, meetings. Family recovery center is a blessing because I am working in recovery. So like I'm working and being in recovery. I can always talk about the needs for improvement but really, I just need to continue. I have a sponsor; I am working my steps. But just to balance is because especially with addicts, we can think everything is going fine, and the next thing we know we're like totally out of balance and it's way too deep to even get out of.

Prayer. A majority of the women felt that praying opened the door for healing and helped them to deal with hardship. Some reported using prayer to as a means to cope with the difficulties of their lives before they began their recovery. The ANNA program promotes the use of prayer to evaluate one's realistic

options and limitations in challenging situations. Traditionally, the "Serenity Prayer" is recited at the end of each meeting: "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference" (Sheehan & Owen, 1999, p. 278). These women spoke of the importance of prayer and its positive consequences:

> (a) But being here, there's something about this program that has captured my spirituality. This place is so spiritual here, Sister, it's the best. My mom was always telling me "Jesus, this and that"; it wasn't until this time around that I really got it. Prayer has been such a source of support and comfort to me. I pray all the time, every day, and it helps keep me on the right track.
>
> (b) Without prayer, I'd be nowhere. I'd be right back to the streets where I was, doing all the same things that I was doing... I just... I just really needed prayer and I really needed to let go of a lot of issues that I had and just give it to God or whoever you have... So that's what I did, I just finally let go and let God and things are falling in place, day by day. I still take it sometimes minute by minute, even today. I'm just being blessed, one day after another... So, now I realize [you have to] to watch what you pray and you're not always going to get your prayers answered when you want them, but they will always be answered.

Several of the women meet at a local church on Saturday nights and one shared:

> It is so awesome to go to a church specifically designed for people in recovery. There is no judgment. Everyone there has been down the same road. It is great to stay in contact with past roommates from the shelter and keep each other going. It is just another avenue to remind us how to stay in recovery.

In summary, as mothers took responsibility for carrying out necessary activities for their recoveries, work schedules, or parenting roles, they defined goals and implemented plans to achieve them. Shelter staff and fellow residents offered new support networks and connections to additional services that

facilitated goal attainment. Adjusting to shelter life, learning to be patient, and using available resources were characteristic of the taking responsibility phase of transition.

One woman who bad lived on her own for a year briefly recapped her steps through the program:

> After I bad my initial intake interview and was accepted to the program, I was ready to work it. I stayed at the shelter. I didn't want to expose my children to living there but I had no choice, I did what I had to. I did what was required of me and I did the program while I was there. I volunteered while I was there. I did everything that was required of me. I worked the program and was proud of it. I made Resident of the Month and can remember the day I graduated. It was one of the best days of my life.

Taking the Life Skills

The *consequences* of creating a better life included *taking the life skills.* During the last phase of shelter stay, mothers took on more responsibilities and experienced positive rewards and results. The final phase of transition was marked by changes in the women's beliefs in their abilities to meet goals and maintain control over their lives. Several of them stated that implementing the life skills learned during their shelter stay helped to create a "new me." They communicated both internal and external changes that proved essential as they moved forward to stable housing.

Life skills. When asked to consider their futures, mothers expressed wishes to take what they bad learned with them. They extended the meaning of skills to include "living life on life's terms"--a definition learned in AA/NA classes, which extends beyond the scope of drug or alcohol addiction. The following examples contain mothers' references to life skills:

(a) The only thing I continue to do is keep using the skills that I got from the shelter, take one day at a time, and ask for help when I need it. That is one thing you never forget, you can come here to get help.

(b) Just knowing that I don't have to use (drugs) and having other skills to help, learning a new way to cope with addiction. It's wonderful for me. I have solutions today that I never knew before. Before I didn't know the way out. I didn't know which way to tum. I have a choice-free, happy life today, and by me continuing to do those things daily... I know I will continue to succeed.

These examples contain explanations of tools and specific activities that helped women maintain recovery and stable housing:

(a) My skills that I learned from the program were the basics--but I needed to work them, and I still do. I go to meetings, call my sponsor, and have a home group. I am still involved with the shelter--but I use the tools every day.

(b) The skills the program taught me were a lot about myself. Teaching me to be open-minded, how to ask for help, how to talk with other people, how to be trusting, how to save my money. It was about teaching me the importance of meetings--not just going to meetings but participating and listening. Also how to work the program by getting a sponsor and reading the books. It was really incredible. They helped me start a new life without drugs; [they taught me] how to shop, cook, keep myself up, really how to care for myself and my kids.

This mother spoke of taking knowledge she learned from life skills classes and her relationships with others at the shelter:

I think each person at the shelter had something to offer, if you can just take one piece with you and then use it later, when you are ready. Some of the things I've learned because there is a budgeting class, my parenting classes...things like that I took with me and have helped me now that I am on my own. So all I can do is take what I did wrong in the past and learn something from it and try over, which is what I am doing now.

Many felt that the exercises of following a structured routine while in the shelter served them well when they left the shelter:

(a) When I left the shelter, I knew the rules. I had to stick with a

plan.

(b) Well, now that I have a place of my own I keep to a routine. Every day is pretty much the same with my structure. I never had that before when I was on drugs. Now my kids know exactly what to expect. We have all our meals together. They get to school on time, they know I will be here to help them with homework when they come home. The biggest problem I have is keeping up with all the laundry. But really, the structure of the program helped me to be better prepared to handle this on my own.

The "New Me"

The following examples contain mothers' direct references to beliefs about newfound capacities to reach goals and to experience the ensuing rewards:

(a) I can see the picture now because I'm not using and as long as I stay clean, keep my head together, I know I won't ever go back there.

(b) It seems that with me, the most important thing was just believing in myself because even today when I have days of when I am really believing in myself, I can do anything. I get so much done. I can do so much with myself, my kids, and my recovery. I am a productive part of society now. I have confidence when I talk to people; I have so much more to say now.

(c) Today it's about taking risks, because I don't know what to do and it's ok about not knowing everything. It' s like I'm getting in touch with the fact that I'm human, which is like this great reward that it's ok to be human because I thought I either had to be super-human or that I was a sub-human. And this balance has given me the opportunity to just go ahead and believe that I can accomplish what I set out to do. The rewards of this risk have been reuniting with my kids and family, acceptance in society, recognition, Bible friends that I'm running to, and a hope shot for those that are still in addiction because I was, like I said, homeless; my drug addiction left me homeless in the streets for many years.

Making changes. Women were asked about things that happened at the shelter that enabled them to become more independent and self-sufficient. In discussing how they had changed and what external things or personal insights

had made a difference, one mother recognized that the numerous changes in her daily routine, personal health, spirituality, and family relationships were essential:

> I exercise every day, even if it is for a short walk. I am aware of everything that goes into my body and for my kids too. Everything is so different, having a routine for everything so we stay on track. I have to do this with four kids so I don't slide back on the frustrating days. We go to aftercare meetings and church. It is like my whole family is different. Even my family treats me different. I see a bright future and I am happy where I am today...
>
> *[Interviewer: You mentioned a lot of things you said have changed, different things that are going on for you now in a spiritual sense. What are some of those things...?]*
>
> I feel great, I feel wonderful...It's just great waking up, being able to not feel sick, being able to *do,* knowing that I have somewhere to go that's positive, knowing that I am liked and accepted for the real me. I don't have fear of being honest. I also have faith and trust and belief in God. Aslong as I am honest, open, and willing, He'll take care of me...and doing the right things, blessings just come.

Some of the women reported changes in the way they viewed others going through difficult times. They now knew they were not alone:

> (a) I'm more mindful of other people's feelings, and my self-esteem has gotten better. The hopelessness has subsided a great deal. It comes and goes but for the most part, I know that I'm not alone and there is help, something I didn't know for so many years. And if I had known this, I believe I wouldn't have stayed in relationships that were abusive. I was scared and confused, had nowhere to go, nowhere to run, so I felt, "What the heck?"
>
> (b) Right now I think I'm a little more compassionate towards people.... I just never realized how bad it is for people and so I do thinktwice about judging because I surely would not want to walk in nine out of ten of their shoes. I know what I went through to be living on my own now, it is like a dream. I couldn't imagine what some of the others had to go through.

Many women named specific beneficial changes in family relationships and personal growth that resulted from staying drug-free and recognized that these changes were ongoing processes:

> (a) I could see myself changing in the process of my recovery, and my children noticed it too. I still work the program to the best of my abilities. I am able to go to school now--I am working on a vocational program so I can be a massage therapist. I've got 13 months clean, going on 14, and I love it. I'm healthy, cleaner, there's a glow in myself [sic].
>
> (b) I've seen so many changes in myself. I am a completely different mom. I am clean and sober with my kids; it is different, for me and for them. It was such a long time since I had been clean around them. They were so used to me acting a certain way because I would be high or even coming down off a high or just too tired just to deal with them. And they have this new mom, and it was a change... I had to change for the better and I had to act and talk different ways...in the beginning it was hard....but I knew it would be all right, though.

Dealing with feelings. Many women articulated beliefs that suppressed feelings of pain and sorrow had compelled them to abuse drugs or alcohol. Identification of feelings, potential triggers, and better coping strategies was necessary so they could learn to exert more control over their lives. This is the process NN/AA calls "to live life on life's terms" (Diamond, 2000). They were encouraged to express and learn about their feelings from other women at the shelter, in NN/AA meetings, from shelter staff, and mental health personnel.

These women detailed the difficult experience of being drug-free and learning how to live with feelings:

> In the beginning, I knew I was going to feel a lot of things. I had to learn how to identify what I was feeling and put a label on it because every time I would feel either hurt, angry, happy, sad, joyous, whatever the occasion was, I always said, "Oh what the hell, I am going to celebrate by getting high, use drugs." And now that I'm not using, I had to deal with those feelings; it was scary, not knowing where they were coming from. I

> remember them telling me, "Just slow down,"--think about what may have brought the feeling on, think the feeling through, it's not going to kill you to feel it, and if you don't get high, you'll just keep continuing, it'll go away. And two years later, I can still remember those early feelings.

For many women, NN/AA meetings were a source of information support, and suggestions about dealing with feelings. One woman explained it in this way:

> They teach you in N/A addiction is a disease of feelings. See, I drank and did drugs not to feel certain things, and that I was trying to hide. So now instead of picking up the drink or the drug, you go to a meeting and share about it, and it helps with the urge to hide everything with the drug. Everyone takes a turn and shares their stories, [and] even if I never had the same experience, they can share how they got through it and that is the process of recovery.

During an individual therapy visit, a psychologist helped normalize one mother's need to experience sadness associated with a personal loss:

> It depends on how bad of a day or how good of a day it is... If I'm having a really bad day, I'm very emotional. I've always been an emotional person, and I'll sit there and cry...The psychologist says that's a part of healing, too. I never realized my feelings were normal. I thought something was wrong with me. It was so good to have the doctor tell me my feelings were normal.

Two more women revealed their methods of managing their feelings--one through participation in art therapy, and another through the process of journaling:

> (a) I couldn't believe how great it was to have a couple hours of the day to color, paint, and create something. It helped release a lot of feelings; there was so much inside waiting to come out. It was very therapeutic. I can' t even draw and I made a beautiful card and felt so good about it. It took me back to happier days when I was in elementary school.
>
> (b) I loved writing in my journal; in fact, just the other day, I picked it upand was amazed at how far I had come in the past 18 months. It wasmy quiet time in my room, and my own way to get my emotions in check. I was able to let go of a lot of my past through writing.

New Support Networks

Opportunities to build relationships were fostered by a safe and hopeful environment. Women felt that affirmation from others played a critical role in their abilities to take responsibilities for their behaviors. They cited several avenues of new support.

Receiving from others. Many women felt immediately supported while in the shelter because of positive interactions with staff and other residents:

> (a) Almost each and every person in here helped me in one way or another... whether they know it or not. Some of the staff, some of the girls that I lived with, I got a little bit out of everybody. My relationship with my case manager was the best, though. I couldn't have made it through the program without her support.
>
> (b) By just talking with people here...they've also gone through things like I had, so it's a support for me. At one point, I just broke down and cried, and I never cried in front of these people before and it just seemed like everybody came and was really helpful and supportive.

One woman felt that change was possible because she now lived in a place and time where she felt respected:

> I was able to become a different person here. I was always getting my point across by being intimidating and nasty--in your face a lot. Just because I was so insecure about everything. Now, I am such a different person. I feel respected and know that when I have something to say, I can just say it: I respect myself.

Finding love, forming bonds. In addition to forming positive relationships with shelter staff and other residents, many women were impressed by the welcoming atmosphere in the AA/NA and domestic violence meetings. "In the rooms" was an expression used to describe meetings where anything could be

spoken and confidentiality was paramount. For the following women, bonds formed at this time gave them a sense of family never before experienced:

(a) I have a new family and it is... the people in the rooms, the people in the shelter, because when I came here, they showed me more love and loyalty than my own family had all my life.

(b) It's the compassion that I received while in the shelter. I was always looking for some unconditional love. And when I came to the shelter, that's what I received. And that gave me a lot of hope. That made me feel like a person. It made me feel like I'm somebody as opposed to getting kicked around or called out [of] my name.

(c) I met some really good women there; I work with one of my friends from there. We got a job at the same place-we ride to work together. We are like family to each other.

Learning to trust. As survivors of abuse, street life traumas, and child or adulthood betrayals, many women described a diminished ability to trust when they came to the shelter. However, they explained how over time trust building was essential to making necessary changes:

(a) Attempts to do it myself, not realizing that this is something that's virtually impossible to do on your own... I even tried seeing a therapist and going to church a short time. When I finally got here, I was hopeless and had such a poor self-esteem. I was desperate to find something that would work that I became very open minded, very willing to try whatever was suggested, which meant going against everything I knew; it meant trusting. I had a whole lot of trust issues.

(b) It was kind of scary for someone [like my case manager] to give me unconditional love without me thinking they wanted something in return from me. What if they had a hidden agenda of their own? That trust was a process. It's still an ongoing process.

Sharing stories. Women used the term "my story" to label their previous life histories before arriving at the shelter. In the following examples, women related how they found strength and unity in sharing their stories in NN/AA or domestic violence meetings or informally among each other while at the shelter:

(a) The program of recovery reinforced my hope by the stories that we share with one another of the accomplishments, of the survival of pain, of just surviving life on life's terms. It also taught me the process of doing that and what that's like to let somebody know where you're at.

(b) We all have a problem, and we're all here for something, so I know that even if my story may not be the same, I know I can say something that can probably help others. I feel comfortable with that.

(c) I'm not the only one in the situation that I'm in, and I think it's a good thing because meeting the other homeless women and battered women, our stories are different, but it's like we get this bond. We all got real close, and it's like the stories may be different but the things we went through are the same.

Shelter program classes. Many women were eager to share stories about the benefits obtained from the daily program classes that included real life instruction in parenting skills, communication techniques, anger management, role playing, nutrition, budgeting tips, health and safety tips, and much more:

(a) The best thing that I can say about the program were [sic] the life skills classes. They taught me everything. I became a responsible adult. The parenting classes were great. I can be a better mom because of it. I never knew how to write a check, [but now] I have a bank account and a savings.

(b) We used to role play. They taught me the right way to communicate. This was my sixth program. The other programs tried to force the program on to you; this was different. The anger management classes were so good for me.

(c) I had never been a mom before. I never had a mom as a role model. I was so scared with my new baby. They taught me the basics and then some. I am going to be the mom that I never had. I can really do this- and do it well.

Hope and Aspirations

Once mothers moved to independent housing, they shared how special it was to have their families together and be in homes of their own. Most of the

women were employed and had aspirations for creating better lives through continued employment, obtaining higher paying jobs, or furthering their education.

Mothers' hopes about future relationships with their children included their acknowledgement of a necessary adjustment period and realistic concerns about home maintenance once they were on their own.

One roof Having their children "under one roof and in their own place" was mentioned several times as a successful outcome:

> It was so much better because we were all together in our own place. We didn't have to be living in one bedroom like at the shelter. It was great to have a roof over our heads there, but it was never our own place. It is so great now to go tuck them into their beds in their own room. We just have our own space. Not a lot of furniture, but what we have is ours. My kids fight a lot less because there are no other kids in the shelter to deal with and they listen to me so much better.

One mother, having served jail time and given up four of her other children, looked forward to parenting responsibilities with her fifth child:

> I had to get clean and stay healthy for him, I couldn't do this to another child. I figured I would have to manage my bills and keep my job, whether I like it or not. I can't depend on public assistance because of my prior legal issues. So I will have to do all the right things and keep my house maintained and take care of my little guy-he deserves it.

Another added:

> What I'm seeing for my future is that I'm actually taking care of my child myself and watching him grow up. I'm actually going to be the one who teaches him how to do all the first things.

Many mothers expressed the hope that they could help prevent their children from experiencing some of the negative consequences they had because of addiction, abuse, or unlawful acts.

> My hope for my children is that they won't really be affected too much by what I did to them. That they can just go on with their lives and fulfill their dreams. And I definitely don't want them to ever use drugs, and I told them that before. "You see what mommy is going through? It's just not the way." You know, they're still young, and they're never going to forget it, but hopefully they'll learn from it--a big experience.

Education. Almost every woman felt that education was important for herself and for her children's futures:

> (a) I'm going to school now and if that means only taking two classes a semester, so be it. It lessens my financial aid but that's okay 'cause I am figuring myself out. I have a great job that I just love but I know that an education will give me a better future.
>
> (b) I need to be a role model for my kids now. I need to show them the value of an education and that if I can do it, they can too. It can be hard but in the end, I know this will provide for my dreams. I want the American dream, a house, white picket fence, and a dog or two.

Staying on Track after the Shelter

Although those women resolved to live independently, the following examples present several concerns they shared about possible obstacles:

Relapse. A realistic concern was whether mothers could maintain their drug-free lifestyles after they left the shelter's supportive, structured environment:

> I was so scared to live on my own because of the potential for relapse. At the shelter, we were surrounded by other women unless we were in our rooms. Who's to say, that maybe after a bad day at work or hassling with the kids, I won't want to have a drink or use crystal again. It is good to have recovering addicts as neighbors. That is why I chose sober living apartments.

Staying in therapy. Several women felt that they needed to continue individual therapy on an outpatient basis so that they would remain stable:

> There is the issue of me, like, keeping everything in. But I know I'll have to just keep in therapy, you know, and be honest with her because I was in therapy before and I just didn't talk about it. And just keep my supports that I found at the shelter and just keep talking.

New support. After leaving the structured living atmosphere in the shelter, loneliness was foreseen as a possible problem by one mother:

> It used to be that when I was having a bad day, I would come back to our home and always have a roommate around to talk to. I was a little worried that I would be lonely after I was on my own, that I would have a crisis and be all alone. My case manager reminded me to pick up the phone and call when I got into a situation. I was lonely at first but then, after a time, the quiet was kind of nice.

Another mother had a new supportive network:

> I have new friends at church, made a couple of friends at my job and they are all really good people. I was a little worried about being friends with someone who didn't know about addiction, but they have really accepted me and constantly tell me how great I am doing.

Returning to old ways. This woman explained that she would need to be mindful of her financial situation:

> If I'm running short on one bill, will I be humble enough to call the bill collector and say, 'well, I'm gonna be a little late...?' Living in the shelter has helped me to learn what things I really need for myself and the kids. We don't have to buy the latest and greatest things. I shop at the thrift store now and know what my money situation is like now.

Being normal. Some women considered street life to be a culture without the rules and structure they now wished to adhere to. Previous examples of lawlessness were behind them as they expressed a sincere desire to return to normal and live within mainstream society.

(a) I hope to be clean for years now. I never want to worry about

my kids. I want to get a better paying job and get off welfare so I can be responsible, a member of society.

(b) For the first time in almost 15 years, I am not on probation. I don't have to check in with my parole officer. I still feel funny sometimes; I mean I don't even jaywalk, I am such a law abiding citizen...like other people in society.

Many women felt that homeless addicts were unfairly judged as worthless by the society that they wished to join. But one woman made the distinction between those who are trying to change and those who are not:

> You know some people were at the shelter because they just didn't care. They might have put themselves in situations like me. I put myself in a situation, but I did something about it. You know, that ' s where society comes in and they try to judge you. Everybody is not the same. Some people come to the shelter and were just using the system for a place to stay so they could save money or have a secure roof over their heads but they never wanted to work the program--there are even people who were at this shelter more than once. I wanted to do this right. I wanted to work the program and change, be a different person. I was ready. There are other people who work on things too but society doesn't see that. They just think when someone is homeless, "Oh it's just a drug addict; just somebody who doesn't want to pay their bills." They just don't know. The fact that you worked the program and are different now is what people need to see.

To live "normally" was often mentioned as a wish for the future.

> A normal life for me would be to have a good job, have a car, maybe own a house someday, and have the white picket fence. I am not looking for anything fancy.

Giving back. When women entered the shelter, they often came in desperation, depleted physically and emotionally. Almost every woman expressed the wish to help others, especially other homeless mothers, after they left the shelter. These examples reveal the women's transformation from thinking that they had nothing to having hopes for the future:

(a) I'm very much involved in service and support. That's why I'm

doing this interview. I know I can help other women just like myself. It is never too late. I want to let them know that they can recover from drug addiction and domestic violence and another part of my life will be giving back what I've so graciously gained, which is the knowledge that I can recover. I'll be volunteering and working with people in homeless situations. I can do my best work there.

(b) And now I have a new dream, having been in the shelter with all the women and seeing what everyone is going through-this is where I can help. I will always give back to the shelter that helped me, in one way or another. I still come back on the weekends and take other kids to the park--1 remember.

(c) Living in the shelter was such a humbling experience for me. It is good to remember someone always has it worse off than I do. For such a long time, it was all about me. Not anymore. It feels so good to give. I am a new person.

Future Service Needs and Advice for Homeless Mothers

At the end of the interviews, mothers were asked whether they would like to add any additional information or share advice for other women in their position. So many described the benefit of coming to a program and realizing there is help available:

(a) [If I could advise anything,] It would be to come to a program where you got support, where you had people that cared about you, where you know that you got a future for yourself.

(b) You might think, "God, my life can't get any worse." But you know what? It can. And unless you make the effort to make it get better, it's gonna. You're either gonna stand still or it's gonna get worse. You have the power to change your world and make your life better, and it's not gonna happen if you are sitting on your butt. You have a goal. It is not coming to you. You have to do it. Like you're in a black hole, get yourself out of it. Use resources but get out of it.

(c) You don't have to be homeless. There's always a choice. A lot of women had it way worse than I did. There's always places they can go. They just have to be willing to give up drugs and give up what they are going through and let someone help. I think going to a program is the best thing that's ever happened to me.

> (d) Don't do drugs, yeah. I wouldn't do drugs. I would have priorities. What's most important, your kids or not? Drugs make you think everything's the best and it's not. Everything else is crumbling behind you, [and] things may be pretty in front of you while you are high, but behind you is nothing but destruction.

Several described the need for more services, not for themselves, but for the children:

> The morns get everything. The kids don't get as much and they really need more. The focus is all about the morns and their recovery--they go through hours of classes during the day and then the kids live all together under one roof... at one point there were thirteen kids in one house, So I think that more needs to be done special for the kids. They need to get out, have fun, go to the park and some really need a lot of counseling...what their morns have dragged them through is already impacting them.

By continuing daily to live drug-free, following rules, and working the shelter program, mothers practiced and gained confidence in valuable life skills they had acquired. Characteristics of this phase included the mothers' preparations to complete the transition from shelter to stable home and family, and evidence of beliefs in their abilities to live and be worthy of healthier, more positive lifestyles. They also foresaw difficulties in the future and could identify specific strategies and resources to help with these challenges.

Most important, mothers who were now confident in their new abilities could articulate the process of how they had changed. They wanted to help others and be productive members of society. One of the women summarized it well:

> It is amazing how a person can change from someone who thought she was useless, with nothing to offer, and become someone who now realizes she has so much and wants to give back to others.

Health Consequences

Women were asked to share any health concerns and comment on how the shelter experience impacted their physical or mental health needs. Self-reported findings were not confirmed.

Information regarding health status revealed that 24 participants (83%) were on Medi-Cal, 4 (14%) had private pay insurance, and one woman had no insurance. Most women (62%) reported that they obtained annual physical exams. When asked about health problems, 18 (62%) reported depression-related issues and 11 (38%) were on medication. Other health issues revealed asthma, arthritis, back injury, diabetes type II, gynecological issues, hypertension, obesity, and pregnancy (see Table 4).

Table 4

Health Information after Shelter Program

N=29

Current Health Information	Number	Percentage
Health Insurance (n, %)		
Medi-cal	24	83%
Private	4	14%
None		3%
*Annual health exam (n, %)		
w/ primary care provider	18	62%
*Mental health (n, %)		
Depression / other	18	62%
On medication	11	38%
Other reported health concerns (n)		
some with > 1 concern		
Asthma	3	
Arthritis		
Back injury	2	
Diabetes Type II		
Gynecological issues	2	
Hypertension	2	
Obesity	3	
Pregnancy		

*self-reported

General Health

Overall, the women in this sample reported few physical ailments or diseases. None reported having hepatitis or HIV/AIDS. Self-reported concerns among these participants were addressed by a health care provider.

One participant shared her past exposure to street life and health concerns:

> Before I went to the shelter, my health was really bad, um, hanging out with real homeless people, living off dirty conditions...just for the high. I've had two STDs in my life because of being with dirty people. I am so lucky I didn't get anything else. Now, I take real good care of myself and one thing that still makes me happy is a good hot shower.

One older participant shares her difficulty with diabetes and obesity:

> I was doing, shooting up, and I just didn't want no more--heroin and crystal. I told my sister, please stick by me. I'm a diabetic and I have high blood pressure and that other stuff, so my health was a huge concern when I was coming off drugs. They were giving me stuff but finally, I had to go to the hospital for three days. I thought the hospital experience was going smoothly, but from what I've been told, I was a hell raiser. So after that experience, I will never do drugs again. My health was really on the line. It still is and I have to see the doctor at least every month or so.

The shelter helped promote health and wellness for these participants:

(a) That's another thing about the shelter--they make you pay attention and find out what condition you are in regarding your health. Um, immediately they urge you to go and get a physical done for you as well as your children. We were all getting physicals. Then they also have you see a therapist to check your mental health.

(b) My health is really good actually, I'm ... I feel really good about myself. You know, I want to lose a couple of pounds of course and I really should exercise, but I have so much going on right now.

This mother shared her desire for preventative care:

> You gotta get yourself healthy, you know, so you can keep going. I go to the dentist regularly and have had lots of work done on my teeth and I get shuffled around on Medi-Cal. I don't even know who my doctor is now so I go to Planned Parenthood for my exams.

Mental Health

Mental health impacted most of the women in this study. As self-reported, concerns ranged from mild to severe depression, bipolar disorder, and schizophrenia. Several of the women discontinued medication once they were in

their own housing. Explanations for discontinuing medications varied. Some stated that they no longer needed it, others felt that they were inaccurately diagnosed with depression, and others didn't like "taking drugs of any kind."

This participant had a positive experience after diagnosis of depression:

> I went to the hospital because I thought I was really sick; I was vomiting all the time. The doctor came in and told me everything was fine with me. It was just my depression physically made me ill. So they wanted me to go to therapy and start on medication. I got on medication when I was at the shelter and I am a new person.

This woman discontinued her medication once she left the shelter:

> When I went to the shelter, they put me on meds for bipolar, for depression, for a bunch of stuff. I was on anti-depressants, anti-anxiety medicine, and I think it was for restlessness. So...but I eventually said, "Excuse me, I was already happier just being at the shelter" and wasn't sure if I needed the medication.
>
> *[Interviewer: OK, now that you are living on your own, are you on medication?]*
>
> No, I stopped taking all medication when I moved out. But I've been ok. I feel ok. I think it's not the medicine that I needed, it was the education I needed. I needed to learn more about what was wrong with me. And why I was doing the negative things I was doing. And I'm ok today; it has been 4 months, like I have ups and downs but they are manageable. As long as I'm ok and can handle the stress, I'm alright.

Other women had their versions of depression:

> (a) When I came to the shelter, I was never clinically seen for depression, [and] I wasn't diagnosed. I am one of those people that unless medication is a dire need, I won't do it. At this point when I look back at me being depressed--because I think I was--it was just a symptom of my living environment. I don't ever see myself getting that depressed again. 'Cause I am happy with who I am right now. I'm so like, 'Tm gonna do this and beat it."
>
> (b) I had been diagnosed with clinical depression all my life and um, I wasn't taking my medication and they [shelter] got me put back on my medication... so I got real stable. When I was using drugs, I never liked

> to mix crystal meth and antidepressants so I would take antidepressants off and on.

One participant summarized her shelter experience and health:

> I guess you can say that they [shelter] just helped me build healthy relationships with myself and others. They allowed me to be a healthy person in all areas.

Core Dimension: Creating a Better Life

The core dimension that is central to the integration of the experiences of these mothers is that of "creating a better life." Although participants had their own personal journeys at the time of shelter entry, they all had goals of changing their lives. In this study, mothers expressed their desires to live differently, without drugs and violence or other destructive behaviors. The core dimension of creating a better life is appropriate because it speaks to their desire to make the transition from one of homelessness, substance addiction, and/or domestic violence toward a better life. The core dimension in relation to theory development is discussed in the next chapter.

Several mothers who described their appreciation for shelter life referenced this core dimension:

> (a) Because I got what I needed, they taught me ... they gave me the time to look within myself, to deal with what I needed to deal with to make a better life. Not that it was done right away, but the beginning part of it all was there. Then I was in a position to be better equipped.
>
> (b) My husband was still partying the whole time and, um, I told him he needed to go to a program, you know, and I just never stood my ground. Never stood my ground until now. I knew I needed help because like on my own I didn't know how to stay clean. And like this time, I was really done. Like, I just didn't want to do it anymore...! wanted a better life. So I called the shelter and they accepted me.

Another added:

Thank God I've never been CPS involved, so my kids have always been with me. I realized I needed a safe environment. I was ready for a different life; I was tired of living the life I was in.

CHAPTERS

Discussion

This study addressed the following research questions: (1) What is the process of homeless women's transitions from living in a shelter to establishing stable housing? (2) What factors impact the transition process? (3) What knowledge, skills, or supports are perceived to be important during this process? (4) What are women's physical and psychosocial health needs and concerns whilein the shelter and once independently housed?

Transition Process

The transitions experienced by women and their children from homelessness to sheltered living and independent, stable housing were shaped by individual "take charge" efforts in which major lifestyle changes occurred. Changes were identified in the areas of physical and mental health, self-concept, social connectedness, and goal achievement. Several phases of the process were identified: the *turning point, reality check, taking responsibility,* and *taking the life skills.*

The transition process varied in duration (from 6 months to 2 years) and course for each woman in this study, and was dependent on each woman's

personal goals. In addition to finding housing, other goals included finding employment, completing a high school education, job training or furthering education, and completing court-mandated programs for drug rehabilitation, child custody, or other legal matters.

Phases of transition were not limited by definitive beginning or end points, but overlapped during the process of becoming stably housed. During the *turning point* phase, all women described living in situations with at least one (often several) stressful, harmful events such as drug addiction, domestic abuse, depression, or hopelessness. During the *reality check* phase, the mothers evaluated and contemplated alternatives to lifestyles no longer considered desirable or manageable.

As their decisions to enter the shelter were motivated by the wish to make major lifestyle changes, they were able to admit their problems and ask for help. In the subsequent *taking responsibility* phase, mothers took initiative to utilize the shelter program and appropriate resources. As they focused on necessary tasks to achieve their personal goals, they developed a new ability to control their lives.

Lastly, the *taking the life skills* phase was marked by gradual internal changes and the development of a "new me," which allowed women to view themselves as worthy, capable, and hopeful. With their many efforts to make lifestyle changes, work the shelter program and set and achieve goals, and the recognition of such accomplishments by roommates, shelter staff, and friends, the women were further encouraged to continually move forward. The integration of their new lives, maintained sobriety and routine, and connection with positive

support networks enabled the women to move from the shelter into stable housing.

Factors Impacting Phase Progression

Progress through each of the four phases of the transition process was significantly impacted by various social factors and connection to social networks, all discussed below.

Factors Impacting the Turning Point Phase

Substance abuse. In twenty-four cases, women expressed significant problems associated with substance abuse for several months to many years before their shelter stay. They also reported multiple efforts to stay clean and sober resulted in relapses.

Living on the street. Descriptions of street life included stories of daily risk taking, including threats of physical harm, vulnerability to sexually transmitted diseases, and arrests for theft or drugs. Several women were incarcerated repeatedly as a direct result of illegal activities.

Mental health. In some cases, mothers had depressive symptoms that went untreated for many months--or they elected to stop prescribed medication. These symptoms interfered with their ability to work, maintain relationships, and care for their children.

Isolation. Women frequently shared that they felt alone while using drugs, and thus they tended to stick to themselves. Some felt shunned by their families and believed no one cared about them or could help. Varying degrees of worthlessness and hopelessness were reported at some time by all of the women.

Separation from children. Many of the women lost parental rights to their children through adoption, other family members, or CPS involvement. For some, contact with their children before recovery or shelter was sporadic. Mothers frequently discussed guilt over children who were left alone or in the care of others while mothers were preoccupied with their addictions.

Factors Impacting the Reality Check Phase

During this phase, women acknowledged that previous lifestyle choices had resulted in disappointment and desperation. Most were unemployed and homeless. After deliberation of possible avenues for change, and sometimes with no other option available to them, the mothers in this study decided to enter the shelter.

Critical events. For many of the women, significant events such as severe domestic violence or homelessness were described as hitting rock bottom or experiencing wake-up calls that impacted their decisions to seek help.

Recovery. Women came to the shelter after their critical events for varied reasons. Many who were struggling to remain drug-free were not successful with their own attempts. Some, incarcerated before entering the shelter, found the prospect of leaving jail and returning to their previous lifestyle was not a viable solution. Two needed to escape unsafe neighborhoods and gang affiliation.

Fear of losing children/wanting them back. Women understood ramifications that their negative lifestyles had on their children, and most feared losing their children to CPS. All wished to stay drug-free and away from violence

so they could keep their children with them but a few struggled to provide an atmosphere free of violence so that they could keep their children.

Desire to leave the street life. Women frequently reported being sick and tired of living on the street, doubled up with family or friends, or in and out of jail, and no longer wanted to live under those uncertain terms.

Encouragement by social links. Friends, family members, ministry contacts, or social service agencies (other shelters, prenatal clinics, CPS) encouraged mothers to get help for their problems. Some mothers were inspired by examples set by other women who had successfully completed this particular shelter program.

Factors Impacting the Taking Responsibility Phase

As women accepted their situations and resolved to take responsibility for making changes in their lives, they had to learn to trust those who offered help--a difficult task for some. Many of the women described a sense of readiness to make the changes required for shelter life, including adherence to structured routines, interacting with many personalities, and learning the good coping and communication skills that are advantageous in negotiating daily challenges of shelter life. For many women, spirituality was a resource for developing patience and shaping new internal values.

Acceptance and surrender. Keys to making lifestyle changes were honest assessment and acknowledgement of problems (e.g., drug addiction, depression, anger management, domestic violence, homelessness). Being able to ask for help and subsequently follow through on suggestions marked the beginning of change

for most. Behaviors such as staying clean, sharing stories at NN/AA meetings, and interacting well with staff and other shelter women led to rewards of improved health, increased self-confidence and praise from others, and positivelyinfluenced their motivation to continue healthier routines.

Taking charge, using resources. By taking responsibility for change, women became active in recovery programs, therapy, family visits, and job and housing applications. By following rules, carrying out assigned tasks, and participating in meetings, women signaled to shelter staff their commitment to change. In tum, staff provided them with more encouragement and counsel on an as-needed basis. Several women described this process as very supportive and helpful through the early process of their recovery.

Gradually, the need for support decreased as they became more confident and independent through participation in the recovery program and the daily life skills classes that moved them toward self-sufficiency. Taking advantage of shelter and community resources promoted the women's awareness of available supports such as legal help (homeless court), job training, and individual therapy.

Social support. Affirmation and a sense of belonging were important experiences facilitated by other women in the shelter, supportive shelter staff, and fellow addicts at NN/AA meetings. Women shared their stories and learned they were not alone.

Introspection. Having the courage to face painful or anxiety-provoking feelings was paramount to understanding addiction and depression. Women who utilized individual therapy, life skills classes, NN/AA meetings or conversations

with other women to work on these issues were better able to share healing insights they learned.

Meeting challenges. Learning how to be patient and avoid relapse were some of the difficulties for those in recovery. Some women relied on their spirituality to help with hard times, and others utilized journaling or shared their thoughts with others.

Factors Impacting the Taking the Life Skills Phase

In this phase, women experienced changes in their beliefs about themselves and their capabilities to control their own environments. The development of their "new me" allowed them to be confident in their ability to stay drug-free, maintain stable housing and/or secure employment, and improve family relationships. Women demonstrated their strengthened "new me" by describing long-term goals and visualizing goal attainment. Additionally, women shared a sense of optimism that replaced feelings of hopelessness as they gained confidence in their ability to live as productive members of society.

Individual steps to change. Women recognized the major changes they had made in self-esteem, beliefs, and expectations. They discussed how the gradual formation of trusting relationships with others in or related to the shelter helped them to make important changes, providing social support and important role models of healthier lifestyle choices. Women could also convey the specific steps to their achievement of these changes (e.g., developing insight, complying with rules, utilizing resources) and draw contrasts in how they now approached challenging tasks or anxiety-provoking events occurring in daily life. All

described some skills obtained during the shelter program that helped them feel better equipped to live independently and parent their children appropriately.

Life skills. Women described with confidence that the life skills acquired during their shelter stay had helped them make strides toward living independently. Frequently, they shared that they were never going back. Important skills associated with the knowledge of how to stay drug-free were budgeting personal finances, taking care of their health, and most importantly, knowing when and where to seek assistance. Some women kept the structure of daily shelter life in their new routines.

Foreseeing possible difficulties. All women could name potential obstacles to maintaining gains in recovery and independent housing, including the difficulty of staying drug-free, the tendency to feel isolated, and becoming careless in financial, housing, or parental responsibilities. Women described varying plans to tackle these obstacles, including confidence and a positive attitude.

Giving back. Shelter workers who were formerly homeless or others who volunteered at the shelter were powerful role models. Women hoped to help other homeless women once they established their own housing--and several did. For them, the opportunity to share their story and encouragement with others was a milestone of their accomplishment.

Factors Associated with the Leaving the Shelter

In this study, transitions were considered a success when the women were able to complete their primary goal of moving to independent housing, or when

they had stable housing connected with the shelter. Twenty-one of the women were living in their own apartments, six were in stable housing connected with the shelter, one mother lived with a roommate, and one mother was temporarily living with her father after graduating from the shelter.

In review of the transcripts, factors such as age, education level, previous incarcerations, length of time spent living on the street, and relapse history did not prevent the transition process with this particular sample of women. These were all successful graduates of the shelter program; however, this does not mean there were not obstacles encountered during the transition process related to the factors mentioned above such as education, previous incarceration, relapse history, etc. Some women reported difficulty finding housing, which meant they needed to stay at the shelter longer than they would have if housing were available. Some women applied for low-income housing and placed their names on rental lists at the onset of their shelter stay. Those who had histories of financial instability, bad credit, or multiple evictions had further difficulties, with the exception of one woman, all secured housing within the two-year allowable shelter stay.

One woman who remained connected to the shelter described her inability to work because of a child with severe ADHD and added difficulty because she was not eligible for TANF or Section 8 related to multiple prior felony convictions. Her application for SSI for her child was still pending. She was counting on that future income to provide her with a means to secure her own housing and stabilize her son so she could work.

Employment was not essential for all women to be independently housed. Some women were able to manage on TANF and/or food stamps, though their reported income and expenses left no margin for error. All women expressed concern for employment and/or better paying jobs, and the desire to "get off welfare" was shared by many. Several of the women had returned to school or were in vocational programs in an effort to increase their sources of income. Three had educational grants that enabled them to continue an education and meet their housing/financial needs.

Three women cited health issues as a barrier for employment. Pregnancy was a concern for one, who shared that she was "too far along" to get a job. One of the older participants stated she has never had a job and was too ashamed of her obesity to consider one at this time in her life. Another shared how a back injury rendered her unable to perform work of any kind.

Transportation was essential to women who were independently housed. Eighty-three percent of women in this sample owned a car. Those who did not have a car used public transportation, or if they were residing in transitional shelter housing, the shelter van provided minimal assistance.

Childcare and children with special needs required women to adjust to new circumstances once they left the shelter. They had the option to keep their children in the daycare provided by the shelter if they wished. Some women expressed difficulty with this if their new housing was not conveniently located to the daycare facility. Other women described the expense of daycare, but through special programs, some were placed on a sliding scale for the cost of daycare.

Children with special needs such as ADHD or severe disabilities were a major factor requiring women to utilize all resources and continue to stay connected to the shelter.

Common themes identified in the stories of a majority of women who experienced a more favorable transition included: (1) the perception of the shelter experience as saving them from destructive, possibly fatal, continued drug use or domestic violence; (2) an enthusiastic willingness to implement new strategies and work the program; (3) the motivation to identify and understand underlying causes of past harmful behaviors; (4) the recognition of the necessity for a new social network and support; (6) pride in accomplishing small and large goals; (7) utilization of available resources; and (8) identification with others who survived and overcame multiple traumas to become productive members of society.

Health Concerns and the Transition Process

The physical and psychosocial health concerns for women living in the shelter varied depending on the situation that necessitated shelter stay. Many of the women described the positive effects of living in the shelter related to current health status. Informational health classes were provided as part of the program structure that women were required to attend. Classes offered information on health and nutrition for mothers and children. Women were offered confidential bi-monthly *HN* screening done onsite. Case managers and program coordinators assisted women in obtaining health benefits through Medi-Cal as needed.

When women arrived at the shelter, some had not received medical care in quite some time because it had not been a priority. As one mother shared, the

shelter assisted with immediate physical exams for herself and her children in order that they be current with immunizations and be eligible for school.

Twenty-four women (62%) reported that they see a health care provider on an annual basis. Several stated health concerns such as asthma, depression, diabetes, hypertension, and obesity-related issues that necessitated regular follow-up with a health care provider.

The shelter provided valuable resources for women with mental health needs and part of the program included individual therapy at a local wellness center staffed with psychiatrists and psychologists. Eighteen (62%) of the women reported mental health issues, yet 38% had discontinued medication. This study did not address the issue of medication discontinuance or compliance.

An Explanation of Homeless Women's Transitions from Shelter to Stable Housing

The process of homeless women's transitions from shelter to independent housing is a complex integration of internal and external phenomena. There are no uniform steps for all transitions; each homeless woman has unique circumstances. However, as discussed in Chapter 4, the core motivator of *creatinga better life* explained most of the events in the transition process. Homeless women evaluated their situations, made decisions to change negative lifestyle behaviors, and made the necessary changes (internal and external) to accomplish the goal of creating a better life.

This goal informed the subsequent phases of the transition process: *turning point* (context), *reality check* (conditions), *taking responsibility* (processes/actions), and *taking the life skills* (consequences). Each of these phases

provides a conceptual framework for examining the interplay of conditions, strategies, and consequences during the complicated task of changing beliefs, behaviors, and surroundings. Additionally, each phase features significant events that contribute to women ' s abilities to make critical decisions, change long-term negative lifestyle behaviors, and remain committed to their new lives.

The context of creating a better life was defined in the *turning point* phase. Prior to making their decisions to create better lives, women were living in high-stress environments of poverty, domestic violence, homelessness, substance dependence, incarceration, physical and mental health instability, isolation from family, and for some, the loss or threat of loss of children. In these high-risk, unpredictable living conditions, women relied on themselves for survival.

In the *reality check* phase, women's dissatisfaction with their lifestyles led to an evaluation of their options by (1) considering alternative solutions, (2) acknowledging losses or negative consequences to current conditions (sometimes as a result of a crisis event), and (3) obtaining information from others. After deliberation, women either decided to try to change their situations or returned to previous conditions. Choosing to change prompted the decision to enter the shelter.

The key dimension of the *taking responsibility* phase is that women in the shelter accepted their need for help in order to change and they took on necessary responsibilities to be in control of the change. These steps included: (1) being open to following rules and suggestions, (2) building trusting relationships with those who could help, (3) feeling connected to others in the same situation, (4)

learning from role models, (5) gaining personal insights about themselves, (6) learning and implementing healthy coping strategies, (7) utilizing available resources, and (8) completing required tasks. When the women accepted their personal addictions, domestic violence or mental health issues, and the structured environment of the shelter, they were ready to take the necessary steps to make major life changes. If they were not ready to remain drug-free, get treatment, or follow the rules, they left the shelter and discontinued their transition.

The consequences of creating a better life included *taking the life skills* they learned in the shelter in order to move forward. As women took on added responsibilities, they experienced positive consequences that enhanced their sense of self. Equipped with confidence and skills, women slowly began to discover a "new me" as they (1) recognized important changes in themselves, (2) visualized and implemented plans for reaching realistic short- and long-term goals, (3) understood limitations or obstacles to goals, (4) continued to utilize resources and social networks for additional assistance, and (5) felt positively reinforced by continued efforts to maintain gains and pursue new goals. Women who recognized these activities as part of a long-term plan for maintaining gains in their recovery and within themselves were able to translate these skills into independent and stable living.

Summary: Steps to Creating a Better Life

The transition process was difficult, but all women voiced appreciation for some facets of the shelter experience. Although some of their success may be attributable to acquisition of more appropriate coping strategies (modeled by staff

and fellow shelter residents), the changes reported by these women were not only in visible outward actions but also in behavioral changes of self-concept. The women reported their shelter experience as one of personal growth and opportunity to implement positive changes in their daily routines. They committed to recovery from drug addiction, vowed to not return to abusive situations, and worked toward creating better lives for themselves and their children. They were able to adapt to shelter rules and regulations. They participated in routines and group activities and received support from shelter caseworkers and some of their peers. Some were surprised by the number of community resources available to them. As they continued to attend meetings, work the program, and stay sober, they described feeling stronger both physically and emotionally.

The women spoke of a gradual change as they were able to reflect on past patterns of behavior and thought. They were willing to try changes in many aspects of their lives (a skill they learned in the shelter): handling conflicts, parenting, keeping appointments, and being responsible. They felt that they gained more control over their lives, but at the same time, they expressed relianceon their spirituality during hard times. This was especially true during the early days of their shelter stay when they felt little self-worth and depended on others' words of encouragement.

Because they felt that a second chance had been granted to them, many were fearful of regressing to old ways of addiction and dependence on others. They described the achievement of small goals, followed by bigger

accomplishments: longer periods of sobriety, improved interpersonal relationships, progress in custody decisions and legal, financial, and housing issues, gaining employment, and achieving educational goals. A successful transition from shelter to independent housing marked these women's significant achievements on multiple levels. They developed a positive self-concept that, integrated with productive daily activities, allowed them to build new relationships with others in recovery, shelter staff, their families, and communities. They accepted help, followed suggestions, learned new strategies to face challenges, and accomplished their goals to "live normally." In summary, these women created better lives and acquired the life skills necessary to keep them moving forward in the right direction.

The Concept of Creating a Better Life and Existing Theoretical Models

The current substantive explanation for creating a better life relates to existing formal theories that examine processes of behavior change, trauma recovery, role identification, and trajectory. Several theoretical models that address some key aspects of the women's transitions are examined here.

Behavior changes. As findings from this study indicated, the majority of the women in this study reported substance abuse as a primary motivator for change; therefore, participation in recovery-related activities was essential during the transition phases for these women. The behavior changes exhibited by these women parallels the stages of change identified in the transtheoretical model (TIM). This familiar model has been well-known for its framework in understanding health related behavior change. Early work with this model focused

on a single target behavior (e.g. smoking). However, over the past 15 years, the TIM has been applied fairly extensively to readiness for substance abuse treatment (Prochaska, & Velicer, 1997). The model identifies (through stages) how individuals modify a problem behavior or acquire a positive behavior (Prochaska, DiClemente, & Norcross, 1994). The TIM**,** with its core constructs organized around stages of change include ordered categories along a continuum of motivational readiness to change a problem behavior.

The five stages of change are: precontemplation, contemplation, preparation, action, and maintenance. Prochaska and DiClemente (1992) found that process activity differed by stages and two different concepts are employed: these include behavior intention and duration of behavior. Before the target behavior change occurs, the cognitive or temporal dimension is conceptualized in terms of behavioral intention. This is evident during the precontemplation, contemplation, and preparation stages. Behavioral processes, conceptualized in terms of duration of behavior (over time) are valuable and intentional behaviors during the action and maintenance stages.

Similarly, in this study the major focus for women's efforts during the *turning point* and *reality check* phases was on evaluating and decision-making processes. During the last two phases, *taking responsibility* and *taking the life skills,* women concentrated on intentional actions--shelter rules, compliance, and remaining drug-free--that demonstrated their desire and efforts to change. A comparison of the five stages of change and the phases of transition for homeless women is highlighted in Table 5.

Table 5

Comparison Stages of Change: Transtheoretical Model (TTM) Prochaska, DiClemente & Norcross (1992) and Transition Phases of Homeless Women

Transtheoretical Model: Behavior Stage	Process Activities	Transition of Homeless Women
Precontemplation	Lack of awareness that life can be improved by a change in behavior.	Status Quo
Contemplation	Recognition of problem, consideration of change, information gathering about solutions/problems.	Turning Point
Preparation	Takes steps to change, a transition phase. Attitude and behavior signal readiness.Take action, set goals, commit to move forward.	Reality Check
Action	Implementation of practices needed for successful behavior change. Requires considerable commitment, time and energy.	Taking Responsibility
Maintenance	Sustain behavior change, prevent relapse and consolidate gains attained during action.	Taking the Life Skills

It is during the maintenance stage of the TIM that individuals work to prevent relapse and consolidate gains attained during action. For addictive behaviors, this stage extends from 6 months to 3 years or more past the initial action. Failing to reach sustained behavior change during the action phase and maintenance phase is not uncommon. This is known as the spiral model of the stages of change, which suggests that when an individual regresses to previous stages, he or she does not typically completely fall back to where they started. The

individual advances through the stages, making progress and losing ground, learning from mistakes over time and using those gains to move forward. As reported by the women in this study, recidivism rates of 2 or more shelter stays occurred in 69% and high rates of relapse were present in this sample of women prior to their current success in the maintenance phase.

While this model identifies behavior change through the five stages, it does not address or explain the processes of personal transformation (covert and overt) that one may use to progress through each phase.

Trauma and recovery. Judith Herman's (1997) model for working with trauma survivors has relevance to the emotional needs of homeless women who reported histories of multiple traumas. Dr. Herman suggests people who have endured horrible events suffer predictable psychological harm. There is a spectrum of traumatic disorders, ranging from a single overwhelming event to themore complicated effects of repeated and prolonged abuse. Because traumatic syndromes have basic features in common, the recovery process can also follow a common pathway.

In this sample, 79% of the women reported incidents of domestic violence, 40% suffered molestation or rape as a child, and 14% fled to the shelter to escape immediate danger. In hindsight, several women shared their drug abuse and desire to self-medicate for pain and suffering could be traced to childhood and/or adult traumatic experiences.

In Herman's model, recovery from trauma is based on the empowerment of the survivor and the creation of new connections. Recovery takes place within

the context of relationships; it cannot occur in isolation. The three stages of recovery: establishment of safety, remembrance and mourning, and reconnection within a social life, are processes that occur over time.

Herman maintains that recovery does not occur in a straightforward sequence but happens gradually as survivors perceive their new sense of safety, control, and social connection. The survivor's empowerment is gained through mutual support and individual autonomy, "where her experience is validated and her strengths are recognized and encouraged" (p. 134). This concept is similar to that of the 12-Step Program of Alcoholics Anonymous (Diamond, **2000),** which emphasizes confronting difficult feelings by self-examination and sharing with others. In this study, women initially needed to feel safe and affirmed by others in the shelter. With support, they gained insight about past events, acquired more positive lifestyle routines, and finally, as in the third stage of trauma recovery, became able to actively participate with their peers in the shelter.

Role identity. In Blumer's (1969) symbolic interaction theory, self-perception is shaped by others' reactions. Symbolic interaction with others is not random, but is influenced by one's expectations of how others will act (Charon, 2004). It is a process that accompanies all human interaction, all symbolic communication, almost all human cooperation, much of how we learn, and much of how we influence others (Charon, 1998).

Role taking, or imagining the world from another's perspective, spurs us to act; as we place ourselves in another's role and see the world from his or her own perspective, we learn how to become friends, when to flee, how to become

part of a group, how to act morally, how to win, how to understand, how to share, and how to communicate (Charon, 1998). This concept is particularly applicable to the transition process described by women in this study, who expressed a strong desire to change their self-perceptions as well as the judgments of others who viewed them as homeless or addicts. For the former substance abuser, this required disconnecting from past friends, activities, and other attributes that rendered them an addict and connecting to the new identity and lifestyle of a person in recovery. Conditions that supported this role change were having a new family of friends, sober connections, and affiliation with groups such as Narcotics Anonymous or religious organizations.

In order to establish a new role identity, women in this study did whatever they could to avoid relapse and a return to homelessness, including joining churches, attending job training, and going to events where they knew there would be others like them in recovery.

Trajectory Theory of Chronic Illness Management

A classic study by Corbin and Strauss (1989, 1991) carefully looked at experiences with chronic illness over a 30-year period. It evolved from both a series of research projects about chronic conditions and the practice of nurses, who brought to the classroom their experiences in the care of persons with different chronic illnesses. Through their work, a middle range nursing theory was proposed.

Trajectory, the key theoretical concept of their study, evolved from looking at a phenomenon of "management of an evolving and changing course

over time" (Corbin & Strauss, 1991; p. 156). Trajectory represented the physiological development and the work in managing chronic illness, the impact the illness has on their lives, and the changes that are required for both the clients and their families when living with their new situation. The trajectory framework implies that chronic illness has "a course that varies and changes over time" (Corbin & Strauss, 1991, p. 156). The concept of chronic illness trajectory includes notions of direction of the short- and long-term course, the relative stability, and the degree of uncertainty about the course of the condition. Within this framework are examples of the trajectory phases in parentheses compared with the trajectory of women moving out of homelessness in this study (see Figure 3).

The concept of trajectory is applicable to the women in this study for several reasons. First, addiction is a medical illness and develops in the same way as many other chronic illnesses. There is plenty of evidence between genetic components and addiction to drugs and alcohol. By analyzing patterns of inheritance, researchers have learned that heredity accounts for about half of the likelihood that a person will develop an addiction (Halpern, 2002). A person with some underlying genetic vulnerability is exposed to an environment that brings on the illness. In the case of these participant's stories, their substance addiction can be traced back to a myriad of stressful and troubling situations plus the availability of the addictive substance.

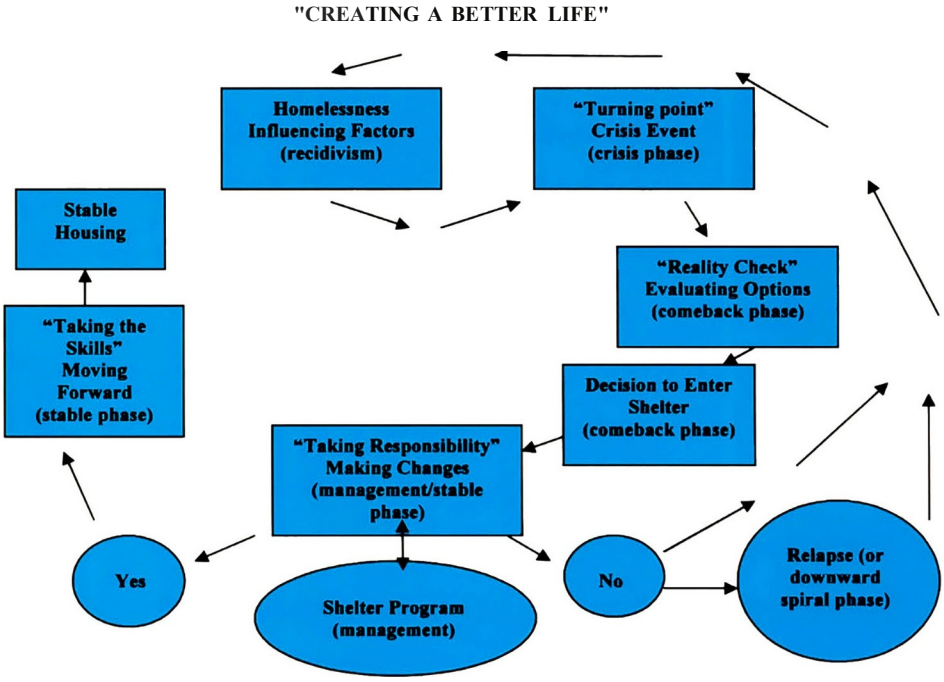

Figure 3. Proposed trajectory framework of creating a better life.

The stories of the women with addiction and homelessness described the process of a turning point similar to the *acute* phase or *crisis* phase in the trajectory framework. Within the Corbin-Strauss trajectory model, the crisis phase is a life-threatening event requiring immediate attention, and the acute phase is an active illness or complication requiring intervention for management. Similarly, prior to entering the shelter, many women experienced a turning point, where they described the addiction as controlling their lives or as a crisis event that necessitated immediate intervention. The phase of reality check for these women can be compared to the acute phase of the trajectory model where intervention is necessary.

Trajectory management shapes the illness process (Corbin & Strauss, 1991). Within the trajectory framework, the clients, their families, and health care providers all have a part in managing chronic illness and they all have different positions on how the illness should be managed. In this study, the women with addictions were able to work toward managing their sobriety. They shared many examples of utilizing supportive networks within the shelter to maintain a phase of stability. At the time of interviews, the women remained in the stable trajectory phase and related this to connections with sober, supportive networks such as NA/AA, church, friends, family, and shelter contacts.

In the cases of substance relapse and repeated episodes of homelessness, the Corbin & Strauss trajectory framework provides for this with its downward and comeback phases. Depending on the circumstances, both of these may applicable to this population at varying times of their lives. While women in this study were currently in the stable phase, they had prior histories of substance relapse and homeless recidivism that is compatible with a notion of trajectory for these types of chronic conditions.

Critique of the Study

A critique of the study is offered that focuses on both limitations and strengths of the study design and limitations.

Limitations

This study focused on a sample of women from one homeless women's shelter in a city in the Southwestern United States. Due to the limited geographic

area and sample size, the results may not be generalized to other areas and may not be representative of the experience of all homeless women.

The single interview design limited the amount of information that could be collected regarding long-term outcomes of housing and self-sufficiency after leaving the shelter. Even though the average length of time from shelter stay to participant interview was 13 months, this study did not provide for longitudinal comparisons.

Participants were admitted into the shelter after an intake interview with a case manager and after further review during a clinical team meeting. The only admission requirements this researcher was aware of were that women: be mothers and have children with them (12 years of age or under), be motivated to "work the program," maintain sobriety, and comply with shelter rules. It is not known if other restrictions were considered by shelter staff or if the women were triaged through the process.

Given the prescreening by the shelter's case managers, this sample of homeless women may have represented one segment of the population. In spite of this limitation, the heterogeneity of the homeless population suggests that knowledge about this segment of the population will add to our information about variability among homeless women.

The researcher elected to recruit only participants who had completed the program. The participants in this study were all "graduates" of this program, were volunteers from aftercare meetings, and were referred by case workers or other

study participants. Women who had not graduated from the program or who had exited from the shelter were not included in this study.

Strengths

This study developed a substantive explanation and theoretical framework of the transition process for homeless women as they moved from shelter to independent living. Women who participated in this study had been independently housed for an average of thirteen months. Twelve (41%) had been self-sufficient and independently housed for more than one year, and half of this group had been away from transitional shelter living for two or more years. While this research does not provide a longitudinal comparison, it does explore how these women are doing many months after their shelter experience. This study contributes to an accumulating body of knowledge documenting factors associated with the procurement of stable housing.

Implications

Recommendations for Future Research

The current qualitative study included a sample of urban women in a "children-only" shelter who successfully completed the shelter program. Studies of different types of shelter settings and residents may reveal comparative information about the transition process. For example, this shelter served only homeless mothers; future studies with single women are needed as well as studies with women who did not complete a particular shelter program. Their stories would provide additional information about the transition process. Further

grounded theory studies such as these can also identify other themes, patterns, and processes related to moving from shelters to independent housing.

Findings from other studies can inform and further define the theoretical framework. Testing of this model with other groups would add to the strength of the trajectory framework. Refinement of dimensions through further research can lead to the development necessary to measure these dimensions. In order to fully explore the issues surrounding the transition from shelter to independent housing, further research studies with qualitative, quantitative, and mixed methodologies are suggested. Utilizing various methodologies would produce rich data and a deeper understanding of the multiple aspects of this phenomenon.

Studies using quantitative methodology are also needed for this type of research. Instrument testing and development based on the key dimensions identified in the dimensional matrix and trajectory framework would be a future step in moving studies in this area forward. Instruments that are already in use and have been tested with other groups could be modified and tested with this group of women. Results of quantitative studies would give added strength to the trajectory framework.

Many funding agencies want statistical evidence of various issues and concerns relating to helping the homeless. Program evaluation research would be helpful in discovering what programs and program components actually work and are viewed by the recipients of care as effective assistance programs. Action research could move an intervention into testing, and the participants could work

with researchers to discover the best ways of implementing change in programs, policies, and procedures.

Existing shelters would benefit from research that confirms and/or suggests areas for change in program implementation or structure to ensure that the best possible outcome from the shelter experience is achieved. Program directors and case managers would have the ability to tailor programs to the types of populations served, which could significantly alter results--producing a successful and single transition to financial implications shared by all--for the individual and society.

Implications for Clinical Practice and Education

Recognition that many homeless women are able to make significant lifestyle changes with focused commitment and support services can provide fundamental knowledge to health care providers and policy makers. This study may help nurses, health care providers, and other social service providers better understand the experiences of homeless women, specifically those in transitional shelters. By detailing the transition phases and the conditions and strategies occurring during the phases, this study has provided a theoretical framework to examine this phenomenon.

The multi-disciplinary approach of shelter service provision--availability of consistent case management, support groups, and mental health and drug and alcohol treatment opportunities--is critical during and after shelter stay, and interventions to promote successful transition should address relapse prevention and life skills development (e.g. budgeting, parenting, housekeeping) long after

the women have left the shelter. Further understanding that the shelter experience may provide an important opportunity for women to explore healthier behaviors as they acquire skills and strategies to live independently has implications for future interventions.

The interest in education that the women expressed for themselves and their children suggests that schools could be utilized for opportunities to support different kinds of assistance. Target areas for prevention of drug abuse and isolation could include after-school programs and community-based groups that strive to promote positive affiliation and role modeling (e.g. after school all-stars, boys/girls clubs, etc.).

Women recovering from drug abuse and homelessness shared an increased desire to participate in their recovery efforts when they felt validated, connected, and supported. The establishment of trusting relationships formed with shelter staff (case managers), health care providers, ministers, and volunteers impacted their abilities to take advantage of available services. In order to further support recovering women, health care providers should be familiar with 12-step and other drug rehabilitation resources so that their interventions can enhance existing support structures in the community.

Individual and family counseling can be a support for many women who wish to deal with the past or to examine their addictions. Their histories of drug dependency, trauma, and relationship violence underscore the need for health care providers to act as sources of support and healing during the transition process.

Forming therapeutic alliances with health care providers gives the women another opportunity to build trusting relationships as they continue to create better lives.

Social and Political Implications

Transitional shelter has traditionally been viewed as a "one-size-fits-all" intervention. Typical programming includes educational opportunities, job training, and life skills instruction--all designed to promote self-sufficiency. Little programming accommodation is made for the specific needs of different household types other than the provision of onsite child care and the inclusion of parenting classes in the mix. This study suggests that homeless mothers may have different problems and consequently different needs than do single women or two-parent households. As a result, future programming for all shelters should incorporate activities that address these different needs. Given the significant numbers of women with substance abuse requiring rehabilitation in this particular study, this program addressed the needs specific to that population.

To respond to the alienation and isolation of homeless mothers, shelters should consider incorporating programs that promote social interaction to help build social networks. Therapeutic group programs and other group activities can help nurture the skills needed to break through years of isolation and distrust. This could be of additional importance as most of the women in this shelter needed to leave their past support behind.

To reduce the risk of recidivism, formerly homeless women should be helped to begin building supportive relationships outside the shelter system. This may include efforts to reestablish healthy relationships with family members

(when possible) or create a new supportive network. By strengthening these relationships before shelter exit--especially in cases where residents may leave to stay with family or friends--the possibility of making a successful break from homelessness may be increased.

The special needs of families should be addressed, and services should expand beyond parenting classes. The stress of homelessness and shelter life creates changes in family relationships that may undermine the family's ability to transition out of homelessness together. Families should be offered therapeutic help to develop tools to address painful or difficult issues that arise both as a result of homelessness, and as a result of shelter life. Special attention should be given to the needs of children as well as adults. Additionally, shelter rules that break up families should be rethought, given that family instability seems to have a detrimental effect on the ability to transition out of homelessness.

Case management services in transitional programs should be extended to households after program exit. This will continue the social supports developed inside the shelter, providing a network of relationships to draw on should problems arise. By continuing case management services through the transition to independent living, families and individuals will have help to meet the challenges of the world outside the shelter environment.

Philosophically, the myth of "self-sufficiency" should be reconsidered as it is described as a goal for formerly homeless families. Successful families do not go it alone. They receive support from a wide range of social networks, including family, friends, shelter workers, NA/AA groups, churches, on-the-job

relationships, and more. By focusing on self-sufficiency and individual success, transitional shelters fail to help disaffiliated individuals regain a sense of place in the wider community.

While the sheltered women in this study did not address the role of ethnicity in the transition process, they did feel that terms such as *homeless* and *addict* influenced society' s distorted viewpoint. For western society, the state of homelessness signifies both financial and social failure. The general public perceives the bag lady or panhandler to be representative of all homeless persons. A more accurate public awareness of the needs and efforts of the homeless would foster a better climate for shelter and rehabilitation program funding.

From a policy standpoint, the overarching needs of families in America should be addressed, especially as they relate to inequities in wealth and housing. Gender issues and racial issues are often ignored. The vast gap between minimum wage earnings and minimum housing costs must be reduced. Provision of affordable housing must become a priority for states and localities and must be supported by federal funding. Health care for families, and safe, affordable child care for working parents must also be made available. Lack of these social supports contributes to the increasing numbers of homeless in our communities.

Finally, efforts should be directed towards ways to build social capital among the homeless. The feelings of alienation and isolation reported by many homeless persons, especially women, do not disappear with the provision of shelter. They can only be reduced by building connections to other individuals, neighborhoods, and the larger community. Those of us in helping professions

such as nursing must look for innovative ways to reach out to this vulnerable group of mothers and families.

Concluding Remarks

The 29 women who participated in this study not only wanted to speak about their experiences, they also wanted women, and especially other women in a similar position, to know what they now know; and they hoped that their experiences would be of help to others. From their stories emerged a substantive explanatory framework detailing the process of *creating a better life* for formerly homeless women as they transitioned from shelter to independent living.

This study underscores the need for more research regarding formerly homeless women and their successful transition to independent living. There are very few research studies that focus on the transition process. This study is an exemplar and lays the groundwork for further research of formerly homeless women's perspectives of creating a better life as they transition to independent living. Nurses have a unique opportunity to make a difference in the lives of these women as they move forward.

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Appendix A

SOCIODEMOGRAPHIC SCALE

1. What year were you born?
2. How old are you?
3. What is your ethnic background? (circle one)
African American
White
Latina
Other (Please specify) _____

4. What is the highest grade in school you completed and received credit for?
00 01 02 03 04 05 06 07 08 09 10 11 12
College/other post high school education: 13 14 15 16
More?_____

5. What is your current marital status? (circle one)

Never Married
Married
Separated
Divorced
Widowed

6. Do you have any children? (circle one)
Yes
No

7. If yes, how many?_____Where are they living?
Now, I'd like to ask you some questions about income assistance you may or may not be getting.

A. SSI (green check) or SSDI (gold check)?	yes	no
B. Unemployment Income?	yes	no
C. General Relief or General Assistance?	yes	no
D. Temporary Aid to Needy Families (TANF)?	yes	no
E. Food Stamps?	yes	no
F. Women, infants, children program (WIC)?	yes	no
G. Help from friends/family?	yes	no

Adapted from Nyamathi, et al., 1992

Appendix B

INTERVIEW GUIDE

In order to achieve study aims, the following questions/probes will be used as an initial focus:

- Tell me about your life before the shelter. What led you to this program?
- What was it like living in the shelter? Can you share some of the things that that happened or were helpful so that you could live on your own?
- Tell me about your health-before the shelter and now that you are living on your own. What are some issues you are currently experiencing?
- What skills or knowledge did you need in order to move out on your own? Can you think of things that were particularly helpful or made it more difficult for you to live on your own? When did you know you were going to make it on your own? What was that moment like?
- Do you count on anyone for support? If so, can you tell me about this person? What impact did they have on your ability to become independent? What kind of support was provided by the shelter staff or theother women in the shelter? Were any services in particular that were especially useful?
- If you could give advice to another homeless woman about what you have been through and your journey here, what would it be? What do you see for your future/future of your children?

Appendix C

University of San Diego

Research Participant Consent Form

Families Moving Forward: Homeless Women with Children Transitioning to Independent Living

Kristin Hoyt is a doctoral student in the Hahn School of Nursing and Science at the University of San Diego. You are invited to participate in a research project she is conducting for the purpose of exploring how homeless women move to independent living.

The project will involve one interview that asks questions about how you became independently housed. The interview will last about 60-90 minutes and also will include some questions about you, such as your age, sources of your income and any benefits you may be receiving. The interview will take place at a time and place convenient for you. Participation is entirely voluntary and you can refuse to answer any question and/or quit at any time. Should you choose to quit, no one will be upset with you and your information will be destroyed right away. If you decide to quit, nothing will change about your access to social and shelter services. Even if you quit, Kristin will provide you with a $25.00 gift card at Target or cash.

The information you give will be analyzed and studied in a manner that protects your identity. That means that a code number will be used and that your

real name will not appear on any of the study materials. All information you provide will remain confidential and locked in a file cabinet in the researcher's office for a minimum of five years before being destroyed.

There may be a risk that filling out the form or participating in the interview may make you feel tired. Remember, you can rest any time. Sometimes people feel anxious or sad when talking or reflecting on the things you will be asked about. If you would like to talk to someone about your feelings, you can call the San Diego Mental Health Hotline at 1-800-479-3339.

By law, disclosure of suspected abuse or threat of harm to yourself or others, must be reported. Also, nurses (Kristin is a nurse) are required by California law to report certain cases of domestic violence to law enforcement. If you choose to tell Kristin Hoyt that you have been involved in this kind of an abusive situation, she must report it.

Remember, you can stop the interview at any time you feel tired or for any other reason.

The benefit to participating will be in knowing that you helped nurses learn how to better help other homeless women that shard similar experiences of moving from the shelter to independent housing. You will receive a $25.00 gift card for merchandise at Target or cash, whether you complete the study or not.

If you have any questions about this research, please contact Kristin Hoyt at 760-803-0398 or her professor, Dr. Diane Hatton at the University of San Diego (619) 260-4548.

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

_____ _____

Signature of Participant Date

_____

Name of Participant (Printed)

_____ _____

Signature of Principal Investigator Date

Appendix D

TRANSCRIBER'S PLEDGE OF CONFIDENTIALITY

I will be participating in the dissertation research project entitled:

Families Moving Forward: Homeless Women with Children Transitioning to Independent Living

I will be transcribing audio recorded interviews into text. I will not know the names of the informants, but if I should recognize information that enables me to identify any of the participants, I agree to maintain their anonymity and confidentiality. By signing this agreement, I pledge to keep all information strictly confidential. I will not discuss the information I transcribe with any person for any reason. I understand that to violate this agreement would constitute a serious and unethical infringement on the informant's right to privacy.

Signature of Transcriptionist

1/24/07

Date

Appendix E

FLYER FOR SHELTER SITE

Would you like to take part in a study about homeless women who have graduated from St. Clare's and are living on your own?

You are invited to share your personal experiences ☐

Sharing your personal experiences will help nurses understand ways we can better help other homeless women who have gone through similar experiences

Your participation in the study will include a 60-90 minute audio-recorded interview and you will be given $25.00 for your time

A graduate student nurse researcher from the University of San Diego is looking for 15-20 women to participate in this research study

If you are interested and want to discuss the study, please contact:

Kristin Hoyt, PhD(c), RN

At 760-xxx-xxxx or email: Kristin@kristinhoyt.com

Appendix G

TWELVE STEPS

(From Narcotics Anonymous, an Introduction Booklet, pages 3-5)

If you want what we have to offer, and are willing to make the effort to get it, then you are ready to take certain steps. These are the principles that made our recovery possible:

- We admitted that we were powerless over our addiction, that our lives had become unmanageable.
- We came to believe that a Power greater than ourselves could restore us to sanity.
- We made a decision to turn our will and our lives over to the care of God as we understand Him.
- We made a searching and fearless moral inventory of ourselves.
- We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- We were entirely ready to have God remove all these defects of character.
- We humbly ask Him to remove our shortcomings.
- We made a list of all persons we had harmed, and became willing to make amends to them all.
- We made direct amends to such people wherever possible, except when to do so would injure them or others.
- We continued to take personal inventory and when we were wrong promptly admitted it.
- We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

Having a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

Appendix H

LETTER OF DIRECTOR SUPORT AND APPROVAL

November 20, 2006

Kristin E. Hoyt, RN, CFNP, PhD (c)
Doctoral Student
Hahn School of Nursing and Health Science
University of San Diego
5998 Alcala Park
San Diego, CA 92210-2492

Dear Kristin,

I am pleased to write a letter supporting your proposed dissertation research regarding "The Journey of Homeless Women Transitioning to Independent Living." It is my understanding that the overall goal of this research is to explore the process by which homeless women become independently housed after residing in a transitional shelter. Additionally, your interest is to identify factors that facilitate or hinder that process.

This research will be of particular importance to homeless women and also to those that serve these women in shelters such as ours. It is a valuable area to explore and we applaud your desire to contribute knowledge to an area that hasn't been explored.

We at Saint Clare's Home appreciate your sensitivity and work with homeless women. Your past experience as a research assistant with Dr. Diane Hatton in 1999-2002 demonstrate your interest and desire to make a difference in the lives of these women.

I believe that your proposed research will further the knowledge base of how homeless women become stably housed after participating in a transitional shelter program, such as ours. You have our full support and cooperation as you proceed with this project.

Sincerely,

Sister Claire Frawley
Executive Director

☎ (760) 741-0122 • Fax (760) 741-1241 • 243 South Escondido Blvd., #120 • Escondido, CA 92025-4116

Appendix I

HUMAN PARTICIPANT PROTECTION EDUCATION FOR RESEARCH GUIDELINES

National Cancer Institute
U.S. National Institutes of Health | www.cancer.gov

NCI Home | Cancer Topics | Clinical Trials | Cancer Statistics | Research & Funding | News

Human Participant Protections Education for Research

Completion Certificate

This is to certify that

Kristin Hoyt

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 11/26/2006.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
http://www.nih.gov