Year 2
2008 - 2009

Strengthening At Risk and Homeless Young Mothers and Children

EVALUATION REPORT

STRENGTHENING
At Risk and Homeless
Young Mothers and Children

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FACT (Family Assertive Community Treatment)

Beacon Therapeutic Diagnostic and Treatment Center

Heartland Alliance for Human Needs and Human Rights

Goldie's Place

Inner Voice

Thresholds Psychiatric Rehabilitation Centers

Voices for Illinois Children

Hope & Home

PROTOTYPES: Centers for Innovation in Health, Mental Health, and Social Services

Foothill Family Service

Strengthening Young Families

Antelope Valley Hospital/Healthy Homes program

Antelope Valley Partners for Health

Mental Health America of Los Angeles

Valley Oasis

United Way of Greater Los Angeles

STRong: Strengthening Our New Generation

Reuben Lindh Family Services

St. Stephen's Human Services

Wayside House, Inc.

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INTRODUCTION

This report is the second in a series of reports from the evaluation of *Strengthening At-Risk and Homeless Young Mothers and Children*. An initiative of the Conrad N. Hilton Foundation, *Strengthening At-Risk and Homeless Young Mothers and Children ("the Initiative")* is intended to serve young homeless and at-risk families (headed by a mother between the ages of 18 and 25 with at least one child age five or under).

Under the guidance of a Coordinating Center consisting of The National Center on Family Homelessness (The National Center), the National Alliance to End Homelessness (the Alliance), and ZERO TO THREE: National Center on Infants, Toddlers and Families (ZTT), the *Initiative* seeks to improve the health, housing and development of young at-risk and homeless young mothers and children. Specific goals of the *Initiative* include the following:

- To ensure better family and individual outcomes for young homeless and at-risk families in the areas of child development, maternal well-being, family functioning, family preservation, and housing stability.
- To create lasting systems change between the housing/homelessness and child development service sectors by supporting replicable, locally-based innovative collaborations.
- To influence policy and practice nationwide by evaluating and disseminating lessons learned from these local collaborations.

The *Initiative* includes four local program sites, each featuring partnerships between multiple agencies:

- Family Assertive Community Treatment (FACT): Chicago, Illinois
- Strengthening Young Families (SYF): Antelope Valley, California
- Hope & Home: Pomona, California
- Strengthening Our New Generation (STRong): Minneapolis, Minnesota

Programs are described in more detail in *Appendix A* at the end of this report. Each partnership includes a housing/homelessness agency and a child welfare/child development agency with other agencies expanding the collaborations' expertise. The projects each offer unique menus of services and modes of service delivery.

To understand and document the lessons of the *Initiative*, The National Center on Family Homelessness is conducting an evaluation of *Strengthening At-Risk and Homeless Young Mothers and Children*. This evaluation utilizes multiple quantitative and qualitative data collection methods to develop a complete picture of the *Initiative's* programs, successes, and challenges, and to better understand the clients that these programs serve. Findings from the evaluation are intended not only to improve the services of the *Initiative*, but to inform the broader field of human services on the needs and means of serving young, homeless and at-risk mothers and their children.

A previous report, the *Evaluation Report: Year 1*, outlined the development and structure of *Initiative* programs (Fusaro, 2009). Building upon that foundation, this report is primarily intended to describe the needs and characteristics of *Initiative* clients. Additionally, this report begins to address emerging practices for serving young, homeless families and preliminary lessons learned from the *Initiative*.

Structure of This Report

This report begins by reviewing enrollment in the *Initiative* to date. Client demographics, based on an initial analysis of the quantitative data collected in the evaluation, are examined. Client characteristics and needs are understood through baseline evaluation data. Broad areas of need covered in this section include:

- Income, Education, and Employment
- Housing and Homelessness
- Health and Well-Being
- Family Functioning

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What are the characteristics and needs of *Initiative* clients?

A number of different factors are important to understanding the *Initiative's* target population. This cross-sectional view of clients' backgrounds and characteristics provides a portrait of *who* the *Initiative* is serving. The data presented here are intended for descriptive purposes only. Differences across sites may be due to deliberate program characteristics, including recruitment strategies and overall program goals.

Initiative Enrollment

As of January 2010, the *Initiative* has served 272 families.[1] FACT has enrolled 47 clients, Strengthening Young Families 66, Hope & Home 40 in its new iteration[2], and STRong 119. There are numerous factors that might contribute to these widely varying participation rates. These numbers do not account for intensity of services, duration of typical enrollment, or differences in population (e.g. clients at one program site might be more transient—and therefore likely to have a shorter or more sporadic enrollment—than clients at another).

Table 1: *Initiative* Enrollment to Date

	Number of Clients Enrolled to Date
Hope & Home	40
FACT	47
STRong	119
SYF	66
Initiative Total	272

Current Enrollment

No program is currently serving all clients ever enrolled. Clients may voluntarily leave, "graduate" from the program, be involuntarily disenrolled, or become lost to a program after a move. During the most recent quarter, the *Initiative* as a whole served 150 clients.

Table 2: Enrollment at End of January 2010

	Number of Clients Currently Enrolled
Hope & Home	19
FACT	39
STRong	58
SYF	34
Initiative Total	150

[1] Note that this number does not include clients served under the original version of Hope & Home, which operated from April 2007 through March 2009.

[2] Hope & Home was redesigned as of April 1, 2010.

Race/Ethnicity

Homeless families are generally members of racial and ethnic minorities, with persons of African-American descent most disproportionately affected (Lowin, Demirel, Estee, & Schreiner, 2001; Rog & Buckner, 2007). Similarly, poor children are disproportionally more likely to be members of minority groups (The National Center on Family Homelessness, 2009). This same pattern is seen among *Initiative* families. *Initiative* clients overwhelmingly represent racial and ethnic minorities, with a majority (60%) identifying as African-American. Twenty-three percent (23%) self-identify as Hispanic.[3] The remaining clients identified as roughly equal portions white (5%), American Indian/Alaska Native (5%), and Other non-Hispanic (6%).

At the site level, there is some variation in the racial and ethnic composition of each program's client base. At three of the four sites—FACT, Strengthening Young Families, and STRong— Black/African American clients comprise the single largest racial/ethnic group. Hispanics represent the largest population served at Hope & Home.

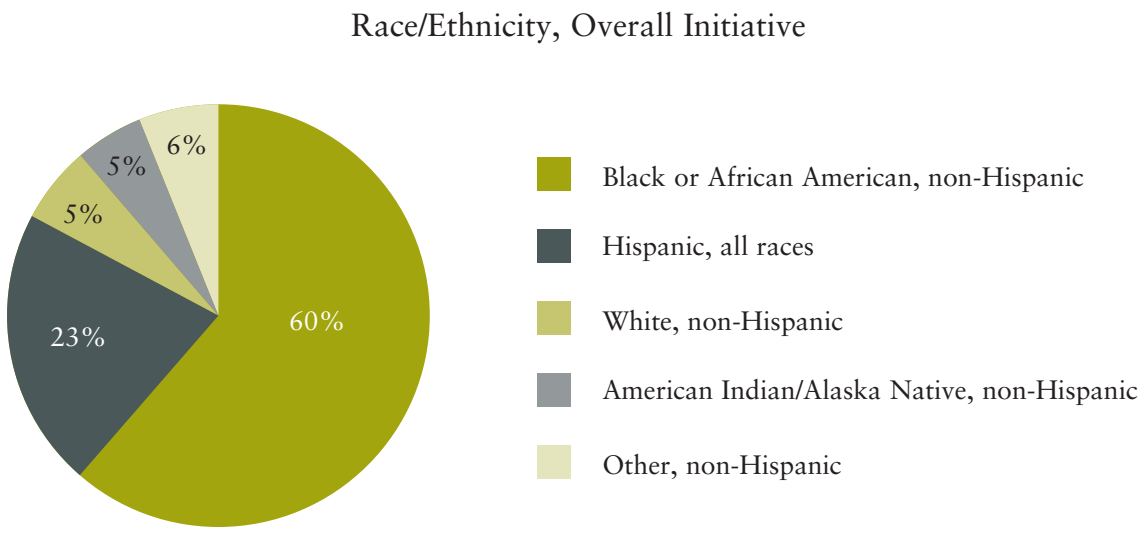

Table 3: Client Race/Ethnicity

	Black/African American (%)	*Hispanic, All Races (%)*	*White (%)*	*American Indian/ Alaska Native (%)*	*Other (%)*
Hope & Home	17	75	0	0	8
FACT	80	18	0	0	2
STRong	73	6	3	11	6
SYF	41	34	12	4	9
Overall *Initiative*	60	23	5	5	6

[3] In paralleling the race/ethnicity categories of the United States Census Bureau, Hispanic identity is considered separate from race and is posed as a separate question. Clients can select, for example, Black/African American as their race and state that they are Hispanic in a follow-up question. For clarity of presentation, in this report clients identifying as Hispanic have been grouped into a single category.

Age

The *Initiative* is intended to serve mothers who are 18-25 years old. The average age of an *Initiative* mother is 21.5 years. The average client age at the program sites is generally between 21 and 22 years.

Table 4: Client Age

Program	*Mean Age*
All programs	21.5
Hope & Home	22.4
FACT	21.2
STRong	21.6
Strengthening Young Families	21.4

Number of Children

The mean number of children in an *Initiative* family is 1.5, and ranges from no children (some clients are pregnant or child may be deceased) to five children. Similar numbers are found at each program site, as shown in the accompanying table. These counts include both biological and adopted children regardless of whether they live with the client.

Table 5: Number of Children in *Initiative* Families

Program	*Mean Number of Children*
All programs	1.5
Hope & Home	1.6
FACT	1.8
STRong	1.5
SYF	1.1

Maternal Foster Care Involvement

Foster care involvement as a child is a common experience for *Initiative* mothers. Approximately 41% of clients spent at least some time before the age of 18 in foster care. A majority of FACT's clients (60%) spent time in foster care while they were growing up. Each of the remaining sites has sizable minorities of clients that experienced foster care involvement as a child, ranging from 25% of Hope & Home clients to 45% of Strengthening Young Families clients.

Table 6: Proportion of *Initiative* Families with Foster Care Involvement

Program	*Involved with Foster care (%)*
All programs	41
Hope & Home	25
FACT	60
STRong	30
SYF	45

Among those clients involved in foster care as a child, it is a central aspect of their lives. "I grew up in DCFS, so I've always been around professional people," said one Strengthening Young Families client. A FACT client discussed the breakup of her family through the child welfare system. Not knowing her father and already separated from her biological mother, "growing up in DCFS, all my siblings were separated [in different foster homes]." Still other clients describe having access to supports and resources while involved with the foster care system, only to have them disappear once they "aged out." Foster care involvement appears to have a range of negative effects for *Initiative* clients. Some, however, describe efforts within the system to alleviate the stress of aging out. "The system is set up for you to have a savings account, for you to be able to pay your rent up for a few months, and for you to be able to go to college once you emancipate out" said a FACT client. She continued that other factors—such as her own depression—prevented her from fully taking advantage of these resources.

Income, Education, and Employment

"Everything is so expensive, and it's hard to be able to pay the rent."
Initiative Client

Homelessness is an outcome of poverty, with economic difficulties driving families into homelessness. The prevailing rents in an area may be out of reach for an individual or family that lacks sufficient income. Alternately, an individual or head of a family may have adequate income, but live "paycheck to paycheck"—with all financial resources dedicated to basic necessities—putting the person or family at great risk for experiencing homelessness.

Income

The average income for an *Initiative* client is quite low, particularly considering that the typical client is a mother with one or more children. Clients in the *Initiative* report a mean income, from all sources, of $771 per month. Income varies somewhat by site, and ranges from an average of $633 per month for FACT clients to an average of $913 per month for Hope & Home clients. Assuming a typical *Initiative* client was to receive the same monthly income over the course of a year, average annual income is approximately $9,252 per year (range $7,596 to $10,956).

Table 7: Monthly and Annual Income

	Average Monthly Income	*Estimated Average Annual Income*[4]
All programs	$771	$9,252
Hope & Home	$913	$10,956
FACT	$633	$7,596
STRong	$859	$10,308
SYF	$738	$8,856

[4] Calculated from reported monthly income, not directly asked of clients.

Clients receive income from several sources. During the past year, the most common sources of income were as follows: food stamps (83%); TANF (68%); earned income (39%); family contributions (23%); and alimony or child support payments (8%). The majority of client income across sites appears to come from public sources, with some clients engaging in paid work and some receiving assistance from their families.

Table 8: Percentage of Clients with Various Sources of Income

	Food Stamps (%)	*Other Benefits (%)*	*Earned Income (%)*	*Family Contributions (%)*	*Alimony/Child Support (%)*
All programs	83	68	39	23	8
Hope & Home	83	75	46	25	17
FACT	85	64	18	30	8
STRong	88	87	47	9	11
SYF	77	68	43	34	4

Despite having economic resources that fail to achieve even a basic standard of living, many *Initiative* clients feel they have enough money to afford many necessities. Over half (63%) report having enough money for food, 45% enough for clothing, 43% enough for housing, and 42% sufficient money for travel around the city. Conversely, only 11% of clients report having enough funds for social activities. At the site level, there are considerable differences by program in client sense of ability to afford various necessities. Notably, a majority of STRong clients feel they have enough money to cover all expenses except social activities, while a majority of Strengthening Young Families clients feel they cannot afford any of the listed expenses.

Table 9: Client Ability to Afford Necessities and Social Activities

	Food (%)	*Clothing (%)*	*Housing (%)*	*Travel (%)*	*Social Activities (%)*
All programs	63	45	43	42	11
Hope & Home	75	25	58	50	8
FACT	55	48	13	30	7
STRong	88	61	67	55	22
SYF	38	29	34	34	2

Source: Baseline client interviews

Employment

Approximately 20% of *Initiative* clients were employed at the time they were interviewed, with a range from 8% of clients at FACT to 30% of clients at STRong.[5] During qualitative interviews, clients frequently described barriers to employment. A pregnant client stated, "most of the time I've been in pain and I can't move," and this has prevented her from searching for a job. She was also concerned that an employer would not hire her knowing she would soon be having a child. Clients regularly state that lack of child care is a barrier to both employment and school. Among those that have been able to access child care, they find the time when their child is being cared for is their prime opportunity to look for jobs, go to school, and engage in employment- or career-related activities.

> *"I never—I don't want to depend on getting help. I want to depend on being strong and know that I can take my own daughter—take care of what I can. Get a job."*
>
> *Initiative* Client

Education

Educational achievement among *Initiative* clients is limited; 45% of clients have not graduated from high school or completed an equivalent such as a GED. This overall pattern holds at the site level, with 40% to 50% of clients at each site having not attained a high school diploma or equivalent. Only 20% of clients have completed some college coursework or a two-year degree and less than 1% (n=1) a four-year degree. For many clients, furthering their education is a key objective. Said one client, "I want to go to school. I want to be able to have an income for my family…so we can be financially stable."

Table 10: Education Level of *Initiative* Mothers

	Less than HS Diploma (%)	*At Least HS Diploma or Equivalent (%)*
All programs	45	55
Hope & Home	50	50
FACT	40	60
STRong	45	55
SYF	48	52

[5] Note that "Sources of Income" included all income in the past year, while "employment" examines current (at the time of the interview) jobs. A client can have earned income in the past year without currently having a job.

Housing & Homelessness

Homelessness History

Many *Initiative* clients have experienced multiple episodes of homelessness, both as adults and as children. Experiences of individual clients are wide ranging. Slightly less than one quarter (23%) of clients have never been homeless as an adult, while approximately 14% report five or more episodes of adult homelessness. Among those that have experienced homelessness since turning 18, the average number of episodes of homelessness is three (the average for the *Initiative* not including clients that reported never experiencing homelessness). A sizable minority of clients (43%) experienced at least one episode of homelessness as a child. Statistics for each program site are presented in the following table.

Table 11: Homeless History

	Experienced Homelessness as Child (%)	*Average Number of Homelessness Episodes as Child*[6]	*Experienced Homelessness as Adult (%)*	*Average Number of Homelessness Episodes as Adult*[6]
All programs	43%	3	77%	3
Hope & Home	42%	3	50%	2
FACT	41%	2	81%	2
STRong	46%	5	72%	3
SYF	41%	6	88%	3

Housing at Baseline

As of the baseline interview, the majority of *Initiative* clients (52%) were in a housing situation that could be considered homeless.[7] Thirty-four percent (34%) of clients were "doubled up," while 18% percent were on the streets, in a shelter, in some type of treatment, or other non-permanent situation.

Table 12: Baseline Housing Status

	Own Apartment (%)	*Other Stable Housing (%)*	*Doubled Up (%)*	*Other Homeless (%)*
All programs	33	14	34	18
Hope & Home	50	17	33	0
FACT	3	20	31	45
STRong	51	5	38	6
SYF	31	22	33	14

[6] Among those that experienced homelessness as child or adult, respectively.
[7] For purposes of this report, doubled-up families are counted as homeless.

Although one-third (33%) of clients overall reported that they had their own apartment at baseline, it is important to note that many baseline interviews were conducted after the client had already begun receiving services. Programs generally follow a "housing first" model, where housing is provided prior to meeting other needs. The number of clients in their own apartments or other stable housing before entering an *Initiative* program was therefore likely lower at the time of enrollment than the data above appear to indicate. Thus, we also examined the number of days spent in each type of housing arrangement in the six months prior to the baseline interview.

In the six months prior to entering a program, *Initiative* clients spent, on average, approximately 41% of nights "doubled up" with family or friends, 29% of nights in their own apartments[8], 13% in some type of supported environment (e.g. transitional housing, group home, or supportive housing), 12% on the street, in a shelter, or in a hotel/motel, 4% in an institutional setting (such as a treatment facility or hospital), and 1% in some other setting. It is important to note that averages are based on a composite of clients; it is unlikely that any individual client will have spent time in each setting during a six month period. It indicates, however, the prevalence of each housing condition among *Initiative* clients, with clients commonly "doubled up" upon entering an *Initiative* program.

The portrait of clients' housing arrangements in the six months prior to joining an Initiative program is slightly different at each program site, as shown in the accompanying table. Generally, the housing conditions accounting for the largest portion of client nights include staying in one's own apartment and "doubling up" with friends or family. The exception to this pattern is FACT, where a roughly equal portion of nights were spent doubled up, "literally homeless" (such as on the street, in a shelter, or in a place not designed for habitation), or in a supported environment.

Table 13: Percent Nights Spent in Housing Arrangements 180 Days Prior to Baseline

	"Doubled Up" (%)	*Own Apartment (%)*	*Supported Environment (%)*	*Street/ Shelter/Etc. (%)*	*Institutional Setting (%)*	*Other (%)*
All programs	41	29	13	12	44	1
Hope & Home	26	35	16	1	21	0
FACT	29	3	28	29	8	3
STRong	41	44	5	8	0	1
SYF	52	26	13	7	1	0

[8] Due to difficulties in logistics and client tracking, some baseline interviews took place several months after the given clients had been enrolled in an *Initiative* program. Actual percent of "nights in own apartment" may be lower than indicated here.

A desired objective of the *Initiative* is to stably house all enrolled families. Program reports provide a view of current client housing status at the end of each quarter, and allow a rough gauge of progress toward this goal. As of the end of the most recent quarter, among the 150 currently enrolled *Initiative* clients, approximately three-quarters (76%) were in some form of stable housing (in their own apartments, transitional housing, or permanent supportive housing), with the other one-quarter (24%) in a situation that could be considered homeless.

Table 14: Percentage of Enrolled Clients in Stable Housing as of April 2010	
All Programs	76
Hope & Home	68
FACT	89
STRong	83
SYF	56

Based on this initial analysis, it would appear FACT and STRong are housing the largest percentages of clients. Caution must be taken in interpreting this data, since these numbers are drawn from site self-reports and *only* include clients currently enrolled in a program. Clients that received services in the past ("graduated") are not captured in the above data, nor are disenrolled clients. A more rigorous examination of housing status will be possible in subsequent evaluation reports, as sufficient follow-up data will be available.

Health and Well-Being

Previous research shows that homeless mothers have experienced numerous traumatic events. In turn, these individuals may experience mental health disorders, the most common being depression (Bassuk, Buckner, Perloff, & Bassuk, 1998). Many also suffer from substance use-related disorders (Rog & Buckner, 2007). The evaluation attempts to gauge the prevalence of these experiences and conditions in developing an understanding of client need. Measures related to each of these domains—trauma/traumatic stress, mental health, and substance use—are included in the outcome evaluation interview.

Trauma

> *"From a child, since I can remember, my mom was a drug addict and an alcoholic and a prostitute. I was stuck in that. And I never knew my father, so I was stuck in that. Growing up in DCFS, all my siblings were separated, so I was stuck in that. By the time I was fourteen, I was an alcoholic and a weed-head, so I was stuck in that. By the time I was seventeen, I had my first child and I dropped out of high school, so I was feeling guilty about that. So it was a chain of negative events where I couldn't focus on the here-and-now."*
>
> *Initiative* Client

Initiative clients have been exposed to many situations capable of causing traumatic stress. The prevalence of the most-common traumatic experiences by *Initiative* program site is shown in the following table. Many clients were exposed to more than one type of traumatic stress, and at least 11% of *Initiative* clients have experienced all eleven events that they were asked about.

Table 15: Percentage of Clients Who Have Experienced the Most Commonly Reported Traumatic Events

	Violence from a family member (%)	*Unexpected death of a family member (%)*	*Molested by stranger (%)*	*Mother abused drugs/alcohol (%)*	*Present when someone injured (%)*
All programs	60	53	45	44	42
Hope & Home	58	33	17	33	33
FACT	83	45	70	63	60
STRong	42	55	22	40	34
SYF	64	60	59	39	39

Generally, violence from a family member was the most widely-experienced traumatic event among clients at each site. Only STRong showed a slightly different pattern, with the unexpected death of a family member being the most widely-experienced event.

Scores on a Posttraumatic Stress Diagnostic Scale indicate that a majority of *Initiative* clients experience "moderate" or greater symptoms of Post-Traumatic Stress Disorder (PTSD). Large portions of clients at each site, ranging from 42% at STRong to 73% at FACT, experience moderate or greater PTSD symptoms.

Table 16: Severity of PTSD Symptoms

	Mild (%)	*Moderate (%)*	*Greater than Moderate (%)*
All programs	44	32	24
Hope & Home	50	42	8
FACT	27	30	43
STRong	58	27	15
SYF	39	37	24

Source: Posttraumatic Stress Diagnostic Scale

Mental Health

Initiative clients report having been diagnosed with a number of mental health conditions, ranging from depression to schizophrenia. As in other studies of homeless families, depression was the most common diagnosed mental health condition, with nearly half (49%) of *Initiative* mothers reporting that a health professional told them they had the condition. Following depression, 19% of clients have been diagnosed with Post-Traumatic Stress Disorder (PTSD), 19% with bipolar disorder and 16% with anxiety. Five percent (5%) or fewer of clients have been diagnosed with any other condition.

At the site level, depression was the most common diagnosed condition across programs. At three of four sites, the next most common condition was PTSD (anxiety being the second most common at STRong). Hope & Home, likely because of the extremely low numbers of interviewed clients (n=12), had no clients diagnosed with any other condition, while bipolar disorder and anxiety were experienced by more than 10% of clients at the remaining sites.

Table 17: Percentage of Clients with Mental Health Diagnosis

	All programs (%)	*Hope & Home (%)*	*FACT (%)*	*STRong (%)*	*SYF (%)*
Depression	49	25	83	39	43
PTSD	19	17	38	6	20
Bipolar	19	0	38	11	20
Anxiety	16	0	18	16	18
Phobic Disorder	5	0	13	3	4
Schizophrenia	4	0	8	2	4

Clients were also asked how much each of these conditions affects their daily lives. Within the three most common conditions (depression, PTSD, and bipolar disorder), the majority of clients diagnosed with each condition reported it affected daily living "somewhat" or "greatly."

Mental health was also assessed using a standardized measure of mental health functioning. Scores for all sites and the national average for women ages 18 to 24 are presented in the table below. Based on a comparison to this norm, it appears that Initiative mothers experience more mental health challenges than other women in their age range.

Table 18: Mental Health Functioning of *Initiative* Clients

	Mental Health Functioning Score
All programs	40.89*
Hope & Home	38.4*
FACT	38.4*
STRong	43.8
SYF	40.0*
National average, females 18-24	44.68

Note: * indicates scores are significantly lower than national average for 18-24 year old females

Suicide

Closely related to the rate of depression among the population served by the *Initiative*, a large number of clients have attempted suicide. Thirty percent (30%) of *Initiative* mothers have made at least one suicide attempt. Among those that have attempted suicide, the median number of attempts is two.[9] The number of attempts reported by clients ranges from a single attempt to as many as sixteen attempts. While most clients that have attempted suicide have made only one or two attempts, a smaller number have made many attempts.

The accompanying table presents the proportion of clients at each site that have attempted suicide and the median number of suicide attempts among those clients. Strikingly, more than half of FACT clients have made at least one suicide attempt.

Table 19: Suicide Attempts by Site

	Attempted Suicide (%)	*Median Number of Attempts*[10]
All programs	30%	2
Hope & Home	8%	1
FACT	53%	2
STRong	24%	1
SYF	29%	2

[9] *Median* is a measure of central tendency that is the middle value of a distribution. Unlike mean, which is a simple average, it is less influenced by extreme values. In examining the data on suicide attempts, a small number of clients (approximately 4%) reported ten or more attempts. Median was therefore selected over mean as a more accurate indicator of this data.

[10] Among clients that have attempted suicide.

The mental health findings among the women served in the Initiative are concerning. Many of these young mothers are experiencing post-traumatic stress and depression so severe that they have attempted suicide. These findings indicate that the current mental health needs of the mothers are so significant that mental health services, if they are not already, should be a core component of the individual projects.

Alcohol and Other Drugs

Among *Initiative* clients, substance use was generally low, with either no use of a given substance (and hence no risk of consequences) or a "low risk" categorization on a screener designed to determine a person's level of risk of consequences (physical, emotional, or social) from substance use. The exceptions to this pattern were alcohol, used at some point in their lives by 84% of clients; tobacco, by 66% of clients; and cannabis, by 67% of clients. Within these substances, 7% of clients overall (8% of users) scored in the "moderate risk" or "high risk" ranges for alcohol use, 40% of clients overall (60% of users) for tobacco, and 17% of clients overall (26% of users) for cannabis. Tables 20 and 21 show the percent of clients falling into the "low risk" and "moderate risk" or "high risk" categories for each substance.

Table 20: Proportion of Clients at Risk of Consequences from Substance Use

	Tobacco	*Alcohol*	*Cannabis*	*Cocaine*	*Speed*	*Inhalants*	*Sedatives*	*Hallucinogens*	*Opiods*	*Other*
Ever Used Substance	66%	84%	67%	20%	23%	10%	14%	11%	10%	7%
Moderate or High Risk of Consequences from Use	40%	7%	17%	4%	6%	1%	2%	1%	2%	0%

This initial, descriptive analysis does not categorize clients across multiple substances; it is possible that a small number of clients are at risk from use of several substances. Alternately, a larger number of clients might be at risk from use of just one or two substances. Further analysis is needed to identify patterns of substance use and associated levels of risk.

The distribution of risk—with tobacco and cannabis emerging as the substances with the largest group of clients at risk of consequences—holds at the individual program sites, with some variation. The following tables provide the percent of clients with moderate or greater scores for the most common substances by site.[11]

Table 21: Percentage of Clients with Moderate or Greater Risk of Consequences of Use by Site

	Tobacco (%)	*Alcohol (%)*	*Cannabis (%)*	*Speed (%)*	*Cocaine (%)*
All Programs	40	7	17	6	4
Hope & Home	33	0	8	17	0
FACT	55	3	25	5	5
STRong	39	14	17	2	3
SYF	30	4	13	9	4

Maternal Health Conditions

The most common health conditions experienced by *Initiative* clients, based on self-reports of having been diagnosed with a condition are as follows: anemia (43%); asthma (33%); and urinary/kidney infections (27%). The following chart lists, by site, the health conditions reported by clients.

Table 22: Percentage of Clients with Diagnosed Health Conditions

	All programs (%)	*Hope & Home (%)*	*FACT (%)*	*STRong (%)*	*SYF (%)*
Anemia	43	33	58	23	56
Asthma	33	17	38	33	34
Urinary/Kidney Infections	27	33	40	13	32
High Blood Pressure	19	25	13	17	23
Rheumatism	17	17	35	14	7
Other Major Illness	13	18	26	3	14

Anemia was the first- or second-most common condition reported at all program sites. Asthma was also quite common at all sites, and urinary/kidney infections were common at all sites except STRong. Also notable, nearly one-quarter of clients at both Strengthening Young Families and Hope & Home report being diagnosed with high blood pressure, while sizable segments of FACT clients report rheumatism and other major illnesses (35% and 26%, respectively).

[11] Hope & Home's speed use rate may be attributable to the small number of clients participating in the evaluation to date.

Child Health Conditions

Among the health conditions experienced by *Initiative* children, the most common were as follows: eczema (28%); ear infections (21%); fevers (17%); bronchitis (16%) and asthma (16%). As shown in the following table, the five most common conditions for the *Initiative* were also the five most common at each program site, though the specific proportion varies.

Table 23: Child Health Conditions

	All programs (%)	*Hope & Home (%)*	*FACT (%)*	*STRong (%)*	*SYF (%)*
Eczema	28	8	32	31	24
Ear Infections	21	8	22	27	14
Fevers	17	25	18	14	19
Bronchitis	16	8	22	16	14
Asthma	16	17	22	16	12

Child Medical Care

The vast majority of the children of *Initiative* mothers appear to receive regular medical care. As reported by clients, 92% of their children, in the past year, have had a physical and 95% have seen a pediatrician. Among children, 93% are current on their immunizations. The rate of dental care among the children of clients was somewhat low, with only 32% having seen a dentist in the past year, but given the relatively young age of children this is not surprising. The pattern of child medical care is repeated at the individual program sites, with over 90% of clients reporting that their children have had physicals, seen a pediatrician, and that immunizations are current.

Table 24: Child Medical & Dental Care

	All programs (%)	*Hope & Home (%)*	*FACT (%)*	*STRong (%)*	*SYF (%)*
Child Had Physical, Past Year	92	92	94	95	91
Child Saw Pediatrician, Past Year	95	100	100	94	95
Immunizations Current	93	92	100	97	86
Child Saw Dentist, Past Year	32	46	33	37	17

Family Functioning

The *Initiative* is ultimately intended to serve families. Families as a unit have particular needs when experiencing homelessness. Here we describe parenting stress, family separation, and child welfare involvement among *Initiative* clients.

Parenting Stress

Parenting stress was examined using an instrument that includes measures of Total Stress (parenting-related), Parental Distress (parenting stress due to personal factors, such as restricted social interaction or a poor relationship with the child's other parent), Parent-Child Dysfunctional Interaction (the parent feels that the child is a negative factor in her life), and Difficult Child (the child has behavioral characteristics that make parenting difficult). Each measure has a range considered higher than normal, with some having special cutoffs indicating a specific need. Total Stress has a level indicating clinically significant stress, Dysfunctional Interaction a level indicating potential for abuse and neglect, and Difficult Child a cutoff indicative of a child with possible severe mental health or emotional issues.

Over one-third (34%) of *Initiative* clients are experiencing high parenting-related stress. Further, 25% of clients overall are experiencing these stresses at a clinically significant level. On the individual measures, 40% are experiencing high stress in the Parental Distress domain, 18% in the Parent-Child Dysfunctional Interaction domain, and 26% in the Difficult Child domain. Ten percent (10%) of clients scored in the "potential for abuse or neglect" range on the Parent-Child Dysfunctional Interaction measure.

Levels of "high stress" are highest at FACT, where 51% score in the high range of "Parental Distress" and at Hope & Home, where a majority of clients scored in the high range on Total Stress and Parental Distress and exactly 50% in the high range on "Parent-Child Dysfunctional Interaction." Again, the small number of clients participating in the evaluation at Hope & Home (n=12) limits the ability to draw larger conclusions from this finding. The following tables outline the site-level distribution of clients scoring in the "high stress" range.

Table 25: High Parenting Stress Scores by Site

	Total Stress (%)	*Parental Distress (%)*	*Dysfunctional Interaction (%)*	*Difficult Child (%)*
All Programs	34	40	18	26
Hope & Home	58	75	50	33
FACT	48	51	23	31
STRong	25	33	11	24
SYF	25	30	17	21

There was a split between sites on the number of clients scoring in the "clinically significant stress" range on the Total Stress measure, with small numbers of clients scoring this high at Strengthening Young Families (13%) and STRong (16%). Larger groups of FACT (38%) and Hope & Home (42%) clients indicate they are experiencing parenting-related stress at this level. At three of the program sites, over 15% of the clients scored in the "potential for abuse or neglect" range on the Parent-Child Dysfunctional Interaction subscale. Finally, the percent of clients with Difficult Child scores at the most concerning level, wherein the child may have significant mental or emotional health issues, is less than 10% at three of the program sites and 25% at Hope & Home.

Table 26: Parenting Stress Specific Needs by Site

	Child may have behavioral/ mental health challenge	*Potential for abuse or neglect (%)*	*Clinically Significant Total Stress (%)*
All Programs	11	10	25
Hope & Home	25	34	42
FACT	9	21	38
STRong	6	5	16
SYF	8	15	13

These findings are consistent with needs described by parents during qualitative interviews, many of whom indicate that interpersonal relationships and/or their own emotional distress makes parenting difficult. Said one parent, "My patience is so short at this moment, like I get so irritated so fast. I'm going to try not to take my irritation out on her [client's daughter] because it's not her fault. If I can finally just come around—have somebody work with me to get around that because I don't want to snap on her one day."

Family Separations

> *"[Child welfare] kept [my son] because they said I wasn't stable. I've been moving from place to place and group homes. So they felt like he needs a permanent living situation and they're saying that I don't have any family, so I'm—I feel like now I need an attorney to help me fight for it [reunification] because they're saying that I don't have any family."*
>
> *Initiative* Client

Approximately 9% of clients report having a child not currently living with them. Among those clients, the median number of children *not* living with the client is one and ranges as high as three. The following table provides the percentage of clients at each program site with a current separation. *(Note: Because the number of clients with a current separation is small when examined by site, the median number of children clients are separated from has not been reported.)*

Table 27: Current Separation by Site

	Clients with current separation (%)
All programs	9
Hope & Home	8
FACT	20
STRong	2
SYF	11

Most notable are the extremes within this data—very few STRong mothers have a current separation, while 20% of FACT mothers are currently experiencing a separation. Strengthening Young Families and Hope & Home fall roughly between these two poles.

Overall, thirty-three percent (33%) of *Initiative* clients report that they have experienced at least one separation during their child(ren)'s lifetime(s). At the individual program sites, between 25% and 40% of clients reported having at least one separation.

Table 28: Lifetime Family Separation by Site

	Clients with at least one separation (lifetime) (%)
All programs	33
Hope & Home	25
FACT	33
STRong	28
SYF	40

Interestingly, while FACT had the largest group of clients with current separations, a greater proportion of Strengthening Young Families clients have experienced a separation in their lifetimes. Some of these separations are voluntary—for example, one client left her child with the child's father while she was residentially unstable—while others, as in the case of child welfare involvement, are not. Mothers involuntarily separated from their children often refer to their homelessness as a contributing factor in the child's removal.

Child Welfare Involvement

Among clients in the *Initiative*, 43% report that child protective services have been involved with their family. Further, 27% indicate that a report of abuse or neglect has been filed regarding one or more of their children. The following table indicates child welfare involvement at the site level.

Table 29: Child Welfare Involvement by Site

	CPS Ever Involved w/ Family (%)	*Report of Abuse or Neglect Filed (%)*
All programs	43	27
Hope & Home	42	33
FACT	77	44
STRong	27	20
SYF	39	20

Many clients feel they are unfairly targeted by the system. "There was an incident where some girl didn't like me and called DCFS. And because I have lost my children once before, it was a red flag for them. So instead of DCFS just seeing that the allegations were not true, [my case] remained open." Taken in the context of the rate of maternal foster care involvement explored previously in this report, for a number of clients child welfare is a near-constant presence in their lives. They grew up in the system as children and encounter it as parents. Child welfare involvement can also lead to an involuntary separation between the mother and child, with the child coming under the supervision of the foster care system.

In the family domain, the relatively high rates of reported parenting stress, history of children separated from their mothers, and child welfare involvement are indicators of past and or present instability and risk in the lives of the families served in the *Initiative*. These findings underscore the importance of *Initiative* interventions that support and strengthen intact families and reunite separated parents and children.

What promising practices are emerging from the *Initiative*?

The client-level findings presented thus far indicate that family needs are wide-ranging. In this section, we describe some of the ways *Initiative* programs are responding to these needs. Although these responses can only be currently judged based on anecdotal evidence, their importance as emerging service approaches should not be dismissed. The practices described here share a clear linkage with the needs and characteristics of families and, in most cases, are shared by multiple sites.

Economic Self-Sufficiency and Long-Term Stability

> *"You first have to get income. I got approved for SSI in September, and when they found out I got approved for SSI they started the process of the house. Well, we can help you with the housing because you're going to be receiving income"*
>
> *Initiative* Client

The profound degree of poverty among clients is noteworthy—the average *Initiative* mother makes over $5,000 less per year than a person living at the poverty guideline for a family of two ($14,570) (US Department of Health & Human Services, 2009). *Initiative* mothers also appear to already be receiving benefits such as TANF and Food Stamps, but *even with public supports*, the financial resources of clients are at a level that can only be described as dangerously low. Program efforts to alleviate poverty include benefits acquisition, education and training, assistance with concrete needs, and employment assistance.

Enhancing employment supports. Across projects, case managers assist families to access an array of community services. Two projects are actively working with all of their clients on assessing their readiness for employment and their needs for further education. FACT is taking a particularly systematic, multi-pronged approach to employment and economic self-sufficiency. The FACT employment specialist conducts a career exploration interest assessment or employability profile, staff conduct life skills sessions, and the program ensures that clients are receiving all of the benefits and concrete services to which they are entitled. By hiring an employment specialist, FACT demonstrated a real investment in helping clients to become independent. Hope & Home screens all clients for the GAIN (Greater Avenues for Independence) Program, a work education program in Los Angeles County. Another project is just beginning to develop a jobs training component.

Adapting mainstream resources. Communities often have successful, publicly-funded social service programs that are operational and achieving strong outcomes but are not adequately serving at-risk and homeless families. By identifying these potential resources and developing strategies to improve the accessibility and appropriateness of these services for young families experiencing homelessness, the programs have been able to offer much richer services than they could otherwise.

In Antelope Valley, Healthy Homes, a program of Antelope Valley Hospital, was not targeting homeless young mothers, a highly vulnerable population. As a partner in Strengthening Young Families, young pregnant mothers who might not otherwise have received pre-natal services are receiving medical support and, at the same time, are receiving a richer array of services through the partnership. In Minneapolis, STRong has adapted its successful county-wide rapid exit program to meet the needs of young mothers who otherwise wouldn't qualify under the existing requirements (e.g. primarily mothers who are doubled-up and not in the shelter system). With appropriate evaluation and advocacy, a goal can be additional public outlays for enhanced outcomes and more clients served.

Housing

> *"I slept in the back of a car before. I slept in Jack-in-the-Box before. I slept in hotels before"*
>
> *Initiative* Client

A central objective of the Initiative is to stably house all enrolled families. The *Evaluation Report: Year 1* documented the central role stable housing plays in the lives of formerly homeless clients. Emerging best practices in this area are described below.

Making housing a priority. By securing housing, programs create an opportunity to develop the trust necessary to address other issues. Lack of stable housing affects every area of a family's life. Likewise, the stability, privacy, and safety of housing provide benefits in many areas, including parenting. One mother describes the impact of housing by saying "So, in the time that it has been [since I obtained housing], I've made healthier decisions, healthier choices. So, my parenting is definitely more healthier." *Initiative* programs act quickly using multiple tools to attempt to stabilize housing for clients. Program services that respond to clients' needs for identifying permanent housing include housing search, housing classes, apartment inspections, and a flexible funding pool that may be used for first and last month's rent. To help clients retain housing, projects provide tenant advocacy and flex fund assistance. Project staff members have found that housing stabilization is a major contributor to improving other areas of their and their children's lives. As reported by one administrator, "Once the initial housing crisis is overcome, many mothers quickly stabilize, address their health issues, and their parenting skills are more easily assessed."

Making housing affordable. Although follow-up data on housing are not yet available, the qualitative data suggest that projects have variable access to housing. Client and staff interview data suggest that housing vouchers are often obtained on a case-by-case basis, and that some projects lack the linkages to housing programs that could provide dedicated housing slots. In southern California, the dearth of affordable housing is particularly acute, making it difficult for any program to eliminate homelessness within its client base. In spite of the challenges, three of the four projects have been able to obtain vouchers or housing slots for many of their clients.

- STRong has been able to obtain and manage 21 Long Term Homelessness Housing Vouchers lasting five years. STRong has made housing a cornerstone of its project by adapting a nationally recognized housing model, "Rapid Exit Program," for young families by intervening before they enter shelter. The purpose of this program is to provide rapid re-housing followed by supportive services. To facilitate this goal, STRong was able to obtain 11 Homelessness Prevention Rapid Re-Housing Vouchers. STRong also benefits from a strong partnership with St. Stephens Human Services, a housing agency, which provides both advocacy and vouchers.
- FACT has a housing resource developer who is SOAR (SSI/SSDI Outreach, Access, and Recovery)-trained, and has recently received a new HUD contract which will provide up to 15 permanent housing units to the project. FACT has over 20 Low Income Housing Trust Fund Vouchers and Heartland Alliance prioritizes FACT clients for units in their Families Building Community program.
- Strengthening Young Families' partnership with Mental Health America brings a number of dedicated units. In addition, they created "The Cottage," a multi-family, transitional housing unit at Valley Oasis, another of the program's partner agencies. As one client described it, "Living there is nice. You get to do a lot of stuff you want to, like if you get along with the girls—I get along with them. We cook together. We make meals. Sometime we make cakes."

One project has experimented with several strategies for increasing access to housing, but is still working toward an effective approach. In the absence of a housing partner or dedicated slots, one of the case managers was trained as a housing specialist. That position has been eliminated, but the associated responsibilities transitioned to the two case managers. The project has recently started working with a transitional housing partner that may provide prioritized slots.

Health and Well-being

One of the most striking findings from the quantitative data was the high prevalence of diagnosable mental health problems among the mothers served in the program. However, projects' response to addressing these mental health needs has been mixed. While two of the projects have expertise in adult mental health, two lack clinical expertise and have focused primarily on parenting and child development. Based on qualitative data collection, promising practices to enhance the health and well being of young homeless mothers are described below.

Comprehensively identifying and addressing mental health needs. Homeless services are often designed with basic services at the forefront of service delivery. In general, paraprofessionals are the primary client contact and they "call-in" or refer to specialists. Both Hope & Home and FACT are using a more clinically driven approach, with clinicians leading cases and paraprofessionals providing supplemental supports. The projects that have the most comprehensive responses to women's mental health and substance use needs have several characteristics in common: mental health specialists on the team; treatment planning; access to the services of a psychiatrist; and expertise in (or access to) substance abuse treatment. These projects report that they have been trained in Stages of Change theory, and, at one project, an expert in Motivational Interviewing attends team meetings. All programs have received training in trauma-informed care, but it is currently unclear how projects are applying this knowledge.

Utilizing a team approach in service provision. At three of the sites, the staff works as a team, with young mothers receiving services from several providers to meet their own specific needs and those of their children. Overall, clients report satisfaction with this specialized approach and clients benefit not only from their specialist's expertise, but also from the expertise of each member of the team. Case conferencing appears to be key to this model's success, as it provides a forum in which diverse professional perspectives can be shared and a well-informed plan for intervention crafted. The team approach offers several benefits to team members and to clients. Team members can avoid the burnout that sometimes accompanies work with vulnerable populations by being assured that on days when they need to step back, someone else can step up. For clients, the benefit of a team approach is that when one person can't help you, another one can. FACT clients also described a feeling of empowerment associated with knowing that team members were accountable to each other and to a supervisor to whom they had direct access.

Creating and enhancing social support networks for young moms. Mothers in the *Initiative* are young, vulnerable, and have limited social networks and community connections. This impacts their overall well-being and ability to maximize the benefits of program participation. Two of the sites – Strengthening Young Families and STRong – are actively focusing on creating networks of supports among their young clients to provide mutual support and encouragement. In Antelope Valley, the networks arose out of groups for parents focusing on promoting child development. An unanticipated but significant product of the group was the relationships participants established with each other. The staff is now seeking to expand opportunities to enhance social supports. At STRong, the program hosts social activities and group training activities that encourage social interaction. In response to their clients' requests, they are also creating support groups around common themes and areas of interest. In addition to the need for socialization,

project staff across programs have learned that when serving young mothers, it is essential to work with their existing support networks, including siblings, mothers, grandparents, significant others, and fathers. Sites find connecting to fathers particularly important. The Coordinating Center responded by offering a training by the National Fatherhood Initiative. One of the sites then replicated this effort by repeating the training for their entire agency.

Planning for aftercare. The process of engagement—building client strengths and addressing challenges—can take some time. However, at some point, many families are ready for a less intense level of involvement from service providers. Identifying benchmarks to program completion and systems for ensuring that clients remain supported after intensive services are lessened is critical to long-term success. Both STRong and Strengthening Young Families are implementing client "graduation" ceremonies to reinforce success and build confidence. STRong is further developing this model through planning a mentor group, with the dual goal of providing support to new clients while keeping "graduates" connected without providing intensive services.

Supporting Families and Children

> *"I was suffering from depression, domestic violence, and dropped out of school. I could have used DCFS to my advantage, but I don't believe that I was where I needed to be mentally, and I didn't have that emotional support, so when I aged out of the system, I had nothing."*
>
> *Initiative* Client

Services that promote family functioning include parenting education, family reunification strategies, child care, educational advocacy, socialization, and home and community visiting. It is in this domain that *Initiative* projects have invested the most significant amount of energy. Findings from a review of documents from the local sites and project-level qualitative data center on several themes: the importance of parenting education; the need for connections to foster care systems; the importance of family unification; and the benefits home visiting.

Parenting education. All of the individual projects gravitated to parenting education as a cornerstone of their family well-being strategies. One project has implemented Parents as Teachers, three projects received Preventing Child Abuse and Neglect (PCAN) training, and one project uses Healthy Families America, a home visiting model targeted to young parents. Two specific examples of parenting education are described below.

- *Parents as Teachers*: In an effort to enhance its focus on parenting education, STRong evaluated several home visiting curriculums and models. In addition, the staff conducted a survey to explore interest in implementing parenting groups. Based on their findings, the STRong team decided to integrate Parents as Teachers (PAT) into their program. PAT works with family units to enhance child development and school readiness and is targeted to high need groups such as low-income families and adolescent parents. Consistent with PAT curriculum guidelines, STRong plans to convene parenting groups on a quarterly basis.
- *Preventing Child Abuse and Neglect*: Three projects received training in Preventing Child Abuse and Neglect (PCAN), a research-based approach to helping families promote positive parenting and healthy social-emotional development in their children. The model also teaches staff how to build program components that are protective against child abuse and neglect, such as a welcoming atmosphere. Upon receiving the training, all three projects are pursuing implementation of PCAN—with the support of the Coordinating Center—in their individual programs or communities.

STRong is working with the Minnesota Department of Human Services to discuss ideas for implementing curriculum in a more systematic way across the city. Hope & Home will use PCAN at monthly team meetings to identify program gaps and incorporate principles into practice. FACT has incorporated PCAN in parenting groups and individual sessions.

Making connections to foster care. Clients describe aging out of foster care as a time of great instability. Reaching out to this subpopulation may, therefore, alleviate or prevent homelessness. Two of the projects report a programmatic emphasis on youth aging out of foster care. For example, FACT has developed a list of documentation needed to exit DCFS and is advocating to increase the transition period before official emancipation to give the client time to obtain benefits in the adult system.

Unifying families. To date, 17 children have been reunified with a parent enrolled in the *Initiative*.[12] Clients that have been reunified often feel that merely being enrolled in a program such as those supported by the *Initiative* improves the chances for reunification. One client noted that "when they [DCFS] found out that [an *Initiative* program], that I was working with them and had been working with them for a couple of months, they went ahead and they closed it [her DCFS case]. For others, participation in an *Initiative* program is part of a formal plan with the child welfare system or courts to reunify the client with the child.

Direct services for children. Addressing the developmental, behavioral, and educational needs of young children involves developmental screening and assessment, early childhood education, and child mental health treatment. Early childhood services appear to be a strength of these projects. Each provides early childhood services, either in the home or in specialized programs directly affiliated with project agencies. Child mental health services are offered by three of the projects, and staff members at one project are enrolled in an "Infant and Early Childhood Mental Health Certificate Program." These staff members are bringing what they are learning back to staff at their own agency, thereby building agency-wide capacity in infant mental health. One project reports that their therapists are providing a number of evidence-based therapies for young children as well as Child Parent Psychotherapy (CPP).

Providing services in the home. Homeless service provision has traditionally been provided on-site in shelter settings. Primarily introduced by the child development partners, each of the four sites are now relying on the provision of in-home services to support families, serving them wherever they reside (i.e., their own apartment, transitional housing, while "doubled up," etc.). This approach minimizes the transportation challenges homeless families face. Providers are reporting parents are more comfortable and forthcoming in their interactions with staff when they are served in their own home, maximizing the service impact. This model will be particularly important as the homelessness service system transitions to new approaches such as rapid re-housing and scattered site shelter, separating clients from a centralized location such as a traditional shelter.

Integrating Services and Creating Successful Collaborations

Overall, projects have shown great progress in integrating their services to better meet the needs of the families they serve. In the next year, it will be important to continue to document the positive outcomes associated with enhanced service integration. Specific strategies for integrating services utilized by *Initiative* programs include staff co-location, team meetings, case conferencing, joint supervision, joint case files, and cross-training. All four *Initiative* projects continued to nurture their

[12] The number of reunifications does not include children reunified under the original version of Hope & Home.

cross-agency collaborations during the past year, as evidenced by improvements in team structure, cross-training, and enhancements to their service array.

Team meetings. Although universally implemented, team meetings varied widely in frequency, from four days a week in the projects adopting ACT principles to once per month. In addition, the purpose of these meetings ranged from "check-ins" on administrative matters to discussing specific client issues (essentially combining team meetings with case conferencing). Across projects, all direct service staff attend these meetings. Key consultants (e.g., therapy director, director of homeless services, health educator) attend on an as-needed basis. In addition to formal team meetings, staff report frequent contact with one another via telephone, email and/or text messaging.

Case conferencing. All four projects engage in formal case conferencing. This strategy occurred at least once per week in all sites, with one site meeting four days per week. In most sites, direct service staff such as case managers, an early interventionist, or a child development specialist, and administrative or clinical supervisors attended the meetings. The structure and content of the meetings was variable, used to discuss client needs, to provide updates, to share resources, and/or to reassess client service plans. As awareness of the high prevalence of mental health problems among the mothers builds, some of the projects may need to build enhanced clinical consultation into their case conferences. One concern that was raised by two of the four projects is that funding cuts have resulted in elimination or reduction of clinical staff, thereby reducing access to clinical consultation. A third project, recognizing the need for more clinical input to its paraprofessional team, hired a part-time clinician consultant.

Cross-training & co-location. All of the projects have benefited from cross-training and/or external training to share expertise and to enhance the overall knowledge and skills of all team members, irrespective of discipline. STRong has experienced particular success in implementing these strategies. It has engaged in both cross-training and specialized staff training. Its housing staff has been trained in child development, and the STRong team is now taking this training to the broader community. STRong's team of case managers has been trained to provide parenting education, housing advocacy, early childhood education, trauma, ASQ administration, chemical dependency screens, and mental health referrals. While there is some documentation of how sites are incorporating what they've learned into practice, there has been little formal study of the impact of training on service delivery. STRong also co-locates staff from all the partner agencies at the child development partner agency, which provides a welcoming environment that is accessible to young women and their children.

Creating systems change. Evaluating client-based outcomes is critical to ensure community programs address residents' needs. But, identifying systems challenges and developing strategies to address them can generate broader change that is ultimately more sustainable and impactful. As part of FACT, a systems integration specialist was added to the project for just this purpose. The systems integration focus has resulted in a planning coalition comprised of public and private sector leaders who work together to address challenges such as the high number of youth aging out of foster care who become homeless. FACT has successfully fostered relationships with public sector officials in a variety of departments and is working collaboratively to improve program policies that will maximize the supports available to them.

What are the lessons learned from the *Initiative* so far?

Both the evaluation and the *Initiative* are on-going, so it is premature to draw definitive conclusions from data collected to date. Preliminary findings, however, suggest some important lessons for the field and for the projects themselves.

- The needs of young families in the *Initiative* are similar to those experienced by homeless families in general. However, qualitative data suggest that these needs may be exacerbated by parenting at a very young age and may place these families at greater risk of continued instability.
- Across projects, parenting services are core program components that address multiple client needs.
- Clients' mental health needs are significant, yet individual projects' capacity to address these issues is variable and should be addressed.
- The cross-agency partnership model upon which the *Initiative* is predicated appears to benefit clients and the participating agencies themselves.

Each of these lessons is further discussed below. However, it must be remembered that these conclusions are drawn from data that is still being collected from programs that are still being refined.

The Needs of Young Families Experiencing Homelessness

Initiative mothers, like many other poor and homeless parents, are a highly vulnerable population. Data collected in the evaluation to date indicate that clients have a high degree of need in each domain examined. While all *Initiative* clients, by definition, have difficulties related to housing they also have a myriad of other needs. A substantial subgroup has attempted suicide. Still others have experienced traumatic events beyond homelessness and have symptoms consistent with post-traumatic stress disorder. Many experience parenting challenges or are overwhelmed by the parenting experience. Many clients experience a significant number of these issues.

One goal of the *Initiative* is to explore how the needs of younger homeless and at-risk mothers compare to the needs of older homeless peers. Based on the data presented in this report, some comparisons can be made.

- In the United States, the typical homeless family has one or two children under the age of 6 (Rog & Buckner, 2007). Similarly, *Initiative* mothers have an average of 1.5 children.
- For many clients the period of homelessness leading up to their participation in the *Initiative* is simply the most recent point in a larger pattern of instability. This pattern is similar to that of other homeless mothers (Buckner & Rog, 2007).
- A sizable minority of *Initiative* mothers have not graduated from high school or completed an equivalency program. High school graduation or equivalency rates for homeless mothers in other studies are similar (35-61%) (Rog & Buckner, 2007).
- *Initiative* mothers have a relatively high rate of depression, PTSD and exposure to traumatic events, and anxiety, which parallels findings from other studies of family homelessness (Bassuk et al., 1998). Diagnosis of bipolar disorder is higher among *Initiative* clients than in other studies.
- The rate of suicide attempts among clients aligns with previous findings regarding homeless families (Bassuk et al., 1996; Rog et al., 1995).
- The health status of *Initiative* mothers is roughly what might be expected, with rates in excess of national averages. The elevated asthma and anemia rates are in line with previous research.

While these characteristics may not reveal substantial differences for younger homeless mothers as compared to other homeless mothers, the qualitative data suggests that age exacerbates existing vulnerabilities and limits future opportunities. As stated by one mother, "at a detrimental point in my life I had children…[rather than] going to school. Pursuing schools and careers and stuff like that, I'm pretty sure that everybody else in [the program] would like to do that but you know there's issues with childcare." Having children at a young age may preclude opportunities for economic stability and increase pressure on existing social support networks. The stress of parenting at a young age, with few role models or supports, can be overwhelming for *Initiative* mothers. Though these clients' views do not firmly assert that young homeless mothers are different from other homeless mothers, they do hint that the younger group may face additional social challenges.

Parenting Services as Core Program Components

Evaluation data suggests that *Initiative* families have a high degree of need related to parenting, and all four projects are responding to that need. Mothers frequently cited parenting as a primary concern and that, as a result of their involvement in the *Initiative*, they have seen positive changes in their relationships with their children. It is heartening that each program has placed parenting at the center of its services. Parenting is also the area of need in which projects have most actively sought training and incorporated evidence-based practices into their service array. While the evaluation is not intended to compare the effectiveness of different parenting education techniques, the use of tested strategies increases the likelihood of positive parenting outcomes. Follow-up parenting stress and child development data will provide information on parent and child outcomes in the coming year.

One of the key findings from the qualitative data is that young mothers see a number of benefits associated with their participation in activities around parenting. By providing some of the parenting interventions in group settings, young women are able to expand their existing social networks and create supports where none previously existed. Service providers also report that parenting education can engage and build trust with mothers in a non-threatening context. Once that trust is established, providers have been able to build on parents' investment in the well-being of their children and generate interest in additional services.

The centrality of parenting to each *Initiative* program should provide guidance for future programs intended to serve young, homeless families. Inclusion of parenting services appears to be needed and appreciated; preliminary indications are that it is beneficial to clients.

The Importance of Maternal Mental Health

The quantitative data suggests that clients have a high degree of mental health need, with depression, post-traumatic stress disorder, anxiety, and bi-polar disorder being inordinately common. That nearly one third of clients have attempted suicide indicates that the lives of these women may be at risk if depression, PTSD, and other conditions go untreated. The presence of these mental health issues is concerning not only for the mother's well-being, but the child's. Maternal mental health issues have been demonstrated to have a negative association with child development, academic success, interpersonal relationships, and mental health (Beardslee et al., 1996; Barocas, Seifer & Sameroff, 1985; Sameroff & Seifer, 1983; Weintraub & Neal, 1984). Treating a mother's depression is not only of benefit to the mother, but also decreases the likelihood of poor childhood outcomes for her children. Programs intending to serve young, homeless families should therefore be prepared to address these needs.

The Benefits of Partnership

As originally conceived, the *Initiative* was structured to develop collaborative, integrated homelessness/housing and child development/child welfare services to aid young families experiencing homelessness. Findings to date reinforce the necessity of providing services that are comprehensive in nature as young women and their children transition to permanent housing. Many mothers describe housing as the lynchpin that allows them to, with the support of other *Initiative* services, stabilize their families' lives. Partnerships appear to be working as a mechanism for achieving this goal.

Project staff report numerous benefits accruing to their families and to their agencies as their cross-agency partnerships develop: 1) increased access to housing vouchers, landlord education, and other housing supports; 2) increased staff expertise and knowledge in addressing housing needs, trauma, and enhanced parent/child relationships. Where these partnerships are highly developed, project leadership from both agencies cite improved quality of care. There are early signs from the interview data that some of these benefits are being extended to the wider network of community providers.

Although partnerships appear to hold benefits for clients and programs, partnerships can also be challenging. Creating a shared vision, coordinating logistics, rules, services, record keeping, and staffing have proven to be difficult in some cases. Hope & Home addressed these challenges by undergoing a complete re-evaluation of its program operations and services in an effort to become more unified. The project made significant changes on the administrative and direct service levels. Managers from each agency worked together to improve and streamline program operations (e.g. intake, assessment, outreach and engagement, and staffing), with the result that clients are now *Initiative* clients rather than clients of one or the other agency. Clients now have access to all of the services of both agencies. The project built a team comprised of members from the two partner agencies that incorporates the ACT principles of frequent, interdisciplinary team meetings (twice per week), and frequent (one to three times per week) visits to clients to address treatment plan goals developed in a comprehensive plan of care. This case example offers insight into how a productive partnership can transform a project from an expansion of services as usual into a unique program tailored to the needs of young families at risk for homelessness.

Conclusion

Both the evaluation and the *Initiative* are ongoing, so it is premature to draw definitive conclusions from data collected to date. However, baseline evaluation data indicate the *Initiative* is reaching its intended target population and that the needs of this population are broad. It is heartening that program responses are similarly comprehensive in nature. The promising practices emerging from the *Initiative* indicate that programs are attempting to be responsive to the needs of clients and their children. Families report an array of positive changes associated with *Initiative* services, including housing, family unification, and social supports. Future evaluation reports will provide more information about how clients' lives change over the course of the *Initiative*, and will include more information about the children in *Initiative* families.

Appendix A: Project Descriptions

STRong: Strengthening Our New Generation (Minneapolis, MN): *Rapid Re-housing with services targeted to the needs of young families*

Partner Agencies: Reuben Lindh Family Services; St. Stephen's Human Services; and Wayside House

The STRong initiative primarily serves young mothers with young children who remain outside the county's shelter system. This focus allows the project to intervene before families enter shelter. With an immediate and primary goal of getting families into housing, STRong offers an array of housing assistance packages to meet the individualized needs of each household. Supportive services – including those addressing child development and parenting – are provided to each family early in the process and continue after the family has been re-housed. A central programmatic component is an identified Family Worker who provides intensive one-to-one support to the young women. Most important to this program's success is the specialized knowledge of each partner agency and the transfer of this expertise and resources to the overall collaboration.

Strengthening Young Families (Antelope Valley, CA): *Creating a mobile, community-based system of care*

Partner Agencies: Valley Oasis; Mental Health America; Healthy Homes, a program of Antelope Valley Hospital; Antelope Valley Partners for Health; and United Way of Greater Los Angeles

Antelope Valley is a rural exurb of Los Angeles that lacks the range of services of urban communities and shares the challenges of most rural communities with minimal housing and transportation resources. Young homeless and at-risk mothers are particularly isolated in this under-resourced community, and the program has been innovative in designing supports and strategies to reach them. Using a mobile, team-based approach, young women develop relationships with several specialists who address their needs – including parenting, child development, mental health and housing assistance. Parenting Groups are offered in accessible locations, which have the dual purpose of skill-building and providing a support network for young mothers. The inclusion of the Antelope Valley Hospital's Healthy Homes program enables young pregnant mothers to receive immediate referrals for prenatal care. Program participants receive prioritized, coordinated access to all of the partner agencies' resources. The collaboration is creating a bridge to mainstream service systems encouraging a deepened understanding of homelessness in the community and strengthening the capacity to respond to this issue.

FACT (Chicago, IL): *Using a demonstration project to impact community services and policies*

Partner Agencies: Beacon Therapeutic Diagnostic and Treatment Center; Heartland Alliance; Goldie's Place; Inner Voice; Thresholds Psychiatric Rehabilitation Centers and Voices for Illinois Children

Using a family-based adaptation of the Assertive Community Treatment (ACT) model, FACT applies a "wraparound services" approach to meet client needs. A multi-disciplinary team, which includes licensed clinicians, provides the bulk of services; clients are generally served by more than one worker. The partnership in Chicago focuses on ensuring that lessons learned from its intervention are translated to the broader service community to create a systemic impact. A key component of this project is a full-time position dedicated to systems integration. This position leads the effort to pull together the diverse stakeholders, including private and public sector representatives, consumers and other community leaders to create a meaningful partnership. Some initial successes are emerging from this systems-focused approach. Most notably is the relationship with the Department of Children and Family Services (DCFS). Young mothers

aging out of foster care are referred directly to FACT, ensuring they do not experience the disorienting sharp withdrawal of supports. FACT is also working with DCFS to facilitate access to Family Unification Program (FUP) vouchers so that young adults receive housing assistance to live independently. FACT anticipates ongoing collaboration with DCFS to improve policies and practices for youth aging out of care with children and other child welfare involved families. Lessons from this successful collaboration will be used to craft partnerships with other public systems that support low-income families.

Hope & Home (Pomona, CA): *An intensive mental health approach to working with young moms and children*

Partner Agencies: PROTOTYPES: Centers for Innovations in Health, Mental Health and Social Services and Foothill Family Services

Hope & Home targets families in which the parent requires specialized mental health services.[13] Together, the two partner agencies offer intensive mental health services for both the parents and children. The program is a comprehensive, trauma-informed project providing a range of integrated and coordinated services using a team approach. Each family works with a therapist who also coordinates and oversees the delivery of support services offered by the team – parenting, employment, housing, education and chemical dependency. The Department of Mental Health, through its Early Periodic Screening Diagnosis and Treatment (EPSDT) and MHSA (Mental Health Services Act) TAY (Transitional Age Youth) funding streams, provides matching funds for this program, demonstrating its commitment to the outcomes of this program model and maximizing the potential for long-term sustainability.

Appendix B: Methods

The evaluation of *Strengthening At-Risk and Homeless Young Mothers and Children* utilizes a mixed methods approach to develop a complete portrait of the *Initiative's* programs, clients, and effects. It includes both a process study to document the progress of the *Initiative* and an outcome study to gauge its impact. Quantitative and qualitative methods are utilized for both portions of the evaluation. No one element of the evaluation is more important that another; rather, components are intended to complement one another. For example, the outcome study may show that many clients' housing situations stabilize after receiving *Initiative* services. This finding, however, would lack context—it would not be possible to describe why the change might have occurred. Qualitative focus groups might subsequently reveal that clients feel that a particular element of *Initiative* programming led to improved housing stability. The qualitative study supports the quantitative research and vice versa.

Qualitative Methods

The major qualitative component of the evaluation consists of annual site visits to each program. During each two-day visit, two staff members conduct meetings with program management, direct service staff, and partner agency leadership. A focus group is held with between four and eight program clients. Individual interviews are also conducted with an additional four to eight consumers. Questions during meetings, interviews, and focus groups are generally open-ended, allowing the program representative or client to answer as they see fit. Specific questioning protocols are flexible, being updated for each site visit and adapted for each program site. While the sites themselves select clients to participate in focus groups and key informant interviews, they

[13] Hope & Home implemented this program design on April 1, 2009.

are instructed to—and generally do—include a variety of clients in the sample. For example, prior to visits, sites are asked to recruit consumers both satisfied and dissatisfied with the program, clients that are relatively new to services and clients that have been enrolled for long periods, clients that have been interviewed before and clients that have not been previously interviewed, etc. Analysis of the evaluation's qualitative data begins with transcription of all meetings, focus groups, and interviews. Transcripts are then examined for common themes and, for this report, information related to client need and the services delivered by *Initiative* programs.

Programs also complete and submit quarterly reports to *Initiative* leadership. These reports document each program's own assessment of its successes and challenges and describe plans for the coming quarter. While these documents are primarily qualitative, programs are asked to report on a variety of performance indicators (e.g. number of clients receiving a particular service). These reports provide the evaluation team with additional information about the programs' approach, development, and accomplishments.

Quantitative Methods

The quantitative, outcome-focused portion of the evaluation collects data on a variety of client characteristics and needs using a standardized data collection instrument. This instrument consists of commonly used measures in such areas as housing and homelessness, mental health, substance abuse, and physical health. Each client participating in the evaluation completes four interviews: a baseline interview shortly after enrollment in an *Initiative* program: a six-month interview; a one year interview; and a two year interview. This design allows the evaluation to track client progress over time using quantifiable measures and provides some sense of the *Initiative's* impact on client outcomes in its target areas. Specific measures and instruments utilized in data collection are described under "Data Collection" below.

As this report is intended to describe client needs identified through the evaluation, its quantitative elements focus solely on baseline data—the first interview a client completes. This frame examines clients before or shortly after they receive services, thus providing the best view of need. Analysis primarily uses descriptive statistics—for example, how many clients reported a particular problem, or received a score indicating a clinical need on a mental health scale. These findings are then compared to existing knowledge of homeless families. With limited exceptions, no statistical tests have been conducted to analyze how similar or different *Initiative* clients are from other homeless mothers. Rather, the data has been examined to determine if it fits with trends identified in the current body of knowledge concerning homeless families. If, for example, it is known that homeless mothers have high rates of depression, do *Initiative* mothers also appear to have high rates of depression?

Sample and Response Rates

Participation during qualitative program site visits has generally been excellent. During all meetings –project management, agency leadership, and direct service staff – nearly every individual required for the given meeting has been present, with only occasional gaps due to schedule conflicts, illness, etc. Focus groups have included between three and nine clients; individual interviews have been conducted with three to eight clients per site visit.

The return rates (the number of clients participating in the evaluation out of the total number of clients) for the outcome evaluation vary considerably by program site. Overall, 172 of 272 clients have participated in at least a baseline interview as of January, 2010, a return rate of 63%. The FACT program and Strengthening Young Families each succeeded in conducting baseline interviews with 85% of clients. STRong interviewed 54%; Hope & Home had the lowest return rate at 30%. The evaluation attempts to take a 'census' of clients—it is not randomized.

The intent is to interview every client. Generally, the higher the return rate the more confident we can be that evaluation results accurately reflect the needs and characteristics of a program's clients.

Table 30: Evaluation Return Rates

	Clients Enrolled[14]	*Clients Interviewed (N)*	*Return Rate*
FACT	47	40	85%
Strengthening Young Families	66	56	85%
Hope & Home	40	12	30%
STRong	119	64	54%
Initiative	272	172	63%

Note that these return rates may not be reflective of the all interviews conducted by January, 2010, as data collection is ongoing. An interview may have been conducted, but the documentation not yet received by evaluation staff. Therefore, the actual return rate may be higher.

Data Collection Instruments

The data collection instrument utilized in the outcome study is primarily composed of pre-existing, recognized scales and questionnaires of accepted validity and reliability. In some cases (for example, items related to foster care experience) questions were developed specifically for this evaluation. Reflecting areas of need discussed in the body of the report, measures in the data collection instrument used in this report include the following:

Demographics

The race/ethnicity data is gathered using two questions items, one on race (e.g. Black/African American, American Indian/Alaska Native, etc.) and one on Hispanic ethnicity. This pattern reflects the United States census, which treats Hispanic identity as a separate construct from race. Client age is derived from their birthday, which is reported during the interview. A "household roster," in which clients list the people they live with, is used to determine the number of children the client is currently living with. In a separate set of questions, clients list the children from which they are currently separated. Combined, these two data elements calculate the total number of client's children. Finally, whether the client spent time in foster care as a child is asked within a list of possible living situations the client might have experienced before the age of 18.

Income, Employment, & Education

Several poverty-related measures are included in the evaluation instrument. Clients are first asked about their sources of income, using a simple "yes" or "no" response to a list of sources (e.g. Food Stamps, earned income, Social Security). They are then asked, considering all sources of income, for their monthly income and whether they feel they have enough money to cover certain categories of expenses (such as food or clothing). Clients are next asked about their current employment. Finally, an inquiry into the level of education the client has achieved—an antecedent to stable employment—is made using a single question with multiple response choices (e.g. "some high school," "high school diploma," "some college").

[14] Clients enrolled and clients interviewed are as of January, 2010.

Housing and Homelessness

The evaluation examines housing and experiences of homelessness in several ways. First, each client is asked how many times she experienced an episode of homelessness as child (prior to the age of 18) and the total length of time she was homeless as a child. Second, the client is asked about number of episodes and total length of time homeless as an adult (since turning 18). Finally, the client completes the "Residential Follow-back Inventory." The Follow-Back Inventory is an instrument designed to gather data on the last six months of housing. With the assistance of the interviewer, who might prompt the client to remember particular dates by referencing holidays or other significant events, the client completes a calendar outlining where she slept on every night in the past six months (approximately 180 days). The calendar then allows a count of the number of nights spent in one's own apartment, number of nights "doubled up" with family or friends, nights in a supported environment (group home, transitional housing, or permanent supportive housing), nights in an institutional setting (such as a treatment facility or hospital) and nights homeless (e.g. on the streets, in a shelter, in a hotel/motel) (Tsemberis et al., 2007). The multiple measures of homelessness included in the evaluation combine to generate a general description of a client's homelessness history as both a child and an adult and a more specific outline of the recent past.

Behavioral Health

Measures related to mental health fall into sub-domains of trauma and traumatic stress, mental health, and substance use. Trauma and exposure to traumatic events are examined using two subscales of the modified Post-Traumatic Stress Disorder Scale, one group evaluating exposure to traumatic events and a section measuring reactions to traumatic stress (Foa, 1995). The exposure to traumatic stress section lists a number of traumatic events (e.g., experiencing violence from family member, experiencing a natural disaster) and asks the client whether she has ever experienced that particular event. The reactions to the traumatic stress component provide the client with a symptom, such as having nightmares, and asks how often the client experiences the symptom, ranging from never to 5 or more times a week. Combined, the symptoms scale provides Symptom Severity Ratings for clients from mild to severe, giving a general sense of the client's difficulty in dealing with traumatic stress.

Client mental health is gauged using two tools. First, clients are asked whether they have been diagnosed, by a health care professional, with any of a number of mental health conditions using a simple "yes" or "no" response to a list of conditions. For all "yes" responses, the client is asked the degree to which the conditions affect her daily life. Finally, the SF-8 Health Survey, which also measures physical health, is provided. This brief screening tool is designed to measure eight concepts related to health functioning: general health, physical functioning, role limitations due to physical factors ("role physical"), bodily pain, vitality, social functioning, mental health, and role limitations due to emotional factors ("role emotional"). This instrument has been nationally normed, including breakdowns by gender and age group (Ware, Kosinski, Dewey, & Gandek, 2001). Additionally, a related (and directly comparable) instrument was used in the Worcester Family Research Project (WFRP), a seminal study in the field of family homelessness (Weinreb, Buckner, Williams, & Nicholson, 2006). Direct comparisons, using statistical tests, can be made to both the national norms and WFRP data.

The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) was used to gauge client use of addictive substances and the potential for consequences of use. Clients are asked about their frequency of use and consequences of use of a variety of substances. This information is used to generate "Specific Substance Involvement Scores," which then allows clients to be divided into "low risk," "moderate risk," and "high risk" categories for each substance. A "low risk" client may use substances occasionally, but is likely not

experiencing or at risk of developing social and health problems related to use. A "moderate risk" client is using the given substance in a harmful manner and may experience consequences, while a "high risk" client is at risk for dependence and is likely experiencing health and/or social consequences related to use (Henry-Edwards et al., 2003).

Child & Family Needs

Based on known needs of homeless families, the evaluation examines parenting stress, family separation, and child welfare involvement among *Initiative* clients. Parenting stress is measured using the Parenting Stress Index Short Form (PSI-SF). This instrument generates scores on three subscales—Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child—as well as provides a measure of overall stress related to parenting. Each PSI-SF subscale measures a unique aspect of parenting stress. The Parental Distress subscale relates to personal factors, such as restricted social interaction or a difficult relationship with the child's other parent. Parent-Child Dysfunctional Interaction relates to the parent's relationship with the child. "Dysfunctional Interaction" means the parent feels that the child is a negative factor in her life, for example feeling alienated from the child. The Difficult Child subscale quantifies behavioral characteristics of the child that may make parenting difficult. For example, the child may be non-compliant or have trouble self-regulating. The overall Total Stress score indicates the mother's overall stress *as related to parenting*. It does not examine stress and stressors outside the client's role as a parent (Abidin, 1995).

The results of the PSI-SF are analyzed by comparing client scores to the range of scores for the general population. If the client's score falls at or above the 85th percentile for the general population on the Total Stress measure or a subscale, it is considered a high score that may indicate a problem. Additional percentile cutoffs indicate a specialized need. A score higher than the 95th percentile on "Dysfunction Interaction" indicates a level of frustration that may lead to abuse or neglect. A Difficult Child score above the 95th percentile, meanwhile, indicates that the child may have severe mental health or emotional issues. Finally, a Total Stress score at or above the 90th percentile is indicative of a level of stress considered clinically significant (Abidin, 1995).

The evaluation examines parent-child separation using two groups of questions. Clients are first directly asked if there are any children with whom they are currently not living. They are then asked about lifetime separation, with the criteria that the separation have a duration of at least two weeks. Foster care involvement was investigated using two "yes"/"no" questions—has CPS/DSS ever been involved with the family, and has a report of abuse or neglect ever been filed for any of the client's children.

Health & Health Care

Clients' physical health, children's physical health, and the treatment of physical health issues are examined through the evaluation. Parent health is measured using a catalog of physical health conditions and the SF-8 Health Survey. The catalog of physical health conditions provides an overview of what illnesses and conditions impact *Initiative* clients. It asks respondents whether a healthcare professional has ever told them they have any of a range of illness or conditions. Response is a simple "yes" or "no." All "yes" responses are then followed-up with an inquiry into the degree having the condition affects the client's daily life. The SF-8 health survey is an 8-question scale that measures eight domains of health:

- General health
- Physical functioning
- Role limitations due to physical factors
- Bodily pain
- Vitality
- Social functioning
- Mental health
- Role limitations due to emotional factors

Each category produces a score, with higher scores indicating better functioning in the given domain (Ware et al., 2001). As a normed instrument, comparisons can be made to the general United States population. Additionally, a directly comparable instrument, the SF-36, was utilized in the Worcester Family Research Project (Weinreb et al., 2006). With this commonality, evaluation data can be examined for differences between *Initiative* mothers and a different sample of homeless mothers. Comparisons to WFRP carry a caveat. That study examined homeless (and housed low-income) mothers generally, without an age restriction. There is some overlap between WFRP mothers and *Initiative* clients, with many WFRP subjects between the ages of 18 and 25. Some differences between younger and other homeless mothers may go undetected because of the overlap.

Child-level data available for this report focuses primarily on child health. During outcome evaluation interviews, a "target child" is randomly selected so that the client is only answering for one of their children. The client is first asked whether the child has ever been diagnosed with any of a number of mental and physical health issues (i.e. allergies, asthma, attention deficit disorder) using a list with a simple "yes" or "no" response. Next, she is asked whether the target child is receiving regular medical care, has up-to-date immunizations, and is receiving dental care.

Limitations

No study is without limitations, and the evaluation of *Strengthening At-Risk and Homeless Young Mothers and Children* is no exception. Some limitations accompany all studies using self-response techniques such as interviews and focus groups. It is possible that respondents might provide answers they feel the interviewer wants to hear, or may not disclose a personal or embarrassing issue to an interviewer. One key limitation to this evaluation is that the outcome study does not use a comparison group. Data is collected only on clients enrolled in the *Initiative*. Without the ability to compare *Initiative* clients to a similar group, it is difficult to determine what client changes might be attributable to participation in a program and what changes might be due to other factors. The inclusion of qualitative consumer interviews and focus groups aids in overcoming this limitation, as clients have an opportunity to describe the factors impacting their development.

The outcome evaluation return rates also impact the study. FACT and Strengthening Young Families have relatively high return rates at 85% each. Hope & Home and STRong, however, have lower rates at 54% and 30%. Evaluation findings for programs with higher participation in baseline interviews are likely better representative of those they serve, as it is less likely that some subgroup of clients is missed. In programs with lower return rates, it is not possible to determine whether evaluation findings are truly representative of their clientele overall.

Each *Initiative* program is unique, and each serves a slightly different subset of the larger population of homeless families. It is, therefore, difficult to consider "*Initiative* clients" as a whole since, for example, FACT families have slightly different needs than those of STRong families. While this report describes the needs of clients as a group, it is important to remember that clients reside in four different cities and are served by four different programs. They are not necessarily representative of all young homeless families.

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Strengthening At Risk and Homeless Young Mothers and Children is generating knowledge on improving the housing, health and development of young homeless and at-risk young mothers and their children.

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For more information on this *Initiative*, please contact The National Center on Family Homelessness, 181 Wells Avenue, Newton Centre, MA; (617) 964-3834 or at www.familyhomelessness.org.

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