Mothers experiencing Homelessness: Implications of Stress and Coping Theory in the Development of Services

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Commentary on papers submitted: Mothers experiencing Homelessness: Implications of Stress and Coping Theory in the Development of Services

5. Short Form-36

6. Hospital Anxiety and Depression Scale

7. Parenting Daily Hassles Scale

8. Eyberg Child Behaviour Inventory

9. The Health of the Nation Outcome Scales for Children and Adolescents

10. Example of coded qualitative data and coding summary report

11. Thabet, A.A.M, Tischler, V. and Vostanis, P (2004) Maltreatment and coping strategies among male adolescents living in the Gaza strip. Child Abuse and Neglect 28, 77-91.

Introduction

This selection of published works represent pioneering studies of coping and outcomes in homeless mothers. The papers also document the development and evaluation of mental health and social care services for homeless families in England (see Table 1). The body of work presented was published in a range of journals from a variety of different disciplines. The methodologies used and knowledge generated make a unique contribution to knowledge in the emergent field of family homelessness research. This commentary will contextualise the research by 1) presenting background information about the problem and referring to frameworks for the support and care of families who experience homelessness, 2) examining previous research findings in this population, 3) discussing the development of services for homeless mothers and children and presenting research findings related to their evaluation, 4) examining stress and coping theory and the application of such theories to vulnerable female populations and presenting research findings on coping in homeless mothers, 5) discussing methodological considerations in researching homeless and vulnerable populations and 6) suggesting directions for future research and development of services.

Table 1: Time line for research and summary of study design, location of data collection and type of research for each paper.

Paper	Year	Study design	Area	Data/analysis
1 Psychiatric Bulletin	2000	Review of case records	Birmingham	Quantitative
2 International Journal of Social Psychiatry	2001	Cross sectional	Birmingham	Quantitative
3 Archives of Disease in Childhood	2002	Prospective/ evaluation	Birmingham	Mixed methods-baseline/follow-up
4 Housing, Care & Support	2002	Cross sectional/exploratory	Leicester[1]	Qualitative
5 Health & Social Care in the Community	2004	Cross sectional	Leicester	Mixed methods-baseline
6 International Journal of Social Psychiatry	2006	Prospective	Leicester	Baseline/follow-up
7 Journal of Community & Applied Social Psychology	2007	Prospective	Birmingham	Baseline/follow-up
8 Health & Social Care in the Community	2007	Cross sectional	Birmingham	Qualitative baseline data
9 Community, Work & Family	2007	Cross sectional	Birmingham	Qualitative follow up data
10 Qualitative Research in Psychology	-	Cross sectional	Birmingham	Qualitative baseline data

[1] Relates to a separate Leicester-based study: research for Beaumont Leys Independent Support Service (BLISS).

Family Homelessness – background to the problem and policy context

The number of families experiencing homelessness is large. Of the 93 910 households[2] accepted as homeless in England on 30th June 2006, 69 790 (or 74%) of those contained dependent children and/or a pregnant woman (National Statistics, 2006). Lone female parents comprised 39% of all households accepted as homeless and placed in temporary accommodation in the period 2004/2005 (Office of the Deputy Prime Minister [ODPM], 2006). Recent figures estimated that 130 000 children were homeless (Woods, 2006).

Homelessness is defined by statute and in the UK the Housing Act 1996 places a duty on local authorities to provide assistance to individuals who are homeless or threatened with homelessness. The legislation defines a person as being homeless if they have no home in the UK or elsewhere, they have accommodation but cannot access it, the accommodation is unsuitable, they are likely to become homeless within 28 days, or they or their family members are threatened with violence in their current accommodation (Smith, 2003). These individuals must be unintentionally homeless, that is they have not made themselves deliberately homeless, and must be in priority need. Groups in priority need include households which contain dependent children, a pregnant woman, or those who are

[2] Includes single persons and families

otherwise vulnerable, for example, those that contain persons who have mental health problems (National Statistics, 2006).

The present body of work focuses on mothers with dependent children who experience homelessness. The Homelessness Act 2002 placed a duty on Local Authorities to undertake a more strategic approach to prevention of homelessness and to the assistance provided to individuals experiencing homelessness as recommended by the Governments green paper 'Quality and choice, a decent home for all' (Department for Communities and Local Government [DCLG], 2000). The legislation encouraged Local Authorities to work with other agencies to prevent homelessness and to provide support to those experiencing homelessness (Shelter, 2006). The Government has also pledged to tackle the causes of homelessness, to help prevent homelessness (ODPM, 2003a) and to decrease by half the numbers of households living in insecure accommodation by 2010 (ODPM, 2005).

A number of large scale initiatives to tackle homelessness have been implemented, namely the development of the Social Exclusion Unit and Supporting People programme. The Social Exclusion Unit, part of the Cabinet Office, aims to assist individuals who are affected by poverty and disadvantage. Its report on mental health noted the difficulties that homeless individuals with complex needs have in accessing statutory services (ODPM, 2004).

A Government taskforce was announced in June 2006 and an action plan published, 'Reaching Out', which detailed planned initiatives such as early intervention, for example, parenting support and targeted services for those with multiple needs (Cabinet Office, 2006). 'Supporting People', established by the ODPM in 2003, aims to prevent homelessness, support tenancies and promote independence (O'Connell, 2003; ODPM, 2003b). Targeting the health of children living in temporary accommodation is also a key indicator in the report 'Tackling Health Inequalities. A programme for action' (Department of Health, 2003). 'Every Child Matters' is a further Government initiative which aims to improve the life chances and well being of children, especially those in care, with learning disabilities, or not in education. The programme promotes joint agency working to ensure children are safe, healthy and reach their potential (Department for Education and Skills, 2005).

Such Government policies and initiatives are informed by the concept of social capital (Helliwell & Putnam, 2004; Putnam, 1995). Social capital refers to the value of social networks, peoples' participation in them and the benefits that such involvements bring to individuals and communities, such as trust and reciprocity. It is argued that strengthening social and community networks and participation in them, will promote positive health outcomes. Yet societal changes need to be incorporated in modern conceptions of social capital. These include the increasing mobility and fragmentation within society and the increasing importance of informal

networks of friends and neighbours which may have replaced involvement in voluntary groups (Campbell & Gilles, 2001). Women's status, which involves issues such as employment, health and well-being has also been associated with social capital (Caiazza & Putnam, 2005). This suggests that economically poor, disempowered women such as those affected by homelessness may have little access to social capital. The development of services for socially excluded individuals who are homeless reflects the wider agenda of delivery of services in the community using a variety of agencies, utilising a so called 'joined up' approach (Salmon, 2006; H M Treasury, 2006; O'Connell, 2003; Roche, 2004; Vostanis, 2002).

The Government has also pledged to end child poverty by 2020. Recent figures show that 700 000 children were lifted out of poverty between 1998-2005, a 17% decrease which did not meet the Government's target of 25% (Joseph Rowntree Foundation, 2006). It is estimated that 3.4 million children still live in poverty in the UK (Guardian, 2006). This administrative framework introduces many of the factors that impact on families which become homeless and suggest that it is not simply a housing problem but one that involves health, economic and social factors as well. The current research focuses on health and social factors related to family homelessness.

Homelessness Research - what is already known?

The literature concerning homelessness has been described as atheoretical, often focussing on either individual deficits or structural issues such as housing policy rather than adopting a holistic view of the broader social context (Anderson, 2003; Banyard & Graham-Bermann, 1995; Toro, 2006). Homelessness involves macro and micro level factors which have combined to make individuals vulnerable to losing their homes (Anderson & Christian, 2003).

A number of vulnerability factors have been consistently associated with homelessness. Homelessness has been ascribed to poverty (Choi & Snyder, 1999), described as "a function of poverty" (Burt and Cohen, 1989, p. 521) and an indicator of poverty (New Policy Institute, 2006). In a review of food pantry users in the US, who are eligible to receive food parcels due to their low-incomes, 44% were homeless (Algert *et al*, 2006). Single mothers who are dependent on welfare benefits are at risk of homelessness. One parent families, nine out of ten of whom are single mothers, have the greatest risk of poverty compared to other family types (Ghate & Hazel, 2002). Thirty three percent of one parent families live on gross incomes of £200 per week or less compared to 3% of married and 10% of cohabiting couples (One Parent Families, 2006). When compared to married mothers, single mothers have been reported to be twice as likely to experience financial hardship and depression (Baker & North,

1999; Brown and Moran, 1997). Poverty has also been associated with poor mental health in women (e.g. Belle, 1990; Weinreb *et al*, 2006b).

Poor mental health is a well-documented risk factor for homelessness (e.g. Bassuk *et al*, 1997; Dean & Craig, 1999; Lauber *et al*, 2006) and is frequently reported by mothers who are currently homeless (Bassuk *et al*, 1986; Memmott & Young, 1993; Zima *et al*, 1996). A study using clinical interviews and screening questionnaires reported that mental health problems were up to four times as high in a homeless sample as compared to the UK general population (Gill *et al*, 1996). Similar results have been reported internationally but the research often focuses on single homeless adults who may face different stressors compared to women with dependent children (e.g. Cougnard *et al*, 2006). One UK study comparing homeless and low income but housed single mothers found that mental health problems as measured by the General Health Questionnaire (GHQ) were three times higher in the homeless sample compared to those who were housed (Vostanis *et al*, 1998).

Other studies confirm the serious disadvantages experienced by this population. It is reported that women with children who become homeless have histories of abuse (Bassuk *et al*, 1996; North *et al*, 1996), spent time in foster care (Bassuk *et al*, 1997), poor physical health (Weinreb *et al*, 1998), substance abuse problems (Bassuk *et al*, 1998) and poor social support (Bassuk & Rosenberg, 1988; Bassuk, 1990; Toohey *et al*, 2004). High rates of developmental delay and behavioural problems have been

found in children who are homeless (e.g. Anooshian, 2005; Bassuk & Rosenberg, 1990; Vostanis *et al*, 1996; Vostanis *et al*, 1997; Vostanis *et al*, 1998) and poor school and day care attendance (Cumella *et al*, 1998; Harpaz-Rotem, 2006) have been reported.

It has been argued that homelessness is a temporary state and that structural solutions such as the adequate provision of low-cost housing promote housing stability (Shinn, 1997; Stojanovic *et al*, 1999). However, it has been widely acknowledged that housing is not the sole solution for individuals who are poor and have often experienced victimisation and trauma as the aforementioned studies testify (ODPM, 2003a; Stickley *et al*, 2005). Despite this, secure housing appears to play a significant role in the promotion of health. In a review of homelessness studies, almost 50% of respondents reported that the provision of permanent housing alleviated symptoms of mental illness (Smith, 2005). Being housed (Wong & Piliavin, 2001) and better housing quality have been associated with improvements in mental health (Evans *et al*, 2000).

Other research has begun to explore the psychosocial and economic processes which relate to the experience of homelessness. Some suggest that psychological factors such as motivation and attitude determine a woman's success in escaping from homelessness (Lindsey, 1998). Another small (n=9) longitudinal study of formerly homeless families showed that resettlement was a long term process (Dunlap & Fogel,

1998). At two year follow-up, it was reported that families were economically more stable but were restrained by lack of education and unable to afford housing in more prosperous areas. The research evidence tends to suggest that the health of marginalised groups is promoted by change at both individual and macro levels (Campbell & Murray, 2004).

The state of being homeless indicates a disconnection from community and social networks. It has been suggested that homelessness is considered a type of social exclusion due to the coexistence of poverty and dislocation from social networks (Craig & Timms, 2000) combined with a poor environment and a lack of opportunities (Baker, 2002). Indeed homelessness has been described as 'a manifestation of social exclusion' by the Government (ODPM, 2003a), the Auditor General called it "a symptom of social exclusion" (Bourn, 2005, p. 1) and it is suggested that children experiencing homelessness face indirect discrimination due to stigma and poor access to services (Webb, 2004). Homelessness can, however, provide an opportunity to promote social inclusion as individuals are able to access services and social networking can occur.

Much previous research identifying the health and social problems experienced by this population has been led by medical researchers. This body of research has been criticised for it's medicalisation of homelessness, leading to the assumption of mental ill health, development of compulsory counselling services and isolation of families

from social networks (Bogard *et al*, 1999). This neglects the fact that such findings have considerably raised the profile of a previously 'hidden' population, and that becoming homeless provides an opportunity for poor and marginalised families to engage with specialist services and to improve their health and well-being. For example, women who have been subject to domestic violence can access psychological services such as counselling which can be used to address issues such as low self-esteem and reappraisal of behaviours such as returning to an abusive partner (Carlson, 1997). Many of the previous studies have used a cross sectional design or review of case records (e.g. North *et al*, 1996) therefore they neglect issues of process and cannot assess outcomes. This indicates a need for further prospective research.

This complex picture suggests that effective responses to family homelessness must address the multiple problems of poverty, ill health, trauma and marginalisation. The research to date has highlighted this serious social problem however is limited by its narrow range of methods and focus on American populations. The presented research focuses specifically on mental health, coping and support needs of homeless families in a UK context.

Services and Interventions for Homeless Families

Although individuals may be roofless, in temporary or unstable accommodation, the homeless population tends to be characterised by heterogeneity, reflected in the variety and complexity of needs presented.

This suggests that services need to be flexible and responsive and to co-operate with other agencies in order to meet the needs of this population. Recent writing on the promotion of social inclusion in this population suggests that empowering services should help identify a person's ambitions and facilitate exploration of the options available to them (Stickley *et al*, 2005). Despite this, homelessness has been traditionally viewed as a housing problem with Local Authority housing departments and a small number of charitable organisations providing the bulk of services to this population (Gaubatz, 2001; Roche, 2004) and UK research focussing primarily on structural and social policy perspectives (Christian, 2003).

A small number of specialist services have been developed for homeless families and little research exists which evaluates such interventions (D'Souza & Garcia, 2004; Hwang *et al*, 2005). In contrast, well established services exist for other homeless populations, especially single homeless people who are more visible as they may live on the streets, or 'sleep rough' (e.g. Commander *et al*. 1997; Holmes *et al*, 2005; McColl *et al*, 2006; Power & Attenborough, 2003).

Examples of services for homeless families in England which have been evaluated include Shelter's 'Homeless to Home', a health advocacy service and 'Surviving Homelessness'. The outcomes of such services and the rigour of evaluation methods vary.

An evaluation of the 'Homeless to Home' service indicated that it was able to help individuals sustain their tenancies. The service offered a range of interventions including assistance with decorating and gardening, and housing and budgeting advice. In a review of case records it was reported that 82% of families using the service remained in housing nine months after ceasing contact with the service (Jones *et al*, 2002).

An alternative methodology was used in an ambitious evaluation of a health advocacy intervention attached to a primary care service. A controlled, non-randomised trial compared health advocacy delivered in hostels (outreach service), a GP practice based advocate and a control group receiving standard primary care services. The results indicated that users of the outreach advocacy service used fewer primary care resources compared to the other groups. They had fewer consultations with a GP and were prescribed less medication and the advocacy intervention was found to be cost neutral (Reilly *et al*, 2004).

Other services promoted less tangible outcomes. Surviving Homelessness, which has since ceased operation, developed a user-led service model and aimed to break the cycle of homelessness by empowering women through providing peer support and overcoming barriers to achievement of resettlement (Hinton, 2001). This evaluation used action research underpinned by a feminist approach. This utilised a collaborative partnership between the researcher and the researched and promoted social change (Walters & East, 2001). The notion of

empowerment is an important facet of any intervention with vulnerable individuals as it involves building on someone's strengths. Helping that person access resources will have more long term benefit than simply overcoming problems (Banyard & Graham-Bermann, 1995), thus promoting resilience and social inclusion.

One other UK study was identified which reported on services for homeless families. This was an audit of the health and social needs of homeless families. The findings suggested that a part-time dedicated health visiting service for homeless families in central England improved support for families by providing information and developing relationships with other agencies (Riley *et al* 2001). The method for measuring these outcomes was not stated.

Previous research has identified the need for specialist services for homeless families. Despite this only a small number of such services have been established in England and little evidence exists as to their effectiveness. Overall, results suggest that services can have a positive impact yet there is need for further development, in particular to target parental health and child behaviour. The efficacy of such service models requires investigation utilising longitudinal research to establish whether positive outcomes are sustained over time. The previous research emphasis on structural factors associated with homelessness suggests a need to further explore the psychosocial impact of losing ones home. The

impact of services in relation to psychosocial health represents one strand of the research presented.

A number of services were established in England to address the high levels of maternal mental health problems and child behaviour problems identified in families experiencing homelessness (Vostanis *et al*, 1996; Vostanis *et al*, 1997; Vostanis *et al*, 1998) and their problems in accessing services (Cumella *et al*, 1998). This commentary now turns to the development and evaluation of these services.

The first mental health outreach service (MHOS) for this population was established in England **[1] (Tischler, Cumella et al, 2000)**. A review of (n=40) case records revealed high levels of mental health need, yet many mothers requested help with other issues such as re-housing and finance. Inter-group analyses **[2] (Vostanis, Tischler et al, 2001)** revealed the impact of different types of trauma leading to homelessness. Mental health was poorer in those mothers who had been exposed to neighbour harassment compared to those who were homeless due to domestic violence or for other reasons such as eviction. This was also true for the children in families where neighbour harassment had led to homelessness. This may suggest further risk factors and adversities in families exposed to neighbour violence, such as poverty and deprivation in the area of residence prior to homelessness, or it may be due to pre-existing mental health problems in these families. This cannot be

confirmed however as mental health status prior to homelessness was not known.

Mothers using the MHOS reported complex needs and these may be interpreted using Maslow's hierarchy, in which survival needs such as safety, shelter and income must be addressed before an individual pursues higher level needs such as psychological and cognitive exploration (Maslow, 1954). This highlighted the need for 'joined up' working involving liaison between multiple agencies. The service was medically and nursing led, which reflected the backgrounds of staff involved yet fervent attempts were made to promote a multi-agency approach. This met with some resistance from busy organisations concerned about increasing workloads. This was an example of a service which demonstrated the proactive lead that the psychiatric and nursing professions have taken in facilitating advocacy, promoting research and working with a range of mental health problems in the homeless population (Cook *et al*, 2004; McQuistion *et al*, 2003).

The over-representation of lone female parents with dependent children highlighted the gender issues related to family homelessness. The fact that most were homeless because of domestic violence also identified the vulnerability of these women and children and emphasises inequities related to victimised women and children forced to leave their homes to ensure their safety. This issue has been recently addressed in some areas

with ‘sanctuary’ schemes by which families can have security improved within their home and legal assistance with removal of violent aggressors, thus aiming to prevent homelessness (Pawson *et al*, 2006).The need for services to work with traumatised women and children was apparent, particularly once families were stabilised within the hostel. This work also indicates the range of services needed in this population, from meeting immediate safety requirements, through to therapeutic intervention.

A longitudinal, controlled design was used to evaluate the MHOS **[3] (Tischler, Vostanis et al, 2002)**. Two groups of homeless families living in temporary accommodation provided by the Local Authority were compared, one of which received the MHOS and the other receiving usual services. The results indicated the need for flexibility and responsiveness when working with homeless families. Although the service was targeted at child mental health problems, many mothers requested support for themselves, including requests for social care and housing advice suggesting that basic survival needs had yet to be met. The work also highlighted the importance of responding to maternal needs in relation to child health. The association between maternal distress and child behavioural problems has been well documented (Ghate & Hazel, 2002; Naerde *et al*, 2002; Najman *et al*, 2000; Rishel *et al*, 2006; Vostanis *et al*, 1996; Whitaker *et al*, 2006).

The key staff member, a community psychiatric nurse, showed flexibility and skill by providing services as varied as behavioural therapy for children and supporting housing applications. This emphasises the importance of liaison and multi-agency working highlighted in other studies of homeless individuals (Craig & Hodson, 2000; Reilly *et al*, 2004). Follow-up data revealed that child mental health problems improved in the intervention group and improvements were sustained over time, following resettlement of families. This suggests that short-term targeted interventions can be effective in improving child mental health, despite the variety of needs presented. The importance of early intervention in addressing child mental health problems has been recognised elsewhere (e.g. Royal College of Nursing, 2004). This publication has been listed as a resource on several web sites, for example, The European Federation of National Organisations working with the Homeless (FEANTSA, 2006) and the Welsh National Service Framework for Mental Health (Health Evidence Bulletins, 2006).

A small number of other studies have evaluated services for homeless families. These will be critically appraised in turn. An evaluation of a US classroom-based behavioural intervention, which included mental health promotion, compared three groups of children who were homeless and attending a summer camp; one receiving the intervention, one group of children who 'dropped out' of the intervention and another group of children who had received an alternative academic programme (Nabors *et*

al, 2003). The findings reported some improvement in children's behaviour if they completed the intervention related to the number of rewards given by staff. This was partially supported by parental reports of behaviour. Child behaviour was rated poorer in the drop out group however ratings were similar between intervention and academic comparison groups. The lack of difference reported between groups may be due to those 'dropping out' of the intervention as those children are likely to have had more problems which could therefore bias the results. The study did not use a randomised trial so the authors cannot state that the improvements in child behaviour were related solely to the intervention. Additionally, the authors did not describe what criteria were used to allocate participants to the intervention and comparison groups so it may be that the children in each group had different characteristics, for example relating to mental health or behavioural difficulties at baseline.

The need for continuing support has been identified in other studies of homeless individuals (e.g. Pollio *et al*, 2006), as has the requirement for innovative, outreach services (Nabors, 2003; Reilly *et al*, 2004). One US-based intervention offering this type of ongoing provision was reviewed using a retrospective case study design. The Thresholds project for homeless mothers offered psychosocial care management related to mental health and accommodation issues. This program was reported to achieve positive outcomes such as sustained tenancies, reduction in substance misuse and enrolment in education (Hanrahan *et al*, 2005).

The findings from this descriptive, pilot study were based upon a review of a small number of cases (n=24) and relied primarily on the perceptions of staff who recorded case information. The findings may reflect staff biases and the results may therefore not be generalisable. Improvements in mental health were measured according to the number of hospital admissions that participants had in the study period. The use of a standardised questionnaire measuring perceived mental health or a structured clinical interview may have elicited further information related to this outcome. Further the study does not include a comparison group nor information about mothers who left the program during the data collection period suggesting that there may have been differences between those who engaged with the service and those who did not.

An evaluation of a Homeless Families Program (HFP) which aimed to provide 'services-enriched' housing to address the multiple needs of homeless families benefited from a mixed methods approach and collection of data from multiple sources, for example staff and family focus groups, housing authority data and observation of project activities. The results indicated that those in the programme showed improvement in their residential stability compared to the time before they entered the programme, however many families were still dependent on state support and had not achieved educational or employment goals (Rog, 1999) thus reinforcing the complexity of issues related to resettlement after a period of homelessness and the need for intervention at a number of levels to

address this. The results from this study are more likely to be generalisable due to the large sample size and the methodologies used.

Another US study compared outcomes in 148 homeless mothers with substance abuse problems attending two therapeutic community (TC) interventions. The study used a quasi-experimental design. Allocation between the interventions was not randomised, however statistical control was used to adjust for differences between groups. This involved the use of propensity analysis which matches participants between groups and excludes those who cannot be matched. One intervention included homelessness prevention (HP) initiatives including intensive case support and housing input such as budgeting and homemaking. The other received standard TC input such as peer support and self help. The results showed that the mothers in the HP group improved significantly at 12 month follow up in terms of psychological functioning and improved health status and had a higher mean number of children living with them (Sacks *et al*, 2004). Results also showed a trend towards improvements in other domains including reduction in substance use and criminality but may not have reached significance due to lack of power and similarities between the treatments that were being compared. This study makes cautious recommendations based upon the potential overlap in treatment conditions and the limitations of the methodology used. The study ambitiously explored a wide range of psychosocial factors likely to impact

on homeless mothers with children and in that context can be viewed as a good example of an exploratory piece of work.

The identified trends in results indicate that interventions for homeless families can have a positive impact, for example improving parental health and child behaviour and sustaining tenancies. Yet many families had residual needs. This may reflect the heterogeneous nature of the population, the complexity or chronicity of needs presented, or limitations in methodologies used. For the women studied in the presented work, many of whom had troubled backgrounds, homelessness represented an episode in a long period of instability. This suggests that many of these women require ongoing support, indicating that their problem is not merely homelessness but other issues including victimisation, abuse, poverty, and lack of healthy support networks. These multiple issues require a variety of responses including provision of housing, financial and educational support to promote employability, therapeutic intervention to address previous traumas, social skills training, and access to support networks. The research therefore turns to evolving models of service provision to better meet these needs.

The need for flexible services for this population was again highlighted when an exploratory study to inform the development of a resettlement service (Beaumont Leys Independent Support Service - BLISS) was completed **[4] (Tischler & Gregory, 2002)**. Focus groups with

homeless and vulnerably housed individuals were used to assess tenancy needs and awareness of the resettlement service. This type of method was felt to be appropriate for exploring ideas and gaining information using group dynamics to generate discussion (Bowling, 2002). Through interaction participants are able to question their own and others' views of the world, enabling them to review their understanding and to set their beliefs in a social context (Kitzinger, 1994). The participants who were homeless were not receiving the resettlement service and those who were housed were BLISS clients. They were recruited to the study using posters displayed in a homeless hostel for families and the BLISS office. Time was taken at the beginning of each focus group to ensure that participants felt comfortable and able to contribute. Ice-breaker exercises were used, confidentiality assured and the provision of snacks and drinks was used to encourage an informal atmosphere.

Qualitative data indicated that the range of services offered by the resettlement team was important, from information on childcare and schooling to healthcare advice and assistance with removals. The importance of establishing trust and working with these families over time was another key aspect of the service. Almost half of those homeless did not feel that resettlement services could prevent homelessness. The homeless respondents reported a wider range of needs than the housed group. The findings reinforce the complexity of needs and often multiple services that homeless and vulnerably housed individuals require. The

service represented a shift away from a medical or nursing led service to a generic model of provision. This type of 'floating support' has been shown to be cost-effective and to have a positive impact, for example in encouraging independence (Reacroft, 2005) and addressing social exclusion (Baker, 2002).

The development of a family support work (FSW) service **[5] (Tischler, Karim et al, 2004)** described the further evolution of services for this population. It had been recognised that resettlement services may be too basic and that the MHOS may be too specialised, therefore there was a need to move to a service which bridged these two provisions. The generic model of service delivery demonstrated the ability of a social care trained worker to address a wide range of needs presented by families, including increased focus on the needs of children, thus highlighting the de-medicalisation of services for this population. Services offered included the provision of parenting classes, children's activities, liaison with, and referral to, agencies such as mental health and social services, and re-housing support. The profile of families was similar to previous studies with most being single mothers who were victims of domestic or neighbourhood violence. High levels of parental mental ill health and behavioural problems in children were found, concurring with previous findings. Cross-sectional findings indicated that the service was valued by parents although the objectives of the service were at times unclear

which is unsurprising given the range and scope of assistance offered and the varying needs of families.

A major drawback of the service was its limited resources delivered by one full-time family support worker which meant that families could not be followed up after resettlement, an issue which has been identified as key to stabilising families after homelessness (Walters & East, 2001). This limitation has since been addressed as the service has been expanded to five family support workers who are recurrently funded by the Local Authority housing department. Families deemed to be 'at risk' are visited after re-housing for up to six months. The workers are managed by the housing department and also receive supervision from a clinical psychologist working in a Child and Adolescent Mental Health (CAMHS) team. This ensures that therapeutic as well as practical needs are identified. Tenancy support is available in addition to help families resettle (Vostanis, 2006).

Mixed methods were used in a prospective study to follow-up families using the FSW service to determine whether parenting stress, mother's mental health and child behaviour changed from the baseline period of homelessness to re-housing four months later **[6] (Karim, Tischler et al, 2006)**. Mothers' scores on the Hospital Anxiety and Depression Scale (HADS) indicated psychiatric morbidity in 80% of participants at baseline interview. Mental health remained poor at four month follow up as 77% of

mother's HADS scores reached caseness. Perception of parenting problems as measured by Parenting Daily Hassles Scale (PDHS) remained unchanged from baseline to follow-up. Poor child behaviour was associated with experience of domestic violence and this persisted at follow up although disruptive behaviour had improved. This suggests that the service had a limited impact in these domains and that problems are often related to other factors aside from housing as most families were resettled at follow-up. As a small number of families remained homeless at follow-up outcomes were compared for the re-housed and 'still homeless' groups. There was no difference in parental scores on the HADS or PDHS. Children still living in hostels were found to improve in regard to emotional problems and problems within their family. This may be due to the impact of services available in hostels and the safety and respite that hostels may provide compared to a previously chaotic and violent home life.

Qualitative data provided a subjective and more detailed picture of the psychosocial status of these families. Most women who were re-housed stated that their mental health had improved in contrast to the quantitative findings which indicated continued morbidity. This disparity between different types of data may be due to social desirability, that is, people stating positive outcomes in face-to-face interviews because they think that that is what they are expected to report. Also, initial improvements in mental health and child behaviour may not have been

sustained after re-housing. Nevertheless, the findings confirm that individuals who experience homelessness have problems that persist after re-housing and are likely to be related to other issues, again emphasising the importance of follow-up.

Coping and Stress theory

Stress theories provide a valuable context in which to examine homelessness as it has been described variously as a 'psychological trauma' (Goodman *et al*, 1991), "devastating physical deprivation and social isolation" (Wong & Piliavin, 2001, p. 1037-1038), a 'devastating trauma' (Stickley *et al*, 2005), and "an extreme form of disadvantage" (Flouri & Buchanan, 2004, p. 2). Homelessness involves loss of home, possessions and a connection to an individual's local community and social networks. It is often preceded by traumatic events such as domestic violence, neighbour harassment or relationship breakdown. Because homelessness involves acute and chronic stressors and utilises social and health resources to manage these, it is appropriate to examine it using a stress model (Milburn & D'Ercole, 1991).

Social stress is a process which includes the following domains; stressors such as life events and poverty, mediating resources such as coping and social support and manifestations of stress such as mental distress (Pearlin *et al*, 1981). The stressor of family homelessness impacts on children as well as parents. It is well documented that children who

experience homelessness may be traumatised by the experience and by events beforehand such as witnessing domestic violence (Anooshian, 2005) which will create additional parenting stress (Danesco & Holden, 1998; Waldron *et al*, 2001). This stress is compounded in single parents who have to manage with little or no support (Ghate & Hazel, 2002). In a study of families exposed to community violence it was reported that parental distress and coping was an important mediator of distress in children (Aisenberg & Ell, 2005).

In order to understand how mothers manage and overcome the stressor of homelessness their coping skills and support resources were investigated in more detail.

Coping refers to "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Transactional theories of stress and coping suggest that stress arises from interaction between an individual and their environment. Stress occurs when there is an imbalance between the demands placed upon an individual and their ability to meet these demands (Gross, 2005). Appraisal refers to the mediating process that occurs when a person-environment interaction takes place (Lazarus and Folkman, 1984). Appraisal is influenced by person characteristics such as motivation, for example values and commitment, beliefs about self and

the environment, and personal resources such as money, health and energy. These individual differences help to explain why several people may cope very differently when confronted with the same stressor. This means one person may appraise a stressor as a threat whilst another considers it a neutral event. Personality traits have also been associated with types of coping, for example, neuroticism and use of avoidance and denial (Ferguson, 2001).

A distinction can be made between coping styles and coping strategies. Coping styles refer to personality characteristics and more stable, dispositional features such as temperament, whereas coping strategies are used in response to a stressor at a particular point in time (Carver & Scheier, 1994). Stress research should also consider sociological features such as the systems and contexts in which individuals live and work as these are often related to stressors experienced (Pearlin, 1989). Further, an interactional model of stress and coping should incorporate a variety of factors including environmental and personal systems, transitory events, appraisal and coping strategies, and well being and health (Moos & Holahan, 2003). Environmental and personal systems represent relatively stable factors such as chronic stressors and personality traits, whereas transitory conditions include significant life events. These components shape an individual's appraisal and coping choices and, in turn, well-being and health.

Appraisal may be primary or secondary. Primary appraisal refers to an individual's assessment of an event, deciding whether it is threatening, harmful, or challenging. A perception of threat would trigger secondary appraisal, when a person decides what coping behaviours or resources are available to deal with the stressor (Lazarus and Folkman, 1984). Historically coping has frequently been dichotomised as either problem focussed or emotion focussed, where problem-focussed coping involves direct action to manage a stressor and emotion-focussed coping refers to efforts to regulate feelings associated with a stressor.

One theoretical framework particularly appropriate to the multifaceted stressor of homelessness is the Moos Crisis Theory (Moos & Schaefer, 1986). The model suggests that factors related to the crisis, background and personal issues, and the social and physical environment influence how an individual copes with a crisis. Individuals cope by appraising a stressor, undertaking problem solving related to it, and completing other tasks related to general psychosocial functioning. Individuals then utilise specific coping strategies, for example, seeking social support. These processes combine to determine the outcome of a crisis (Sarafino, 2005).

It has been suggested that some types of coping are more adaptive than others, for example, that problem focussed strategies are associated with more adaptive outcomes compared to emotion-focussed coping, for example disengagement has been associated with depression (e.g.

Felsten, 1998; Votta & Manion, 2004). Many other studies reveal similar associations however it may be that the distinction between emotion and problem-focussed coping has been oversimplified (Lazarus, 1999). Mental state is often used as an outcome related to the efficacy of types of coping. It could be that associations between emotion focussed coping and distress are due to the confounding of the two concepts (Coyne & Racioppo, 2000; Snyder, 1999). It has also been suggested that the diversity of items included in emotion focussed coping dimensions makes it difficult to measure as a single construct (Austenfeld & Stanton, 2004). Emotion-focussed and problem-focussed coping are interdependent and therefore should be measured both separately and together (Lazarus, 2000).

The importance of context and coping has also been recognised. This means that coping is situation-specific, therefore the perceived efficacy of the same coping strategy used in two different stressful scenarios will differ. Context relates not only to an individual's situation but also to the social environment in which that person operates, for example, women in an all-female environment such as a hostel may use different coping strategies compared to a situation in which there are males present (Unger, 1990) and emotion-focussed coping, in particular religious beliefs have been reported in male adolescents living in a war zone (Thabet et al, 2004, see Appendix 11). This suggests that emotion-focussed coping may have a potentially protective function where a stressor is traumatic or

uncontrollable. Also, cultural differences in coping styles (Aldwin, 1994) mean that coping strategies should not be rated in terms of their adaptive qualities without considering the wider social context. Further, context should incorporate interactions between individuals and their environment but also the linkages between different systems such as family, school, and Government policies thus taking a more ecological approach which incorporates socioeconomic factors (Moos, 2003). This is applicable to homelessness which is defined by statute and involves government provision of temporary accommodation. In summary, assessment of coping should consider personality factors, biology, culture, gender roles and social context.

There is inconclusive evidence regarding gender differences in methods of coping. Some studies report gender differences in styles of coping, for example that women are more likely than men to use avoidance and emotion focussed coping (Matud, 2004; Ptacek *et al*, 1992). Another study found no gender differences in use of problem solving or avoidance but found that women were more likely than men to use social support as a coping mechanism (Felsten, 1998). Other findings report no gender differences in coping (e.g. Porter & Stone, 1995). It has also been argued that when personality variables and gender roles, that is, masculinity and femininity are considered, there are no differences in coping between genders (Lengua & Stormshak, 2000). Where differences have been found, these are often related to the socialisation hypothesis which

suggests that men and women are socialised to cope with problems differently (Ptacek *et al*, 1994).

Taking a structural viewpoint, it is acknowledged that vulnerable women, such as those living in poverty, will have less access to resources than other groups which may constrain their coping efforts (Banyard & Graham-Bermann, 1993) and that factors such as violence, power and social forces limit marginalised women's coping choices (Lewis *et al*, 2006). Previous qualitative research with mothers experiencing homelessness cautions against labelling coping strategies such as avoidance or diversion as dysfunctional (Cosgrove & Flynn, 2005). In fact, such strategies may be appropriate when dealing with an uncontrollable or traumatic stressor (Lewis *et al*, 2006; Milburn & D'Ercole, 1991). It has also been reported that depressive symptoms, for example, withdrawal may play a protective function when an individual is under stress by acting as a 'shut down' mechanism. This provides a time of respite in which to conserve and rebuild ones resources (Brissett-Chapman, 1998; Nesse, 2000). This suggests that seemingly adaptive coping cannot be assessed without reviewing the wider context in which it takes place, and without considering that other psychosocial resources interact with coping mechanisms.

It has been reported that women who were in an abusive relationship used avoidance to cope, but if abuse became more frequent and severe,

active strategies were utilised to leave the relationship (Arriaga & Capezza, 2005; Waldrop & Resick, 2004). In addition, problem-focussed coping may be related to better outcomes in samples of women drawn from shelters where they are no longer experiencing violence and abuse (Clements & Sawhney, 2000). These findings emphasise that coping is a process which ought to be assessed longitudinally. Importantly, most research involving homeless women takes place in shelters or hostels. Therefore these women may not be typical of all women experiencing homelessness as they may represent 'help-seekers' (Waldrop & Resick, 2004) or a higher functioning section of the population (Banyard & Graham-Bermann, 1998).

The issues discussed above were synthesised in a paper focussing on understanding coping in vulnerable populations **[10] (Tischler, under review)**. A selection of qualitative findings revealed insights into the nature of coping in a population of homeless mothers. The data revealed the interaction between coping and other outcomes such as mental health and also clarified the meaning of the stressor of homelessness for participants, for example, for some homelessness represented a 'means to an end', that is, a route to a new home. This may be considered a type of problem-solving. For others, the stress of the situation was paramount and distress experienced was attributed to homelessness. Disengagement strategies were commonly related to mental distress suggesting that morbidity hampers effective coping or that depressive symptoms such as

withdrawal are an adaptive way to cope whilst homeless. It may also be that mental distress preceded emotion-focussed efforts to cope as it has been suggested that strategies to manage emotion may occur only when that feeling has been experienced (Coyne & Racioppo, 2000). This would appear relevant here, due to the traumatic events experienced by most respondents prior to homelessness.

Factors related to the coping style of the participants including gender, culture and homelessness were discussed. These have been previously identified as influences on women's coping (Banyard & Graham-Bermann, 1993). Most homeless women are economically poor and have histories of abuse and other health problems, all factors which can impair the ability to cope effectively. Thus it is argued that the use of standardised measures of coping, often developed in white, middle class populations may not capture the essence of coping in this population, and may mistakenly depict this group of women as 'poor' copers.

It is suggested that qualitative methods are incorporated into research involving vulnerable populations such as homeless women in order to get a comprehensive picture of coping, including women's motives and intended outcomes, and to capture the context in which coping takes place. Qualitative research is not presented as a substitute for quantitative inquiry; rather it is seen as a valuable adjunct as it provides insights into perceptions and experiences of homelessness. The

potentially therapeutic qualities of qualitative investigation are noted, as it can be empowering for participants. This should be a component in methodologies that incorporate feminist values which aim to involve participants in research and improve their lives in the process (Lindsey, 1997). It could be argued that this approach should be mandatory for any research involving marginalised individuals as it enables people to be heard and their views documented.

It should be acknowledged that qualitative approaches also have limitations as they rely on participants' verbal skills (Britten, 1995), these may be limited in disempowered individuals. Research investigating sensitive issues may cause distress in participants (Kavanaugh & Ayres, 1998) and the boundaries between research and therapeutic work may be unclear to those taking part (Dickson-Swift *et al*, 2006). Also, there is a power differential between the researcher and the researched which may be more pronounced where the research participants are vulnerable (Ensign, 2003).

It is suggested that standardised measures of coping are developed in marginalised populations. Such measures should incorporate assessment of state and trait, and lower and higher order functions of coping. This would capture contextual and personality factors, coping actions and their adaptive functions and would help to gain a comprehensive understanding of the coping process. This will help to explain what type of coping is

optimal for a particular individual in particular circumstances (Somerfield & McCrae, 2000).

A body of research has considered the coping strategies of women who have experienced abuse, victimisation, and violence. These findings are related to the current research as a consistently high proportion of women who become homeless have experienced childhood abuse and domestic violence. Findings indicate associations between suppression of childhood sexual abuse and low self esteem (Perrott *et al*, 1998), use of drugs and alcohol and experience of physical and sexual abuse (Wingood *et al*, 2000), self blame and dysphoria, hopelessness and low self-esteem (Clements *et al*, 2004), avoidance and use of illicit drugs (Nyamathi *et al*, 1995), and disengagement and psychological distress (Coffey *et al*, 1996). Previous studies do however indicate that women who have been abused and who experience homelessness use a variety of engaged and disengaged coping strategies (Banyard, 1995; Lewis *et al*, 2006; Wagner & Menke, 1991).

A longitudinal study explored the relationship between coping, mental health and goal achievement **[7] (Tischler & Vostanis, 2007)**. Results indicated that a range of coping strategies were used as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES), supporting previous findings in homeless women (Banyard & Graham-Bermann, 1998; Wagner & Menke, 1991). Previous cross sectional studies compared

coping in homeless and low-income but housed women. Banyard and Graham-Bermann (1998) reported no differences in active-cognitive and active-behavioural coping between groups but found that avoidance was used more by homeless participants. Within-group comparisons indicated that use of avoidance was associated with depressive symptoms in both groups. A study by Wagner and Menke (1991) noted that although homeless mothers used similar coping strategies to the housed group, the homeless women were more vulnerable as they had experienced more stressors in the previous year, had more children and less education than the comparison group. Both studies indicate that these populations experience similar stressors but that homeless mothers are more vulnerable due to extreme poverty and exposure to violence, than the comparison groups. The lack of difference in the coping results may suggest that trait factors are more important than context or that standardised measures of coping have not been able to detect differences and that a different methodological approach is required.

Self reported mental distress was high as measured by the GHQ, in keeping with other findings in samples of homeless women (e.g. Vostanis *et al*, 1998) and did decrease over time although most participants still had poor mental health even after being re-housed. This was consistent with other findings **[6]** and suggests that mental distress is related to homelessness and other issues such as previous trauma or pre-existing conditions. Those who had been formerly homeless were likely to have

poorer mental health than those who were homeless for the first time. This may indicate additional vulnerability, for example a history of residential instability or chronic domestic violence, in this sub-group of homeless women.

Goal achievement is an example of an outcome measure related to stress and coping and an indicator of coping efficacy. It has been noted that "identifying relevant goals is a prerequisite for understanding how people choose coping strategies and how they focus their coping efforts" (Coyne & Racioppo, 2000, p. 658). It is also important to incorporate the goals of this population into research so that outcomes are linked to individual needs (Somerfield & McCrae, 2000). Further, findings can be used to develop services responsive to need and to help build strengths (Banyard & Graham-Bermann, 1995).

Goal achievement has been measured in a small number of studies with individuals who are homeless. Goals such as returning to education, or seeking employment were commonly reported by homeless women in a qualitative studies (Banyard & Graham-Bermann, 1995; Cosgrove & Flynn, 2005). In one of the few longitudinal studies applying stress and coping theory in a homeless population, utilisation of social support was associated with higher levels of goal achievement in adolescents (Dalton & Packenham, 2002).

The most common goal reported in the presented study was finding new, permanent accommodation which was in keeping with other findings (Banyard & Graham-Bermann, 1995) although a higher number in their sample reported employment and a return to education as goals. The longitudinal methodology allowed process and outcomes to be examined. This meant that goal achievement could be verified as women were asked whether they had accomplished their specified goal at follow-up and most (28/44) responded affirmatively. Use of the coping strategy seeking social support was associated with achievement of goals reinforcing the adaptive quality of this strategy. This may also emphasise the positive role that peer support can play in a hostel environment (Banyard, 1995).

Poorer mental health was associated with lower use of cognitive reframing and seeking social support. This may suggest that poorer mental health impaired coping efforts or it may be that they were using emotion focussed coping when they first became homeless which, as has been noted, may be protective in the short term. Some differences in coping according to reasons for homelessness were established. Those who had been evicted were more likely to use passive appraisal which includes disengagement strategies such as believing in luck and inactive approaches to problem solving. This indicates that families who are homeless for different reasons may have diverse needs and available resources and that support services should be tailored to respond to these individual variations The data related to this finding is cross-sectional so it

could not be established whether respondents used disengagement prior to becoming homeless.

The associations between mental distress and avoidance, whilst consistent, should be interpreted cautiously. Whilst acknowledging the distress of participants and the risks associated with this for themselves and their children, it should be considered that these women may have been managing a stressor in an avoidant way that was appropriate for them at a particular time. Crucially, most achieved their self-defined goals and this was associated with use of social support. This reinforces the interdependence of different types of coping and the process framework which suggests that people sequentially use a variety of coping strategies to manage a stressor. It also suggests that coping choices may be based upon available resources, for example the peer support available within hostels may have facilitated respondent's use of support to cope. This stresses the importance of context when assessing coping and the interaction between situational and individual factors which is often not considered in standardised measures.

Few other studies have used a longitudinal design to examine psychosocial factors in homeless women. One (Rayburn *et al*, 2005) explored the relationship between trauma, mental health, coping and service seeking in homeless and low-income but housed women. They found that those exposed to physical violence or experiencing homelessness between baseline interview and follow-up were more likely

to be depressed than those not experiencing those stressors in that time period. This reinforces the risks to women experiencing violence and homelessness and the need to assist women to break out of abusive relationships which may often be cyclical. Traumatic events such as childhood sexual abuse were associated with avoidant coping and depressive symptoms. Women who used active coping were more likely to seek help from services. It was suggested that training in use of adaptive coping skills could increase women's utilisation of services. Also, identification of women using emotion-focussed coping may detect those who are most at risk.

Another longitudinal study examined factors predicting physical violence in women in shelters and women who had low incomes but were housed (Wenzel *et al*, 2004). Experience of physical violence was associated with being in a homeless shelter at baseline interview compared to the housed group. Physical violence, mental health problems, low levels of social support, and having multiple partners at baseline were all associated with experiencing violence at six month follow-up with no differences between groups according to housed or homeless status. Neither this nor the Rayburn *et al* (2005) study specified which of the respondents were mothers so the findings may reflect a different homeless population which limits comparability.

A branch of psychology labelled 'positive psychology' recognises that crises may provide opportunities for individuals to grow, develop and learn new skills, thus gaining a sense of mastery (Moos, 2002; Moos & Holahan, 2003), pursuing new goals (Moos, 2003; Tedeschi, 1999), and generating positive emotion (Folkman & Moskowitz, 2000). It may be that crises "often provide an essential condition for psychological development" (Moos & Schaefer, 1986, p. 9). In addition to building resilience, positive changes occurring as a result of coping with traumatic events have been described as 'posttraumatic growth' (Tedeschi & Calhoun, 2004; Tedeschi & Kilmer, 2005).

The findings from qualitative interviews with previously homeless mothers supported the concept of 'posttraumatic growth' **[9] (Tischler, in press)**. Most women had reframed what had been a traumatic time often involving past exposure to violent events and the time spent homeless. Women reported resettlement outcomes such as improved health and children attending school which engendered a sense of achievement as they had managed to improve the lives of themselves and their offspring. Many women expressed renewed confidence as they had escaped from a violent relationship with an ex-partner. This can be attributed to a sense of mastery achieved when individuals feel a sense of control over their lives rather than feeling that events are due to chance (Pearlin & Schooler, 1978). This is in contrast to the experiences of victimisation and homelessness which may engender feelings of powerlessness.

The presented study explored the meaning of resettlement which encapsulates complex psychosocial processes including obtaining a home, developing house-keeping skills, and a sense of being in the right place (Rivlin & Moore, 2001). Although the women had gained permanent accommodation and most were satisfied with their new homes, many expressed ambivalence regarding the area in which they were moved, for example they were concerned about drug-dealing in the vicinity. This raised questions about the lack of choice that these women had in regard to housing and their longer term commitment to staying there. This suggests that the element of 'being in the right place' was lacking and is in keeping with other findings which reveal that resettlement is a long-term process often hampered by lack of resources (Rog, 1999). Other findings suggest that homeless individuals are frequently offered poor housing stock, this is reflected in the fact that up to a third request a transfer after being re-housed (Collard, 1997).

Other themes reported included personal growth and a desire to improve the system for others. Similar findings have been reported in other qualitative findings in this population (Hodnicki & Horner, 1993; Meadows-Oliver, 2003). Women were also asked about their hopes for the future which were largely centred around resettlement issues. These included stability of accommodation, education for themselves and their children and seeking employment, results which echo other findings in

this population (Styron *et al*, 2000). The mobilising power of hope has been reported elsewhere (Herth, 1996; Herth, 1998) and could be incorporated into interventions to help empower and build resilience in these women.

Much evidence promotes the protective role that social support contributes to well being and averting stress, that is, the buffering hypothesis (e.g. Holahan & Moos, 1986; Myers, 2002; Taylor, 2006). Findings reveal the mediating role that social support plays in vulnerable populations. In a sample of very poor individuals it was reported that conflict with members of one's social network was predictive of mental distress (Bassuk *et al*, 2002). Other findings suggest that the use of problem solving strategies by female victims of domestic violence was associated with poor mental health where they had low levels of social support (Kocot & Goodman, 2003).

A variety of studies have examined social support in homeless women with mixed findings. Poor social support has been associated with subsequent physical violence (Wenzel *et al*, 2004). Cross- sectional surveys reveal high levels of social isolation (Nyamathi *et al*, 2000b), conflict in intimate relationships (Nyamathi *et al*, 1999), and poor quality of social support, for example from partners who abuse illicit drugs (Nyamathi *et al*, 2000a). A sense of 'connectedness' to others has been reported to engender feelings of hope in a homeless population (Herth,

1996). A cross-sectional examination of the relationship between mental health, social support and child behavioural problems in homeless families **[2]** found that lack of social support from family and professionals predicted poor mental health in mothers and children.

The findings from an exploration of mothers' experiences of homelessness **[8] (Tischler, Rademeyer et al, 2007)** builds on the small body of research using qualitative methods to investigate this phenomenon. The results supported previous findings which associate poor mental health with lack of social support. It should be noted that a small minority reported improvements in their mental health on becoming homeless. This may represent the respite that homelessness can provide following previous traumas. This was noted in another qualitative study of mothers' experiences of homelessness (Styron *et al*, 2000).

The findings revealed a number of reasons why women in this population become socially isolated. Three themes were inductively derived from the data, those who were estranged, 'overstayers' and the geographically isolated. Those women described as estranged had long standing histories of family dysfunction, often involving abuse and neglect. Women who were described as 'overstayers' did engage with members of their social network however these relationships had broken down prior to homelessness, for example, interaction was strained if they were sharing accommodation with family or friends and it was overcrowded. A similar finding was noted in another qualitative study of homeless parents in the

US (Choi & Snyder, 1999). The third group were geographically isolated from their social networks as they had been moved into a different district. This is often a consequence of housing policy as families are moved away from previous violence for reasons of safety.

The importance of peer support from other homeless women was revealed reinforcing the potential opportunity that homelessness provides to build social networks. This challenges the policies of many hostels which discourage contact between residents. This was recognised as a way of coping for respondents as they identified with others in the same situation thus normalising the experience and gaining acceptance. It has been suggested that previously homeless women can be trained as befrienders in order to mentor women who are homeless and to provide informal support following re-housing (Hinton, 2001). Such support could help to enrich the networks of women who have experienced social isolation.

Many respondents described disengagement coping such as suppression of feelings. These findings are in keeping with other qualitative studies of homeless mothers (e.g. Averitt, 2003). One coping strategy noted to be important in Averitt's focus group study of 29 homeless mothers was the importance of religious faith to cope. A meta-synthesis of 18 qualitative studies of homeless mothers also reported that religious faith, for example praying, was a common coping strategy (Meadows-Oliver,

2003). These findings may reflect cultural differences between the UK and US.

The importance of social support from family and other homeless women has been noted in other studies. One small study (n=11) utilised qualitative interviewing and photo-elicitation to gather data about coping and social support (Klitzing, 2004). Another qualitative study involving 64 homeless mothers described the importance of 'coping in connection' which included support received from others such as shelter staff, family, friends, shelter residents, and their children (Banyard, 1995). Lack of social support may be an indicator of other risk factors, for example, one study reported that poor levels of support in low-income and homeless mothers were associated with higher use of secondary health care (Weinreb *et al*, 2006a).

Methodological considerations

It has been suggested that studies of stress, emotion and coping should include the following components; "longitudinal, prospective and microanalytic approaches; in-depth observation; and holism" (Lazarus, 2000, p. 667). A particular strength of the papers submitted is the use of mixed methods, longitudinal and controlled designs.

Mixed Methods

Mixed methods research was used to ensure complementarity. This was considered important in a series of studies involving marginalised women and in order to fully understand the complexities of homelessness and resettlement and the psychosocial processes related to a heterogeneous population. This approach aimed to enhance the quantitative findings by using qualitative data to provide meaningful contextual information (Bowling, 2002). Mixing methods advocates integration of different types of data (Tashakkori & Cresswell, 2007; Bryman, 2007). This approach to research follows a pragmatic philosophy which favours a commonsense approach to research, embracing subjective and objective perspectives in generating data (Johnson & Onwuegbuzie, 2004; Morgan, 2007) and advocates that the methodologies chosen are driven by the research questions asked (Todd & Nerlich, 2004). A more recent analytic approach has been proposed, named composite analysis (Yardley & Bishop, 2007). This approach advocates integrating qualitative and quantitative data such that they elicit unique yet complementary findings.

Qualitative Methodologies

Qualitative methods were considered appropriate for use in studies involving homeless women as they represent a shift towards "naturalistic, contextual, and holistic understanding" (Todd *et al*, 2004, p. 4). This is in contrast to positivist approaches which are often characterised by 'objective' examination of phenomena, focussing on quantitative data

collection (Dyer, 2006). The use of qualitative methods was informed by social constructivism. This philosophical framework advocates that phenomena associated with the social world is understood through social interaction which addresses people's perceptions and experiences and incorporates core values of diversity, ecology and empowerment (Banyard & Miller, 1998; Dyer, 2006; Toro *et al*, 1991). Therefore reality is constructed from different social perspectives (Avis, 2005). In this case the phenomenon of homelessness is illuminated through the perspectives and insights of homeless women.

Qualitative data can help understand and develop the sometimes one-dimensional results that quantitative data can yield. This was considered important in order to describe the multi-faceted phenomena of homelessness and to explicate the complexity of the coping process. A narrative approach was taken in gathering data via semi-structured interviews. This allowed women to tell their own stories; what happened before homelessness, what life was like whilst they were homeless and afterwards, reflecting on their experiences. Issues related to the measurement of coping such as context and motivation as previously discussed warranted a qualitative approach when exploring this concept. Qualitative data has been noted to reveal insights into individuals' thoughts, behaviour and emotions when coping (Folkman & Moskowitz, 2000) and can also help to illustrate the diversity of the coping process (Oakland & Ostell, 1996) and describe complex phenomena (Banyard &

Miller, 1998; Smith *et al*, 1995). This is illustrated in the coded example given in Appendix 10.

A further aim of including qualitative data was to address the limitations of standardised measures of coping. Such 'omnibus' measures have been criticised for producing few generalisable findings as they generate summary scores which convey little information about coping with specific events, individual goals, and the process of events (Coyne & Racioppo, 2000).

The use of participant-derived goals in the presented work ensured that the outcome of 'goal achievement' was contextually relevant to the participants involved (Somerfield & McCrae, 2000).

Alignment of feminist and qualitative research principles can promote vulnerable women's strengths, encourage their empowerment (Cosgrove & Flynn, 2005; Lindsey, 1997; Milburn & D'Ercole, 1991) and validate their experiences (Davis, 2002). Qualitative methods also have some limitations, particularly for use in marginalised populations, which have been referred to earlier, for example, the impact of the power differential between the researcher and participants which may influence the ability of individuals to share information. A mixed methods approach is therefore most suited to research with homeless populations. It offers a pragmatic approach which ensures that qualitative and quantitative data

provide a comprehensive and holistic understanding of the phenomenon under investigation.

Further strengths of the research programme were the use of a prospective, controlled design to evaluate the MHOS **[3]** and assess outcomes such as goal achievement **[7]** and the attempt to recruit a representative sample of study participants. The evaluation of the MHOS recruited participants from multiple sites as recommended by Toro *et al* (1999). This was not possible in other study sites due to the lack of equivalent hostel facilities **[6]**. One disadvantage associated with the use of a controlled design is that selection bias may occur when allocating participants to the intervention or control groups (Tilling *et al*, 2005).

The presented studies represent a body of work carried out in a challenging context and with difficult to reach participants. As such, some methodological problems were experienced, particularly in relation to attrition in the longitudinal studies. The difficulties in engaging individuals in longitudinal studies are well documented. Such designs are especially challenging with indigent populations. Use of longitudinal research methods with populations who are homeless has been described as "daunting and requires extensive resources" (Toro, 2006, p. 348), with high attrition rates (Winship, 2001). Despite this it is acknowledged that longitudinal research is best suited to understanding process and causality (Waldrop & Resick, 2004) and there is a need for more of these type of

studies to address issues such as pathways in and out of homelessness (Anderson, 2003). Such studies will require substantial resources, commitment and tenacity on the part of researchers involved.

The limitations associated with the use of self-report measures, for example, to assess mental health and child behaviour should be acknowledged. The GHQ is a widely used screening tool for detection of mental health problems in community settings and has been used in other studies with vulnerable individuals, for example, those living in poverty (Weich & Lewis, 1998) and refugees (de Jong *et al*, 2000). It is recommended that a structured clinical interview is used to confirm diagnoses of mental illness (Benjamin *et al*, 1991) although it has been noted that diagnostic interviews may be too intrusive for use in homeless centres (Smith, 2005). It is acknowledged that the use of a screening tool such as the GHQ may mean that general distress is being detected rather than mental illness. Reporting of mental health problems in this population may mean that the view of homelessness as a 'medical' problem is perpetuated and the stigma associated with it increased (Bogard *et al*, 1999). In addition, the GHQ is unlikely to detect alcohol and substance misuse (Morris & Goldberg, 1989) although caseness has been associated with illicit drug use (e.g. MacCall *et al*, 2001). Substance misuse has been reported in other studies of homeless mothers (Bassuk *et al*, 1998; Salomon *et al*, 2002; Weinreb *et al*, 1998) and may have accounted for some of the attrition in the presented work. However exploration of sensitive topics such as substance misuse in this population

may result in under-reporting due to fears about child protection procedures.

Maternal distress is known to increase reports of child behaviour problems (Najman *et al*, 2001). The reliability and validity of self-report measures may also be influenced by researcher presence during completion and a noisy environment (Foley *et al*, 2005). These were both factors in the presented work. Also social desirability bias may mean that reports of satisfaction with services and improvements in health should be interpreted cautiously. Despite reassurance that participation in the research would not affect their prospects for re-housing, some women may have felt under pressure to praise the services that were available.

Future Research and Service Development- where to now?

Despite the challenges associated with prospective research in homeless populations there is a need for further research of this type. In particular there is a need for follow-up studies over a longer period of time to investigate whether families remain resettled over a longer period and what skills and resources they require in which to do so. This would inform service provision and development in this country which is still evolving. Further controlled studies should be used to evaluate interventions in this population. Ideally such a design should use randomised allocation as has been used in other studies in homeless populations (e.g. Jones *et al*, 2003). Clinical interviews should be used in

future studies in order to confirm rates of mental ill health, substance misuse, alcohol abuse and to detect co-morbidity in this population.

It would also be beneficial to assess coping at multiple time points to discover whether strategies change in relation to different events in these women's lives and to assess the risks of longer term use of avoidance and disengagement. Use of mixed methodologies would be advisable due to the limitations associated with standardised measures (Coyne & Gottlieb, 1996). The use of daily process methods of assessment such as diary-keeping have been found to elicit more accurate data on coping than more traditional recall methods (Tennen *et al*, 2000) and may be usefully applied in this population although they require substantial resources and commitment.

The variety of needs presented by families was a consistent finding. The complexity of cases suggests that dedicated services should continue to be developed based upon a more generic model with input from specialist services. Findings from the service evaluation **[3]** led to development of services in another region of England. The findings from papers **[5]** and **[6]** were used to secure funding to ensure that follow-up care was available to formerly homeless families. The identification of the importance of peer support in this population recommends the establishment of support groups, befrienders or 'buddy' schemes in hostels. Health professionals can assist women to engage with support

groups (Meadows-Oliver, 2005). Similar provision could continue after re-housing led by resettlement and tenancy support teams.

The mixed findings regarding coping in this population and the limited application of previous findings to intervention (Coyne & Racioppo, 2000) warrant caution in interpretation. However, the identification of coping strategies elicits important information about the resources women may have available and could identify risk factors for mental distress. Equally, identifying mental distress can signify potential deficits in coping skills. This stresses the need for skilled mental health workers to be available to this population. It is possible to teach coping skills, for example, problem-solving and assertiveness. Evidence from other studies indicates that interventions to promote coping skills can have positive benefits, for example, decreasing levels of distress (e.g. Sikkema *et al*, 2006).

Conclusions

In summary, the presented work has demonstrated that families who experience homelessness have multiple health and social needs which can be partially met by both short term mental health and social care interventions. Despite the variety of problems presented, the MHOS improved child behaviour as reported by mothers. This improvement is likely to have a positive impact on maternal health as well. Also, mothers reported a subjective improvement in their mental health after using the same service. The residual health and other difficulties reported at follow-up suggests that families require a range of interventions and multi-

agency co-ordination to meet their needs and that issues such as poor mental health are often long-standing, may precede homelessness and be related to factors other than housing status. This advocates the need for continuing support and intervention for vulnerable families following homelessness as the results suggest that resettlement is a long-term process.

The findings regarding coping in this population indicate that a range of strategies are used but that disengagement and avoidance may be a common yet justifiable consequence of poor mental health, the stress of homelessness, and the traumas experienced beforehand. Despite poor mental health and low use of adaptive coping strategies, short-term goals were achieved suggesting that psychological functioning improved over time.

The perception of isolation in this population and the reported importance of peer support indicates the need to promote social networking whilst homeless and afterwards, for example using mentorship, to encourage social inclusion and to build much needed social capital. In this way homelessness may provide an opportunity to increase social support. The findings also indicated that although stressful, homelessness had provided an opportunity for personal growth as women had improved the lives of themselves and their children.

The mixed methods used in this body of research was a strength and provided a much needed insight into the needs, resources and motivations of this hidden, indigent population over time. Further research should build on this to ensure that the needs of homeless families are highlighted and that the Government agenda of promoting social inclusion in this population is advanced.

List of Publications

[1] Tischler, V., Cumella, S., Bellerby, T. and Vostanis, P. (2000) A Mental health Service for homeless children and families. *Psychiatric Bulletin* 24, 339-341

[2] Vostanis, P. **Tischler, V.**, Cumella, S. and Bellerby, T. (2001) Mental health problems and social supports among homeless mothers and children victims of domestic violence. *International Journal of Social Psychiatry* 47 (4), 30-40

[3] Tischler, V., Vostanis, P., Bellerby, T. and Cumella, S. (2002) Evaluation of a mental health outreach service for homeless families. *Archives of Disease in Childhood* 86, 158-163

[4] Tischler, V. and Gregory, P. (2002) A resettlement service for homeless and vulnerable parents. *Housing, care and support* 5 (4), 33-36

[5] Tischler, V., Karim, K., Rastall, S., Gregory, P. and Vostanis, P. (2004) A Family Support Service for homeless children and parents: users' perspectives and characteristics. *Health and Social Care in the Community* 12 (4), 327-335

[6] Karim, K., **Tischler, V.**, Gregory, P. and Vostanis, P. (2006) Homeless children and parents: short-term mental health outcome. *International Journal of Social Psychiatry* 52 (5), 447-458

[7] Tischler, V. and Vostanis, P. (2007) Homeless Mothers: Is there a Relationship between Coping Strategies, Mental Health and Goal

Achievement? *Journal of Community and Applied Social Psychology* 17, 85-102

[8] Tischler, V., Rademeyer, A. and Vostanis, P (2007) Mothers experiencing homelessness: mental health, support and social care needs. *Health and Social Care in the Community* 15 (3), 246-253

[9] Tischler, V. (in press) Resettlement and Reintegration: Mother's Reflections after Homelessness. *Community, Work and Family*

[10] Tischler, V. (under review) "I'm not coping, I'm surviving": Understanding coping in vulnerable populations. *Qualitative Research in Psychology*

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VICTORIA TISCHLER, STUART CUMELLA, TINA BELLERBY AND PANOS VOSTANIS

Service innovations: a mental health service for homeless children and families

AIMS AND METHOD

Description of the development of an outreach mental health service for homeless children and families, and presentation of referrals characteristics and management of 40 families.

RESULTS

Families became homeless predominantly because of domestic and neighbourhood violence. They were usually referred to the team for assessment of parents and children, without specific mental health concerns. A range of mental health interventions was offered, as well as liaison with other agencies.

CLINICAL IMPLICATIONS

The development of such services requires coordination of different agencies working with children and their parents. Also, designated staff and resources, because of the potential conflict with generic services.

At any one time, over 60 000 families in England are defined as homeless by local authorities. An initial research project including 114 homeless families (with 249 children) in Birmingham identified a high level of unmet mental health needs (Vostanis et *at,* 1997, 1998). Homeless mothers reported significantly higher rates of psychiatric morbidity (up to 50%) than a comparison group of mothers living in permanent housing. Homeless children were more likely to have histories of abuse, living in care, being on the at-risk protection register, delayed communication and higher reported mental health problems. Despite the high rates of psychiatric morbidity in children (estimated at 30%) and parents (estimated at 50%), only 3% of the children and less than 10% of the mothers had been seen by a mental health worker during the preceding year.

In contrast with single adult homeless people (Commander et al, 1997), there has been no systematic development of mental health services for this needy population of children and families, who cannot access mainstream services at the time of crisis. Several service initiatives have been reported, often through the voluntary sector.

The study

Establishment of the service

In addition to organisational difficulties, multi-agency research to evaluate the level of unmet need in similar populations often raises anxiety in the welfare sectors involved. To avoid such problems and to enable the findings of the epidemiological survey to be used in a constructive way that would lead to policy planning and service development, the findings were regularly discussed with and disseminated jointly to the local authority, particularly the Housing Department. At two milestones of the project (the completion of the cross-sectional and the longitudinal studies) conferences were organised with the participation of all sectors involved.

The first conference involved directors and senior managers (commissioners and policy-makers) to set the framework and directions of the service. The second invited the directors of education, social services, housing and health to report on the progress of each sector, but also involved 'front-line' staff from all agencies working with homeless families. Problems were identified in multi-agency workshops and summarised in a conference report. Funding for a designated community psychiatric nurse (CPN) post was made available at this stage.

The next step was the establishment of a multi-agency group for the city. Its aims were to: identify homeless children and families with unmet needs within each sector; advocate for new resources; improve existing services (e.g. health visiting and schooling); and ensure the inclusion of homeless families in policy and commissioning documents (e.g. children's services plans). Participants included a general practitioner, a health visitor, a CPN for the homeless, a child psychiatrist, a consultant paediatrician, a representative of Women's Aid, and managers from housing, health, education and social services. Despite different priorities within each agency, it was essential to establish a group of this nature from the beginning, to prevent conflict between health and local authority agencies.

Service objectives

The service objectives took into account the characteristics of homeless families, i.e. repeated hostel admissions and moves, and the absence or uncoordinated provision of mental health, educational and social services. Pragmatic aims were identified:

(a) assessment and brief treatment of mental disorders in children and parents (e.g. depression, post-traumatic stress disorder);

(b) liaison with appropriate agencies (education, social services, child protection, local mental health services, voluntary and community organisations) to facilitate the re-integration of the family into the community, and particularly their engagement with local services following rehousing; and

(c) training of staff of homeless centres in the understanding, recognition and management of mental illness in children and parents. This is essential, as hostel staff often work in isolation and have little knowledge of the potential severity and consequences of mental health problems in children. It also has implications for other evolving community child mental health care models.

Function of the service

To maximise the impact of limited resources, regular outreach sessions are held at identified centres for homeless families. There is also, however, flexible response if necessary. To avoid screening all admissions, referral criteria have been established, either in relation to mental health concerns in parents and children (including learning disability), or through identification of high-risk families (e.g. those in which there are victims of domestic violence or established or suspected child protection issues). Because of the interface between different agencies, a weekly inter-agency meeting is held at each hostel, when all families are discussed. Certain agencies have been reluctant to be represented fearing an increase in their generic case-load. Intervention by agencies has therefore been ad hoc, their contribution often fragmented and hence not cost-effective.

Direct work with children and families is faced with constraints, because of the brief length of stay and the complexity of psychosocial problems. Mental health care and housing staff are often seen as the only route to a number of services, and workers are faced with a range of social work requests. The need for a designated social worker, keyworker or even advocate is apparent. Despite the limited period of involvement, direct work and treatment can be effective. Time-limited behavioural therapy or advice is given to parents and staff on how to deal with children's aggressive behaviour, bedwetting or sleep problems. Brief supportive psychotherapy is offered to children who have experienced major trauma Children with learning disabilities and special educational needs are over-represented in this population and in urgent need of special school provision. Parents (usually mothers) often have histories of recurrent depressive or anxiety episodes, substance misuse, personality disorders and erratic contact with adult mental health services.

Referrals

During the first 12 months, 40 families with 122 children were referred to the team. Most (72.5%, n=29) were single mothers with children. Of the parents referred, 82.5% (33) were White, 12.5% (5) Asian and 5% (2) African-Caribbean. Of the children 62.5% (25) were White, 22.5% (9) were mixed race, 10% (4) Asian and 5% (2) African-Caribbean. Reasons for homelessness are summarised in Table 1. All families were referred via a weekly inter-agency meeting at homeless centres. For reasons for referral see Table 2. Most families referred to the team (55%) were seen on average for 1-3 sessions, and a further 22.5% were seen 4-6 times. Treatment and interventions are summarised in Table 3.

Discussion

These findings reflect some of the complexities of working with the homeless population. The nature and range of interventions offered demonstrates the multiple needs, such as social, educational and mental health problems, of many homeless families. The findings also indicate some of the difficulties in separating child and parental mental health needs. Despite efforts to focus on the mental health needs of the children, many mothers were preoccupied with their own needs. Around 25% of cases did not attend for appointments. This was frustrating, but not surprising given that the mental health needs of these families are often not their first priority: many state that their primary needs are rehousing and financial stability. In addition, many families perceived that physical health deserved higher priority than mental health. The reason for this is unclear and may require further investigation.

Regular contact with the families is crucial. Some may cope well when they initially become homeless and may feel relieved to have escaped from an unhappy or violent home situation. A prolonged stay in a hostel, however, may provoke the onset of depression in parents or behavioural problems in children. It is therefore important to revisit families who have been homeless for a longer period. Referrals should be discussed in regular team meetings, as hostel staff may be more likely to refer families whose parents can articulate their needs, or whose children have clear behavioural problems. Those families who are quieter or more withdrawn, but who may be no less in need of a service, could then be overlooked.

The needs of homeless families require a multidisciplinary response, and the team has set up a monthly steering group in an endeavour to engage and coordinate other agencies (such as social services, primary care and the voluntary sector) in order to increase the range of services available. This has been problematic, as some

Table1. Reasons for homelessness (n=40 families)

	%	n
Domestic violence	47.5	19
Harassment by neighbour	32.5	13
Eviction	7.5	3
Overcrowding	5.0	2
Family violence	2.5	1
Natural disaster	2.5	1
Released from prison	2.5	1

Table 2. Reasons for referral (n=40 families)

	%	n
General assessment	57.5	23
Assessment of parental mental health	20	8
Child behavioural problems	15	6
Counselling following domestic violence	5	2
School non-attendance	2.5	1

services, for example social services, have resource constraints. Although other agencies acknowledge the significant needs of the homeless population, their direct involvement can often be attributed to the goodwill of a number of committed professionals. A rolling programme of training is offered to housing staff to increase awareness of mental health issues and ensure appropriate referrals to the team. In addition, a quarterly newsletter is produced to try to raise awareness of the problems that homeless families face. It is also important to note that designated time to work with this population has been secured in order to support staff in the team who have an additional generic case-load and therefore competing pressures to deal with.

This service model is currently being evaluated by a research team funded by the NHS Research and Development programme. The service is constantly evolving, often because of changes in the housing legislation and the homeless population. In the past year, there has been a substantial increase in the refugee population outside London. Also, victimising families, rather than victims, are increasingly being moved to homeless centres, as a result of more protective legislation. It is hoped that similar models for socially excluded children and their families will emerge and be developed through local and health authority partnership.

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Table 3. Treatment and intervention (n=40 families)

	n'
Advice/support for parent	20
Behaviour management	13
Counselling	6
Liaison with another agency	9
Referral to another agency	7
Mental health assessment	12
Family meeting 8 Anxiety management	4
Parenting skills training	8
Family meetings	8
Total 95	

1. All families used two or more treatments/interventions.

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MENTAL HEALTH PROBLEMS AND SOCIAL SUPPORTS AMONG HOMELESS MOTHERS AND CHILDREN VICTIMS OF DOMESTIC AND COMMUNITY VIOLENCE

P. VOSTANIS, V. TISCHLER, S. CUMELLA AND T. BELLERBY

SUMMARY

Background: Children and mothers who have suffered domestic or neighbourhood violence constitute a high risk group, although it has not been clear whether their mental health needs are specifically related to the type of violence. This paper reports on the prevalence of mental health problems in homeless parents and children who have experienced domestic and neighbourhood violence and their access to social support networks.

Methods: Three groups of families who had become homeless were compared: those experiencing domestic violence (48 with 75 children), victims of neighbourhood violence (14 with 29 children), and those who became homeless for other reasons (31 with 54 children). Mothers completed a service use semi-structured interview, the Strengths and Difficulties Questionnaire, the General Health Questionnaire, the Family Support Scales, and the SF-36 Health Status Questionnaire.

Results: Levels of psychiatric morbidity were high in the group experiencing domestic violence (35.7% in children and 21.9% in mothers) and higher still in those who were victims of neighbourhood violence (52.2% in children and 50% in mothers). Levels of social support were found to be an important factor, particularly in relation to professional support and support from other family members, as they predicted both child and maternal psychopathology.

Conclusions: Mental health interventions for victims of domestic and neigh-bourhood violence should be integrated with community programmes of social reintegration. Mental health professionals should work in close collaboration with Housing Departments, Social Services, Education and the Police.

INTRODUCTION

The association between exposure to conflict and violence of different types and child psychopathology is well established. The mechanisms are more complex, and have been linked to the direct traumatic experience, the impact on parents or carers, and on mediating longstanding life events and adversities (Quinton & Rutter, 1985; Rutter, 1999).

Most of the evidence arises from studies on children exposed to community violence, particularly in relation to the development of post-traumatic stress

disorders (McCloskey & Walker, 2000). Research has included high risk populations, such as children experiencing war conflict (Thabet & Vostanis, 1999), violent attacks on school children (e.g. sniper attack - Nader et al., 1990; exposure to stabbing or shooting in an urban community - Schwab-Stone et al., 1995).

The extent and impact of domestic violence on women and their children has attracted interest from research groups and policy makers in the last few years (Zuckerman et al., 1995; Hall & Lynch, 1998; Kerker et al., 2000). Domestic violent incidents constitute 25% of all reported violent crimes (Black, 1998). Children can be involved in a number of ways, i.e. by witnessing the violent episode, being aware of their mother's fear, or their lives being disrupted by the violence (Carol, 1994; Black & Newman, 1996). There is also significant overlap with child abuse (Jaffe et al., 1990). Age (cognitive and emotional capacity) and gender are important factors on how children will be affected (Jaffe et al., 1986; Emery, 1989). A series of studies in Canada on children of battered women demonstrated emotional, behavioural and social problems among children exposed to family violence (Wolfe et al., 1985 & 1986; Moffitt & Caspi, 1998). In a US study of mothers in battered women's shelters and the community, McCloskey et al. (1995) found increased risk for child abuse and child psychopathology, but not for specific child psychiatric disorders. Exposure to family violence is among risk factors for adult psychopathology and social adversities, such as homelessness (Koegel et al., 1995). Experiencing both physical and verbal family conflict has been a stronger predictor of child mental health problems (Fantuzzo et al., 1991). A proposed mediating mechanism may be the effect of maternal stress on parenting skills (Holden & Ritchie, 1991; Hausman & Hammen, 1993).

Another series of longitudinal studies in New Zealand examined predictors of violence as part of the Dunedin Multidisciplinary Health and Development Study. Children with conduct disorders were three times more likely than their peers to perpetrate physical violence against their partners as adults (Magdol et al., 1997).

Victims of domestic and community violence are over-represented among the homeless population (Bassuk & Rosenberg, 1990; Haque & Malos, 1994; Weinreb & Rossi, 1995; Bassuk et al., 1996). Studies on families who become homeless for reasons including domestic violence and neighbourhood harassment, have found high rates of mental health problems among both mothers and children (Masten et al., 1993; North et al., 1996; Vostanis et al., 1997). These are often compounded by the resulting social disruption and isolation, loss of friendships and education, and limited access to health and social care services (Cumella et al., 1998; Vostanis et al., 1998; Vostanis & Cumella, 1999). Such factors are often longstanding and interactional, and it is often difficult to establish their relative impact on maternal and child psychopathology. The aim of this study was to assess mental health problems among mothers and children who had been exposed to domestic and community violence at

the study and asked to participate over a period of 18 months. Of those, 61 (35.8%) had already been re-housed or had moved from the hostel within two weeks from admission, and were not included in the study. Of the remaining 109 families, 16 (14.7%) refused to take part or could not be contacted despite repeated attempts, and 93 homeless families participated in the research.

Around half of the sample (48 families) with 75 children aged 3-16 years (this age range was considered appropriate to measure psychopathology) were victims of domestic violence (DV). Fourteen families with 29 children were victims of neighbour harassment (NH). Thirty-one families with 54 children who became homeless for different reasons, without involving violence (NV), i.e. controlling for homelessness but not for exposure to violence, constituted the control group. These reasons included relationship or family breakdown without violence (12), landlord eviction (6), overcrowding (4), rent arrears (4), refugees (4), and natural disaster (1).

Previous studies by the same research group have established significantly higher mental health needs among homeless families (mothers and children) in comparison with poor families in stable housing, and there are population norms for the two measures of psychopathology, therefore a community comparison group was not selected in this study. We rather concentrated on potential differences between families who had become homeless through different routes.

Measures

• *The Strengths and Difficulties Questionnaire (SDQ)* - (Goodman 1997) is a standardized measure of children's mental health problems, and is particularly useful for epidemiological research. Out of the SDQ's 25 items, 14 describe perceived difficulties, 10 perceived strengths and one is neutral ('gets on better with adults than with other children'). Each perceived difficulties item is scored on a 0-2 scale (not true, somewhat true, certainly true). Five perceived strengths items (excluding the pro-social items) are reversely scored, i.e. 2: not true, l: somewhat true, 0: certainly true. The 25 SDQ items are divided in the scales of Hyperactivity, Emotional Problems, Conduct Problems, Peer Problems and Prosocial Scale (five items per scale). Cut-off scores have been established in the UK and other populations, for each scale and the total number of difficulties (Goodman and Scott, 1999; Thabet et al., 2000). The P3-4 (age 3-4 years) and P4-16 (age 4-16 years) versions of the SDQ were completed by parents in this study.

• *The General Health Questionnaire* (GHQ - Goldberg, 1978): a standardised self-report measure of psychiatric morbidity in the parents, with established norms in the general population. Its 28-item version was completed, with four scales of Somatic Symptoms, Anxiety, Social Dysfunction, and Depression.

• *The SF-36 Health Status Questionnaire* (Ware and Sherbourne, 1992), as a measure of perceived health and health service use by the respondents. It includes 36 items divided in eight scales (physical, social, physical role, and emotional role function; mental health, energy/vitality, pain, and general health. It has been previously used with adult homeless people (Usherwood and Jones, 1993). In this study, this was completed by parents, while parallel questions on children's service use were covered by the semi-structured interview (see previous).

• The *Family Support Scale* (FSS - Dunst et al., 1984) is a measure of the degree to which different sources of support are helpful to families rearing a young child, over the last 3-6 months. Ratings are made on a 0-5 point scale. Five sources of support (partner/spouse, informal kinship, formal kinship, social organizations, professional services) are rated on their total number, level of helpfulness, and satisfaction.

•A brief semi-structured interview on reasons for becoming homeless, service use in the previous four months, and parents' hopes for the future.

RESULTS

The family characteristics are presented in Table l. The number of children in the family was strongly correlated with the family weekly income within the total homeless sample (Spearman rank correlation coefficient r=0.657, p=0.000). Not surprisingly, the NH and the control group were more likely to include couples or single fathers than the DV group (x2=18.8, df=4, p=0.001).

NH families were more likely to have been in contact with Social Services in the previous months than DV families (x2 = 8.9, df = 1, p = 0.003). As the sub-groups did not differ on utilisation of other services, the percentages of service use in the previous four months are presented for the total sample of 93 homeless families: about two thirds (61.4%) had seen their GP during that period, 43.3% had contact with hospital services, 21.4% with a health visitor, 50.7% with a social worker, 61.4% with the police, 31.4% with a voluntary agency, and 14.3% with an education welfare officer (52.9% of all homeless children were not attending school at the time of the interview).

When homeless mothers were asked about service deficits at the time of admission to the hostel, only 0.7% identified health as their primary concern. In contrast, 30.2% wanted more advice and information, 16.5% more practical assistance, 11.5% improved housing offers, 5.0% financial support, and 2.2% wished they received legal advice (33.9% did not state a service deficit).

Mothers who had been exposed to community violence had significantly higher scores on most GHQ scales than mothers' victims of domestic violence: Mann-Whitney non parametric U test - somatic symptoms z = 2.2, p = 0.035; anxiety z = 1.8, p = 0.08; total scores z = 1.96, p = 0.049). There was a significantly higher proportion of GHQ cases among the NH compared to the DV families (50.0% and 21.9% respectively; x2 = 5.7, df = l, p = 0.017).

The DV and the NV (non-violence) group did not differ significantly on GHQ scores. However, NV mothers were more likely to describe their mental health as "good since becoming homeless" than DV mothers (x' = 9.0, df = 2, p = 0.011). The only SF-36 item that distinguished the groups was "vitality-feeling worn out", with the NH group scoring higher as "all/most of the time" than the DV group (x2 = 16.7, df = 5, p = 0.005). DV mothers scored lower on two Family Support Scales items than NV mothers, although the difference did not reach statistical significance (Mann-Whitney non-parametric U test): number of social organisation supports z = 1.7, p= 0.09; satisfaction with available partner support z = 1.8, p = 0.6.

The relationship between FSS and GHQ scales was tested by Spearman rank correlation

Table 1
Characteristics of homeless mothers (N = 93)

	Domestic violence (N = 48)	Neighbour harassment (N =14)	Other homeless (N = 31)
Ethnic group			
White (UK)	28 (58.3%)	9(64.3%)	19(61.3%)
White (Irish)	2(4.2%)	1 (7.1%)	1 (3.2%)
White (Middle East)	l(2.1%)	0	1(32%
White (European)	0	0	4(12.9%)
Afro-Caribbean	13 (27.1%)	2(14.3%)	3 (9.7%)
Asian	4(8.3%)	2(14.3%)	3 (9.7%)
Family status			
Single mother	46(95.8%)	12(85.7%)	18 (58.1%)
Couple	2(4.2%)	2(14.3%)	11 (35.5%)
Single father	0	0	2(6.4%
Number of children (mean,	2.5 (1-5)	2.8 (1-7)	2.7(1-
History of homelessness	28 (58.3%)	10(71.4%)	13(41.9%)
Mean length of stay at previous address	39.2	45.3	46.1
In receipt of Income Support	21 (43.8%)	4(28.6%)	17(54.8
Mean family income (£) **per week**	£123	£164	£119
Legal status			
No charges	12	4	
Pressed charges	2	3	
Sought injunction	5		
Dropped case/charges	2		
Solicitor involved	1	1	
Refugee			4
SF-36 general health items (valid %)			
Excellent health	43.5%	80%	32%
Get ill more easily than other people (mostly/definitely true)	18.9%	27.3%	20%
Expect health to get worse (mostly definitely true)	12.5%	7.1%	20%
SF-36 emotional items			
Reduced time on activities	57.6%	75%	50%
Accomplished less than I would like	63.6%	75%	53.6%
SF-36 mental health items			
Felt downhearted and low	36.5%	30%	44.4%
little/some of the time	15.2%	0	14.8%
good bit of the time	36.4%	70%	33.3%
most/all of the time			
Been a very nervous person	60.6%	30%	46.5%
little/some of the time	18.2%	10	10.7%
good bit of the time	12.1%	50	17.8%
most/all of the time			
GHQ scores			
Caseness (above cut-off score - valid	21.9%	50	29.6%
Total score (mean, SD)	109 (7.2)	17.0(8.5)	11.7 (9.1)
Somatic score	3.1 (2.4)	4.8(23	3.1 (2.6)
Anxiety score	3.6 (2.3)	(23	4.0 (2.5)
Depression	23 (3.7)	3.4(2.9)	2.0 (2.7)
Social dysfunction	3.0 (23)	3.8(2.3)	2.6 (2.5)

* Valid percentages are given for the SF-36 and the GHQ, because of varying missing data

within a) the total homeless group, and b) among DV mothers. The number of formal kinship supports was inversely associated with the number of children in the family (r = -0.287, p = 0.019). The length of stay at the previous address (i.e. before becoming homeless) was correlated with satisfaction with available social organisation support (r = 0.50, p = 0.034) and satisfaction with available professional support (r = 0.47, p= 0.050), and inversely correlated with GHQ social dysfunction scores (r =-0.29, p = 0.031). Total GHQ scores were inversely associated with weekly income (r =-0.32, p-0.040), and satisfaction with available social support (total scale score: r=-0.043, p = 0.06), although the latter did not reach statistical significance.

Within the DV family sample, family income and number of children were also correlated (r = 0.78, p = 0.001). The length of stay at the previous tenancy was inversely correlated with the number of formal kinship supports (r = -0.47, p= 0.028), while family income was inversely correlated with the number of available social supports (r =-0.56, p = 0.036). The sociodemographic factors and the FSS items were entered as independent variables in a stepwise linear regression analysis, with total GHQ scores as the dependent variable. Low satisfaction with available social support was the strongest predictor (B = 6.02, p = 0.020). In a similar regression analysis, with caseness according to the GHQ as the dependent variable, and sociodemographic and FSS items as covariates, family size (number of children) and low satisfaction with available informal support were the strongest predictors (respectively chi square = 3.8, p = *0.05* 1; chi square = 4.2, p = 0.040).

Children's SDQ scores are presented in Table 2. Within the total sample, total SDQ scores were inversely correlated with length of stay at the previous residence (Spearman coefficient, r = -0.29, p = 0.002), and younger children tended to come from lower income families (r = 0.42, p = 0.000).

Comparing DV with NH families on the SDQ ratings, NH families were more likely to have a child with peer relationship problems (i.e. above the cut-off score on the SDQ; x2 = 13.2, df = 1, p = 0.000) or a child with significant emotional problems (x^2 = 4.13,

Table 2
Strengths and difficulties questionnaire scores of homeless children (N = 158)

	Experienced domestic violence (N = 75)	Experienced neighbour harassment (N = 29)	Other homeless (N = 54)
Mean age (range 3-16 years)	8.4	11.3	8.2
Cases above the SDQ cut-off	35.7%	52.2%	44.4%
Emotional problems	21.1%	43.5%	31.1%
Conduct problems	31.1%	39.1%	48.9%
Hyperactivity problems	26.8%	30.4%	33.3%
Peer relationship problems	19.3%	60.4%	40.0%
Mean SDQ scores (SD)			
Total score	13.7 (6.8)	17.1 (5.9)	15.7 (7.0)
' Emotional scale	3.0 (2.4)	4.2 (2.7)	3.4 (2.6)
Conduct scale	3.2 (2.7)	3.5 (1.8)	3.7 (2.4)
Hyperactivity scale	4.8 (2.3)	5.1 (1.8)	5.6 (2.2)
Peer relat scale	2.6(l.6)	4.3 (2.2)	3.1 (2.1)

df = 1, p = 0.042). They also presented with higher total SDQ scores (z = 2.09, p = 0.036). When the two groups were compared on SDQ items (symptoms), NH children were reported to have significantly more worries (Mann-Whitney non-parametric test, z= 2.38, p = 0.017), more nervous or clingy in new situations (z = 2.53, p = 0.11), picked on or bullied by other children (z = 2.99, p = 0.003), and less likely to have a close friend (z = 3.55, p = 0.000).

Children who became homeless for reasons other than violence were more likely to have peer relationship problems (above the cut-off score; x' = 5.29, df = 1, p = 0.021) than children who had experienced domestic violence. These two groups did not differ on any SDQ subscales, or total SDQ scores (z = 1.45, p = 0.15).

We then investigated the impact of family and social variables on child psychopathology in the total sample through a series of multiple logistic or linear regression analyses. The SDQ caseness (score of 17 or above on the SDQ) was initially entered as the dependent variable in a stepwise logistic regression, with demographic variables, FSS scales and GHQ caseness as the covariates. The number of formal kinship supports was the strongest predictor of presence of child psychopathology (B = 0.89, p = 0.007), and there was also significant association from the number of professional supports (B = 3.81, p = *0.05* 1). When the presence of clinically significant conduct problems was entered as the dependent variable, a short length of stay at the previous accommodation was the strongest predictor (B=-0.02, p = 0.30). Presence of significant peer relationship problems was predicted by the number of formal kinship supports (GB = 0.99, p = 0.048). In a linear regression analysis, the severity of peer relationship problems (scale score on the SDQ) was significantly predicted by the mother social dysfunction score on the GHQ (beta = 0.82, p = 0.034). When the maternal GHQ was entered as the dependent variable, this was predicted by several social and FSS variables, but not by SDQ scores: income beta = 0.30, p = 0.041; length of stay at previous address beta = 0.26, p = 0.051; number of partner supports beta = 1.72, p = 0.003; number of formal kinship supports beta = 1.06, p = 0.002; number of social organisation supports beta = 0.74, p = 0.026; number of professional services supports beta = 1.15, p = 0.010. In a similar logistic regression, with caseness on the GHQ as the dependent variable, the number of partner supports was the strongest predictor (B = 0.53, p = 0.013). The reason for becoming homeless (DV, NH or other) was not associated with either child or adult psychopathology.

When asked about their hopes and aspirations for the future, the majority of the 93 homeless mothers (72.7%) wished for a new home and resettlement, 7.9% for their children to return to education, 7.2% to get employment, 1.4% to receive further education, and 1.4% to return to their country of origin (9.4% did not state a primary aspiration).

DISCUSSION

In previous studies, we investigated the prevalence of psychiatric morbidity in homeless mothers and their children, and their use of mental health and related services (Vostanis *et al.,* 1998; Cumella *et al.,* 1998). In the study from a new cohort presented in the current paper, we explored in more detail the relationship between mental health problems and types of social support, in specific groups of homeless families, i.e. those who had experienced violence,

either from partners or from neighbours. The frequency rates were high, particularly among children, compared to the general population. The highest rates of morbidity were detected in victims of neighbourhood harassment. All three groups of children (including the remaining families, who had become homeless for reasons other than violence) had high rates of general mental health problems - 35.7% in DV victims, 52.2% in victims of neighbourhood harassment, and 44.4% in the remaining homeless families. This compares with 30% in our previous homeless sample (Vostanis *et al.,* 1997) and 20-25% of mental health problems in the general population (Mental Health Foundation, 1999). These rates are usually established using measures such as the Strengths and Difficulties Questionnaire. Studies using psychiatric interviews in two-stage designs have detected prevalence of more severe and persistent child psychiatric disorders between 10- 15% (e.g. Office of National Statistics, 2000).

The high level of child and adult mental health needs was strongly associated with the number of available family, social and professional supports, and this association was not mediated by the reasons for becoming homeless. This may indicate either that domestic and community violence was longstanding and precipitated the break-up of support networks, or that violence was an acute life-event in families already experiencing a number of chronic psychosocial adversities. These hypotheses could not be tested by this design. Whatever the underlying mechanisms, family, social and professional support strongly predicted the presence of clinically significant mental health problems in children and their mothers.

Of the three groups, children and parents who had suffered from neighbourhood harassment had the highest rates of mental health problems, although their social supports were not significantly different from the other two groups. The high morbidity may be related to confounding factors, such as recurrent episodes of violence and family disruption, which were not taken into account. The length of stay at the previous address predicted both maternal GHQ scores and child emotional problems, and could be a reflection of such a mechanism. Also, these families reported higher level of contact with Social Services, which also supports the previous hypothesis. Children who had experienced community violence were still experiencing significant anxiety symptoms, such as clinginess and worries, and social difficulties, i.e. being bullied and not having a close friend.

The limitations of this study included the lack of child psychiatric interviews, which would have established the presence of specific conditions such as post-traumatic stress disorders. Parents were the only informants and thus may have biased the SDQ ratings (Kuo *et al.,* 2000). The intake of families coincided with their admission to a homeless centre, as it was very difficult to otherwise identify families exposed to violence, or to assess their level of psychopathology prior to becoming homeless. Only the mothers from the control (non-violence) group reported that their mental health had improved since becoming homeless. The psychological effects of violence, in addition to other forms of adversity, may be longer lasting.

The findings suggest that intervention programmes and services for victims of violence, both domestic and in the community, should incorporate mental health services (for example outreach teams - Tischler *et al.,* 2000) alongside Social Services, the Police, Schools, Housing Departments, and voluntary organisations (McGee, 2000), as these families are among the most disadvantaged and experience multiple sets of problems. Initiatives to prevent recurrent homelessness and to assist resettlement should also be encouraged. Future

research would add to our understanding by following up vulnerable families after their re-housing in the community and assessing mental health needs at regular intervals, in relation to families' social integration, coping strategies and, use of services.

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Evaluation of a mental health outreach service for homeless families

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ORIGINAL ARTICLE

Evaluation of a mental health outreach service for homeless families

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Aims: To describe the characteristics of homeless children and families seen by the mental health outreach service (MHOS), to evaluate the impact of this service on the short term psychosocial functioning of children and parents, and to establish perceptions of, and satisfaction with, the service. **Methods:** Twenty seven children from 23 families who were in receipt of the MHOS and 27 children from 23 families residing in other hostels where no such service was available were studied. The MHOS was delivered by a clinical nurse specialist with expertise in child mental health, who offered the following interventions: assessment and brief treatment of mental health disorders in children; liaison with agencies; and training of homeless centre staff. **Results:** Children in the experimental group had a significantly higher decrease in Strengths and Difficulties Questionnaire (SDQ) total scores. Having received the intervention was the strongest predictor of improvement in SDQ total scores. There was no significant impact on parental mental health (General Health Questionnaire) scores. Homeless families and staff expressed high satisfaction with the MHOS.
Conclusion: This MHOS for homeless families is an innovative intervention which meets the complex and multiple needs of a vulnerable population unable to access mainstream mental health services. The primary objective of the service was to improve child mental health problems; however, the service developed in a responsive way by meeting social and practical needs of families in addition to its clinical role.

The high rates of mental health and related needs of homeless children and families are well established.[1] Child needs include behavioural and emotional problems, developmental delays, general health problems and injuries, learning difficulties, and abuse. Homeless parents are at high risk of presenting with depression and substance misuse, and to have suffered domestic violence.[2-9]

In a previous epidemiological study by the authors[6] with 113 homeless families, that included 249 children, mothers reported high rates of abuse (45%) and mental health disorders (50%). Homeless children were at high risk of having histories of abuse, living in care, being on the at risk protection register, having delayed communication, and suffering from significant mental health problems (30%). Despite this high level of mental health needs, only 3% of the children and less than 10% of the mothers had been seen by a mental health worker during the preceding year, and contact with other health care services had been fragmented.[10] At one year follow up, mental health problems among children and mothers, lack of social integration, and children's delayed communication persisted.[11] One third of families had moved house at least once more during this year. Their contact with child or adult mental health services remained very low (5[1]Y. for children and 12% for mothers). Other studies have found similar low access to services.[12-14]

In contrast with single adult homeless people, particularly those with severe psychiatric disorders,[15 16] there has been no systematic development of mental health services for this population of children and families, who cannot access mainstream services at the time of crisis. Several service initiatives

The findings of earlier studies by the authors led to the development of a local interagency policy group and the dissemination of recommendations to housing and health providers and policy makers[23]; findings also led to the establishment of a designated community psychiatric nursing post to provide outreach mental health cover to family hostels in Birmingham.[24] The aim of this study was to evaluate the impact of a designated mental health service for this vulnerable population, by using quantitative and qualitative outcome measures.

METHODS

Procedures

Children and parents

Participants were recruited consecutively over a period of one year and were seen in the hostels where the mental health outreach service was available within the first three weeks of admission. Families leaving the hostel within the first week of admission were excluded from the sample. Of the 44 families with 75 children who were admitted during this period, 23 (52.3%) families were offered and accepted the service, eight (18.2 %) were offered but declined the service, and 13 (29.5%) were not considered in need of a mental health intervention. The experimental group therefore consisted of 23 families and 27 children. The children's mothers completed all measures. They were interviewed again at six months, usually after rehousing had taken place. A number remained homeless and were seen again at the hostel. At least two attempts were made to trace families at follow up.

Table 1 Characteristics of homeless families

	Experimental group (n=23)		Control group (a=37)	
	n	%		
Family composition				
Single mother	16	69.6	27	87.1
Couple	7	30.4	3	9.7
Single father		0		3.2
Number of children	mean 3 (range 1-7)		mean 2 (range 1-5)	
Ethnic group				
UK white	16	69.6	16	51.6
Afro-Caribbean	3	13	8	25.8
Asian	3	13	4	12.9
Other European	1	4.3	1	3.2
Irish	0	0	1	3.2
Middle Eastern	0	0	1	3.2
Main reason for homelessness				
Domestic violence -	10	43.5	19	61.3
Neighbour harassment	4	17.4		12.9
Relationship breakdown	3	13		12.9
Eviction	2	8.7		6.5
Rent arrears	2	8.7		6.5
Overcrowding	1	4.3	0	0
Refugees	I	4.3	0	0

The control group were recruited during the same period from hostels with the same admission criteria but which did not receive the mental health outreach service. Thirty one families with 49 children who were admitted consecutively were recruited to the study. Both groups comprised families with children aged 3-16 years, as there is no reliable measure of child behavioural difficulties for children less than 3 years.

Staff

All staff working with homeless families, and who attended a training day on the mental health needs of homeless children and families, were invited to take part in the focus group to provide their views on the service. The group comprised ten staff from three agencies. These were two housing support workers, one housing department manager, two hostel workers, one family support worker (housing), one family support worker, one project worker (voluntary sector), and two health visitors.

Measures

The General Health Questionnaire (GHQ)

The GHQ[26] is a standardised self report measure of psychiatric morbidity in the parents, with established norms in the general population. Its 28 item version was completed, with four scales (somatic symptoms, anxiety, social dysfunction, and depression), and a total 4/5 cut off score for psychiatric caseness, that is, requiring assessment for clinical treatment.

The Strengths and Difficulties Questionnaire (SDQ)

The SDQ[25-27] " is a standardised measure of children's mental health problems. Of the 25 SDQ items, 14 describe perceived difficulties, 10 perceived strengths, and one is neutral ("gets on better with adults than with other children"). Each perceived difficulties item is scored on a 0-2 scale (not true, somewhat true, certainly true). The 25 SDQ items are divided in the scales of hyperactivity, emotional problems, conduct problems, peer problems, and prosocial scale (five items per scale). Cut off scores have been established in the UK (although not among ethnic minority groups) and other populations, for each scale and the total number of difficulties. [28 29] The P3-4 (age 3-4 years) and P4-16 (age 4-16 years) versions of the SDQ were completed by parents in this study.

Semistructured interview

The interview gathered information including reasons for becoming homeless, recent use of health and social care services by children, and perceptions of and satisfaction with, the mental health outreach service.

Staff focus group

A topic schedule was used. Topics included mental health needs of homeless families, perceptions of the role of the mental health outreach service, and satisfaction with the mental health outreach service and training programme.

Analysis

At the time of first assessment, the Mann-Whitney nonparametric test was used to compare the two groups, as scores were not normally distributed; the x' test was used to compare differences in proportions. Changes in SDQ or GHQ scores were estimated between first and second assessment. Depending on the range and distribution of these data, the two groups were compared by t test (total SDQ change scores), Mann-Whitney test (total GHQ change scores), or x^2 test (SDQ or GHQ subscales scores). Multiple regression was used to investigate the impact of the intervention or the predictive power of other variables on outcome.

The constant comparative method[30] was used for analysis of semistructured interview data. The views of the control group were compared with those of the intervention group on a number of variables: satisfaction with services, mental health, type of help required, and behaviour of children. Thematic analysis[31] was used to identify themes from the focus group.

RESULTS

Demographic characteristics

Table 1 shows the characteristics of the homeless children from both experimental and control samples. The characteristics below describe the experimental group unless specified.

The majority of families consisted of single mothers (16, 69.6%) with an average of three children (range 1-7). Almost

Table 2 Behavioural and mental health problems and contact with services

	Experimental group {n=44}		' Control group (n=49)	
	N		N	%
Children's SDQ score above clinical cut off (caseness)				
Total difficulties	18	37.5	20	35.1
Conduct problems	17	3S.4	20	35.1
Hyperactivity problems	12	25 .	22	38.6
Emotional problems	14	29.2	13	22.8
Peer relationship problems	27	36	16	28.1
Mothers' GHQ scores above	18 (mean = 15.9)		24 (mean = 16.3)	
clinical cut off scores (caseness)				
Contact with services in previous 4 months (any **member of** the family)				
Police	18	78.3	18	58.1
General practitioner	1	65.2	18	58.1
Hospital appointment	12	52.2	11	35.5
Social services	11	47.8	13	41.9
Voluntary organisation	9	39.1	4	12.9
Health visitor	6	26.1	6	19.4
Community psychiatric nurse	5	21.7	1	3.2
Education welfare officer	5	21.7	3	9:7

Data from families at first interview.

half the families (11, 47.8%) had been homeless before. Their mean length of stay at their previous residence was 50 months (range 1-240). Most parents (22, 87%) were unemployed. Their mean weekly family income was £149 (range £80-258). The majority of families constituted single parents with children (16, 69%) while seven (30.4%) were couples with children. The control group included a larger proportion of single parents (27, 87.1 %) and fewer couples (3, 9.7%).

Nineteen mothers (82.6%) had suffered domestic violence, which is more than the families where this was the main reason for becoming homeless-more specifically, physical (15, 65.2%) or a combination of physical, sexual, and emotional abuse (4, 17.4%). Three respondents (13 %) described the severity of abuse as minor/occasional, such as slapping or yelling; five (21.7%) as moderate/regular, including pushing and threats; eight (34.8%) as serious/regular, such as punching or kicking; and two (8.7%) as extreme/regular, including stabbing and abduction. Despite this, only six had pressed charges or sought an injunction against their aggressor. Seven mothers (30.4%) had a criminal history, as well as four (17-4%) children. Children from only 11 (47.8%) families were attending school while at the hostel. Reasons for non-attendance included waiting for a school place, waiting to be rehoused, fear of being traced by violent partner, and tire distance from the hostel to the previous school. Table 2 presents data on behavioural and mental health problems and service contacts prior to homelessness.

Children and families of the two groups (experimental and control) were compared on all variables at the time of first interview, and were not found to differ significantly on socio-demographic characteristics, or GHQ or SDQ scores (table 2). Exceptions were that the experimental group was more likely to consist of couples rather than single mothers or fathers ($X^2 = 6.8$, df = 2, p= 0.032), and perceived their children's problems as more of a burden to the family on the SDQ ($X^{2\cdot} = 9.1$, df = 3, p = 0.028). Experimental families had more children (t test = 2.1 l, p= 0.035) and appeared to have a different ethnic distribution, although this difference did not reach statistical significance (X^2 3.3, df = 5, p = 0.65). As in the previous longitudinal study," a substantial proportion of participant families could not be traced, as they had moved to a first or second address not known to the housing department or any of the agencies involved_ The attrition rate was significantly higher for the control than the experimental group: 18 of the 23 experimental families were followed up (78.3'Y o), in contrast with 18 of the 27 control families (58.1 %).

Table 3 Interventions provided to homeless children and families (n=23 Families)

Type of intervention♔ .	n*
Advice/support (parent)	13
Counselling (child)	7
Mental health assessment (child)	6
Liaison with another agency	6
Behaviour management (child)	4
Advice re parenting skills	4
Referral to another agency	4
Family meeting	3
~ Social growth group (child)	2
Anger management (child)	2
Follow up visit after rehousing	2
Anxiety management (parent)	1
Total	54

*Three families had an initial mental health assessment only; all others utilised two or more treatments/interventions.
♔Focus of intervention-that is, child or potent is indicated in parentheses where relevant.

There were 27 children in experimental families and 27 children in control families who completed the follow up assessment. There was no difference in resettlement at the time of follow up between the two groups ($X^2 = 0.002$, p = 0.96).

The mental health outreach service targeted children and parents. Table 3 presents the types of interventions provided. The mean number of appointments was 6 (range 1-24).

Quantitative outcome measures

Parental mental health

The Mann-Whitney test was used to compare the two groups on GHQ scores. There was no significant difference between the groups (z = -0.32, p= 0.75). Total GHQ scores decreased in both groups, with mean GHQ scores change of -6.05 (SD 7.23) for the experimental, and -6.10 (SD 8.85) for the control group. The proportion of parents that improved on the GHQ depression subscale (compared to those whose scores remained unchanged or deteriorated) was similar among those whose children were seen by the mental health outreach service (38.9%) and controls (36.8%) (Fisher's exact test = 0.58; risk estimate 1.06 (lower 0.46, upper 2.41)). Social dysfunction subscales also decreased, as 61.1% of experimental and

Table 4 Changes in children's SDQ scores

Change in SDQ scores	Experimental children	Control children	Difference
Total difficulties	Mean -2.6A 5D 7.26	Mean 1.88 SD 4.30	t test -2.67 (95% C1 -7.93 to -1.11) p=0.011
% improved on conduct scores	42%	32%	Fisher's test 0.19 Risk estimate 1.3 (95% CI 0.62 to 2.73)
% improved on hyperactivity scores	44%	28%	Fisher's test 0.37 Risk estimate 1.57 (CI 0.73 to 3.34)
% improved on emotional scores	56%	44%	Fisher's test 0.28 Risk estimate 1.27 (CI 0.72 to 2.23)
% improved on peer ' relationships scores	44%	20%	Fisher's test 0.13 Risk estimate 2.2 (CI 0.89 to 5.41)

52.6% of controls improved (Fisher's test = 0.43; risk estimate 1.16 (lower 0.66, upper 2.04)).

Child mental health

Changes in total SDQ scores were normally distributed within each group, therefore the two groups were compared using the t test (equal variances not assumed, because of different standard deviations). Children who had used the mental health outreach service had a significantly higher reduction in SDQ scores than the control sample (mean scores: experimental -2.64, SD 7.26; controls 1.88, SD 4.30; t = 2.67, p = 0.011; 95% CI -7.93 to SDQ subscale scores were dichotomised into improved versus no change/deteriorated, and were compared by the $\mathbf{X^2}$- test. There were higher proportions of experimental children who improved on the different SDQsubscales scores, although the difference did not reach statistical significance (table 4). When groups of children who improved or remained stable on SDQ scores were combined (versus those who deteriorated during the follow up period), a significantly higher proportion fell within the experimental group (88%) than the control group (60%) (Fisher's exact test = 0.025; risk estimate 1.47 (lower 1.03, upper 2.08)).

The potential mediating effect of resettlement (rehousing before follow up interview) was also investigated. Being resettled was entered as the dependent variable in a stepwise logistic regression, with initial SDQ and GHQ scores, contact with a community psychiatric nurse (CPN), and previous reasons for becoming homeless, as the covariates. Reasons for homelessness were the strongest predictor of resettlement outcome (wald 15.31, df = 5, p = 0.009), with children victims of neighbourhood harassment being less likely to be rehoused.

Change in SDQ subscales was then entered as the depend-ent variable, with contact with mental health outreach service, resettlement (now entered as covariate), and initial parent GHQ scores as covariates. Parental GHQ total score was the strongest predictor of conduct problems in children (wald 3.62, df = 1, p = 0.05). Change in SDQ total scores had a wider range and was entered as the dependent variable in a linear regression. Being in the experimental group was significantly associated with improvement in SDQ total scores (B 5.34,p=0.011).

homeless families. They indicated that the service was responsive to a variety of needs experienced by homeless families; indeed many were unaware that the service had a mental health focus. Respondents described service provision, including liaison with other agencies, transport, arranging childcare places, and writing reports for child protection conferences. Comments included:

> She [CPN] has contacted the education department on my behalf and both kids have seen her to talk about their problems in private, it is counselling for them, it's made a lot of difference to them.

> She [CPN] has offered support, has come to talk to me, has liaised with Home Start to find a playgroup, and offered to take me to the DSS [Department of Social Security].

Impact on parental mental health

Many homeless parents felt that the service met their own emotional and psychological needs and were reassured by the regular visits to the hostel by the mental health outreach service. A number of respondents described feeling isolated, depressed, and anxious. Some parents expressed feelings of relief and calm if they had fled from a violent situation; others, however, suggested the lack of stability and conditions in the homeless centres worsened their mental state and led to symptoms such as insomnia and lack of appetite. Many also expressed guilt regarding the negative effects of homelessness on their children. The comment below reveals the impact of the service in response to the mental health problems of a homeless parent:

> She [CPN] came and I got comfort from talking to her, it took the pressure off me because I was feeling suicidal, I was very paranoid.

Impact on child mental health

A number of respondents suggested that the service had positively benefited their children's behaviour and mental health. Many acknowledged their children's mental health needs and expressed concern about the impact of homelessness, especially if the period was prolonged, on their children's behaviour and development. Their comments revealed the variety of interventions offered by the mental health outreach service including counselling, behaviour modification, and group work. The vignettes below show this:

> She asked them about their [children's] behaviour, asked if they were upset and about the violence that they had witnessed. It was good having someone to talk to. The boys were very upset when they come into the hostel.
>
> She talked to [child] about his relationship with his dad and the abuse he had from him and what to do about it.
>
> The work she has done has made a big difference, she ran a group with [children] and she said they did really well on it. I noticed that they grew in confidence and became more assertive after the group. They are more outgoing, they defend themselves and are more positive.

Service needs

Those families interviewed who were not in receipt of the mental health outreach service were more likely than the experimental group to request services to address child and adult mental health. Most stated that they felt hostel staff lacked training in order to meet these needs. These included day care facilities for children and counselling for mental or emotional problems (parents). Two such respondents commented:

> There could be more services for the kids, there is nowhere for them to play and they're bored.
>
> The children need someone to talk to about what they have been through.

Respondents in both groups were critical regarding the lack of facilities and provision in homeless centres such as childcare, play areas, and toys.

Staff satisfaction

The findings revealed that the mental health service was well received by staff from a variety of agencies. Many were relieved that the service was available after managing mental health and behavioural problems in the hostels with little training or access to specialist agencies. Staff commented that the service was a valuable and easily accessible resource. The comments below illustrate this.

> We see her role as another member of staff, she assists people who request her help and a lot do, they [homeless families] are crying out for someone to talk to, they want someone who'll listen and who can do something for them, they're very needy, it does help them.
>
> Before she [CPN] came in, we didn't know where to turn, no one was interested in mental health and behavioural problems. She is a vital link into the mental health services, she knows how to access other services, she has a vital role in that way.

Staff rated the training programme highly. Most felt more confident in identifying mental health problems and had increased their knowledge of specialist agencies to refer to. Respondents commented that the opportunity to network with staff from other agencies and to participate in small group workshops was especially useful.

DISCUSSION

The objectives of this mental health outreach service were to provide assessment and treatment to a vulnerable group of families who could not access mental health services,[10] to liaise with appropriate agencies, and to train hostel staff.[24] The evaluation of this service was faced with constraints and limitations, particularly the mobility and engagement of the population and the resulting sample size,[11] the major environmental changes in the lives of these families during their contact with the service, hence their potentially confounding effect, and the need for an eclectic mental health intervention to meet the needs of children and their parents. For this reason, it was the impact of the service that was evaluated rather than a specific treatment modality such as parent training. [32] The combination of quantitative and qualitative measures was selected to address some of these limitations, particularly regarding a service model with a health and social care interface.[24]

The results indicate that the service was accessible to homeless families, and that it targeted a needy population, with high rates of mental health problems. In their review of child and adolescent mental health services, the Audit Commission[33] highlighted the diversity of provision in the UK and the often indiscriminate referral of children and families to specialist services. Predominantly behavioural, but also other less complex mental health problems, can be successfully dealt with in primary care by a range of non-specialists. Needy and mobile populations such as homeless families or children looked after by local authorities require a rapid and flexible response, different to the "one route" referral to specialist services operating on a waiting list.

The intervention had a positive impact on a range of child mental health problems, which was sustained at six months, when most families had been rehoused. In contrast, it did not improve parents' mental health problems, which it had not been set up to address in the first place. The high levels of parental mental health difficulties, however, show the need for joint service development between child and adult services.

Staff training was a key component in the development of the service, as it raised awareness of mental health issues in children and adults, and developed skills to identify families with such difficulties and refer them appropriately to the service. The need for staff training is crucial as comprehensive interagency child and adolescent services expand.[34]

The qualitative findings reveal the need to target interventions at a number of levels, by responding to the subjective needs of homeless families who are often in crisis. This requires flexibility and skill in multidisciplinary working. Interview data revealed the variety of interventions offered by the mental health outreach service, often outside the remit of a psychiatric provision. Emergent evidence suggested that meeting the patients' expressed needs, whether practical or emotional, was an important precursor to clinical input, again emphasising the flexibility of the service. Weekly visits to the hostels ensured the accessibility of the service, close liaison with housing staff and other agencies (health visitor, general practitioner, local school, social services, and voluntary organisations), and regular monitoring of mental health problems. Parent interviews also showed the absence of comprehensive and multidisciplinary support, which could have enabled the service to focus on child and parental mental health.

Expansion of the service is necessary as it is currently delivered by a sole professional and therefore the impact of the service has been limited. Further service development would enable continuity of treatment after resettlement, when families are most vulnerable, not reintegrated in the community and not accessing mainstream services, and would also make the service more effective. Although there was no cost evaluation of the service, particularly compared to hypothetical referral to secondary or tertiary services, there may be a more cost effective model of deploying non-specialist staff, such as family support workers, for a larger number of children and parents, under the supervision of specialist mental health professionals. Such a model is currently being evaluated by the authors.

Future research could evaluate the specificity of specialist treatment interventions in larger samples, such as parent training for child behavioural problems, and cognitive or brief prychodynamic therapy for children with post-traumatic stress disorders following exposure to violence.[32] Other groups of socially excluded children and families, such as children looked after by local authorities and youth offenders, could also benefit front similar designated, accessible interagency mental health services.

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PV and SC had the original idea for the study and developed the design. VT organised the project, collected and analysed data, and wrote the manuscript. PV contributed to the analysis and writing up. TB contributed to the organisation of the project and the data collection. PV is the guarantor.

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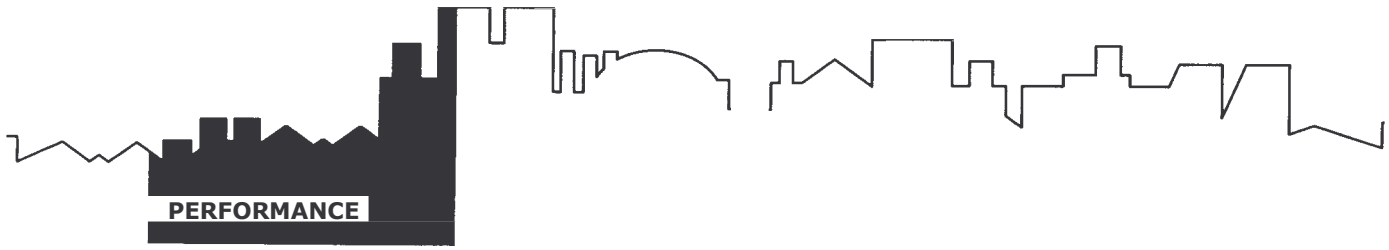

Assessing performance (3):

A resettlement service for homeless and vulnerable parents

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Abstract

The aim of the research described in this paper was to examine the housing and resettlement needs of homeless and vulnerably housed parents, in order to inform the development of a family outreach support worker service for this population. Focus groups and individual semi-structured interviews were used. This exploratory study has demonstrated that both homeless and housed families have complex and multiple needs that can be met by resettlement services.

Introduction

Policy makers are becoming increasingly concerned about levels of repeat homelessness in families. The provision of accommodation alone does not meet the complex needs of those at risk of homelessness or those who are vulnerably housed. Tenancy failures are costly in human and economic terms. Resettlement aims to meet both the accommodation and the support needs of those who struggle to maintain their tenancies. It is accepted as a key element in addressing homelessness (Seddon, *1997).*

The National Resettlement Project (NRP) was established by the National Homeless Alliance in August *1997.* Its mission was to eliminate homelessness and ensure that high-quality resettlement services were available to homeless people across the UK (Seddon, *1997). A* number of initiatives have been established to assist families to resettle in previously deprived estates and to ensure that families remain in accommodation. Resettlement services are concerned with accommodation and support in order to sustain a home. Such input addresses practical and emotional issues and acts as a link to other specialist agencies such as education or drug services (Oldman, *1997).*

Assessing performance (3):A resettlement service for homeless and vulnerable parents

The Beaumont Leys Independent Support Service

This team is one example of a resettlement service. It represents a `floating support scheme', which means that resettlement is not just associated with a particular property, rather it provides support for vulnerable homeless people in a variety of locations, allowing for greater continuity of support (Oldman, 1997). The team is delivered by Leicester City Housing Department with help from Sure Start and the Single Regeneration Budget. This funding targets areas of deprivation and estates with high levels of vacant properties and accommodation failure rates. This area houses many families, including a growing population of asylum seekers.

The team was established in 1999 and comprises an acting team manager, an administrator, and three full-time-equivalent resettlement and tenancy support workers. The service is delivered from a shop front, alongside a laundrette, post office and grocery store, thus making it easily accessible to local residents. The office provides accommodation for staff and a confidential interview room with disabled access. Donations are stored at the office, including clothing, baby food, groceries and baby equipment, which are distributed to families in need. The service is advertised via leaflets in family centres, GP surgeries, hostels and housing offices. Referrals are made by a variety of professionals such as health visitors and social workers, as well as self-referrals.

Development of the floating support worker

In the year from lst April 2001 to 31st March 2002 90 clients used the resettlement and tenancy services. The role of the floating support worker is to provide outreach, intensive support to families re-housed in a geographical area in order to prevent failure of tenancies and so to address the issue of serial homelessness. The service was offered to families with children aged 0-4 years. The workers intend to provide support and to address issues that affect tenancy sustainment. The first contact consists of a comprehensive assessment. This covers topics including budgeting, debt management and general housing issues such as furniture, home safety, repairs advice and budgeting on a low income. Clients whose first language is not English are assisted to access college courses to help them with their language skills. The worker checks general health issues such as whether the client is registered with a general practitioner. Information is given on children's activities such as summer play schemes and assistance is given with registering children in school, if necessary. Community information is provided, for example location of libraries, adult education centres and other schemes in the area.

Objectives of research

The research aimed to address a number of key issues in order to inform the development of the role of the floating support worker as described above. The research questions were:

- Does tenancy support stop people becoming homeless?
- If homeless, why did they become homeless?
- Why aren't the tenancy needs of the homeless population being met?
- What is the level of awareness about the floating support scheme?

In order for the sample to be as representative as possible, participants were chosen from three groups; two were recruited from hostels and were homeless and the third group comprised current clients of the floating support scheme.

Research method

A semi-structured interview was devised using questions that are open-ended and encourage participants to expand on their answers and introduce new topics if they want to (Silverman, 2000). Details are shown in Figure 1, opposite. The interviews were administered during three focus groups. All focus groups and interviews were tape-recorded and transcribed in full. Data was then analysed using a theory developed by Glaser and Strauss (1967) that involves developing themes from raw data, ie transcripts. The aim is to uncover meaning from the

participant's point of view and using their own language. The results presented below,

Figure 1 FOCUS GROUP AND INTERVIEW SCHEDULE: BLISS

Group only:

Introductions and ice breaker (record names) Explain purpose of the group/interview Advise that session will be tape-recorded and transcribed and anonymity ensured

- What (if any) help do you need now?
- Would any of these services be useful? (general help/services exercise/resettlement)

Homeless group:

- What about when you move into your new house?
- Do you/would you need help with any of these? (basic skills exercise eg budgeting, educational advice, tenancy advice, health)

If previously homeless:

- What would stop you becoming homeless again?
- What is tenancy support?
- Have you had any advice about tenancies?
- Do you think tenancy advice could prevent you becoming homeless?
- What are the reasons families become homeless?
- Have you heard of the BLISS team? If so, how did you find out about them and what do they offer?
- Could BLISS be improved? If so, how?

therefore, are set out in this format, using themes that arose from the interview and focus group transcripts. Vignettes are used throughout to illustrate the issues raised, and participants' own language is used as far as possible. Names and places have been changed or removed from vignettes to protect anonymity.

Reasons for homelessness
The most common reason was domestic violence, followed by relationship breakdown either with a partner or with family. The remainder had been evicted from their previous property, often due to rent arrears, or they had experienced violence or harassment from neighbours which led them to flee their previous accommodation.

Most of those now homeless had been living with family or friends prior to homelessness. These arrangements often broke down due to overcrowding or family conflict. The excerpts below describe such circumstances.

'(1 was) staying with mum previously, she was taking over, she didn't mean to'

'(1) was homeless at 18, my mum kicked me out 'cause of a lad I was seeing. 1 stayed with a friend then put my name on housing list 'cause it was overcrowded'

Prevention of homelessness
The respondents were asked whether tenancy support could have prevented them from becoming homeless. Nearly half of the homeless group felt that no such advice or support would have prevented homelessness.

Respondents did indicate that responsive action from organisations, including the police or the council, might have allowed them to remain in their previous property.

Help required after homelessness The homeless respondents had many ideas about the types of assistance that would benefit them when they were rehoused. Practical assistance was viewed as crucial, particularly in the transition period from homelessness to resettlement. A number suggested help with removals, decorating, supply of gas and electricity and provision of furniture.

General support and confidence-building was a key issue for a number of the homeless respondents. Other expectations included health advice and information on childcare and educational provision. Those who were homeless expected a wider range of help, such as support for rehousing and health advice.

All were satisfied with the services offered by the floating support scheme and were very positive about the impact of the team. The most important themes revealed were reliability and regularity of contact, and flexibility and range of services offered. The comment overleaf indicates the positive impact on health and stability of accommodation.

'(It is) very helpful, they don't turn you away, if they can't help they find someone who can, they always find a way of sorting things out, she won't give up on things, she says 'let me ring them', she used to work for housing so knows how they work. Even if 1 moved 1 would call them if 1 needed help, even though they don't cover that area they would tell me who to speak to. 1 don't feel on my own, she is helping me sort my life out, she talks to people on my behalf'

Results

The findings indicate that the floating support scheme is meeting the needs of a sample of vulnerable young families who are at risk of homelessness and housing instability. In a number of cases, respondents indicated that the team was directly responsible for maintaining their tenancy or for encouraging them to take a tenancy in an area that they would not previously have considered. This demonstrates that the aims of the service are being met. The development of the floating support worker post and co-operative work with other agencies will enable the service to make a significant impact in this area.

Future research

This was an exploratory study, designed to gather preliminary data on the needs of a vulnerable population and on the services that they consider valuable. Further research could evaluate the impact of floating support scheme in more detail, investigating whether resettlement services can maintain tenancies, prevent serial homelessness and address the problems associated with vacant properties. It is important to study families longitudinally to investigate whether the impact of a service is sustained over a longer period. Future research could also investigate how to make services more accessible to those who are already homeless.

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A family support service for homeless children and parents: users' perspectives and characteristics

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Abstract

The objective of the present study was to establish the psychosocial characteristics and perspectives of 49 consecutive homeless families who received input from a new designated family support worker (FSW) post at a large statutory hostel for homeless parents and children. The FSW provided: assessment of social, educational and health needs; support and parent training; and liaison with and referral to specialist services. Measures included quantitative questionnaires (i.e. the Hospital Anxiety and Depression Scale, the Parenting Daily Hassles Scale, the Eyberg Child Behaviour Inventory, and the Health of the Nation Outcome Scales for Children and Adolescents), and a qualitative (semistructured) interview on service experiences and satisfaction. The psychosocial measures indicated high rates of parenting difficulties, mental health and related needs among children and their parents. Parenting difficulties were associated with child behaviour problems. Parents expressed satisfaction with the service whilst they were residents at the hostel, but they were often not clear about the objectives of agencies and interventions. Family support interventions have *a key* role in service provision for homeless and other vulnerable families by providing direct parenting interventions and ensuring that specialist agencies are appropriately involved. Family support worker involvement needs to continue when families are re-housed in the community.

Keywords: children, domestic violence, families, family support service, homeless, mental health

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Introduction

Homeless children and their parents have complex and interrelated health, social and educational needs (Connelly & Crown 1994). Children's difficulties include behavioural and emotional problems, developmental delays, general health problems and injuries, learning disabilities, and abuse (Brooks *et al.* 1998, Webb *et al.* 2001). Homeless parents are at high risk of presenting with depression and substance misuse, and to have suffered domestic violence (Bassuk *et al.* 1996, Walters & East 2001). The mobility of homeless families, usually as a direct result of violence or family breakdown, leads to poor access of services through the usual referral routes, such as general practices and schools (Lissauer *et al.* 1993, Power *et al.* 1995). Although there is strong research evidence from these UK and North American studies on homeless families' multiple and unmet needs, there is very limited knowledge of effective interventions and service models.

An outreach mental health service model was established following an earlier epidemiological study with 114 homeless families with 249 children who had been admitted to statutory hostels in Birmingham, UK. The main reasons for becoming homeless were domestic violence (56°h) [or] violence from neighbours (29`7(-; Vostanis

et al. 1997). Homeless mothers reported high rates of abuse (45'70 and mental health disorders (50%). Homeless children were at high risk of having histories of abuse, living in care, being on the at-risk protection register, having delayed communication and suffering from significant mental health problems (30%). Despite this high level of mental health needs, only 3% of the children and less than 10% of the mothers had been seen by a mental health worker during the preceding year, and contact with other services had been fragmented (Cumella et al. 1998). At one-year follow-up, mental health problems among children and mothers, lack of social integration, and children's delayed communication persisted (Vostanis et al. 1998). One-third of families had moved house at least once more during this year. Their contact with child or adult mental health services remained very low (5% for children and 12% for mothers).

The findings also led to: the development of a local interagency Homelessness Forum; the dissemination of recommendations to housing and health providers, as well as policy-makers (Vostanis & Cumella 1999); and also the establishment of a designated child mental health nursing post to provide an outreach mental health service to hostels for homeless families (Tischler et al. 2000). When this service was compared with a control group of children in hostels without access to similar help, the parenting and behavioural interventions provided by the community psychiatric nurse were associated with significant improvement in behavioural problems at 6-month follow-up, and were positively perceived by parents and housing staff (Tischler et al. 2002). However, parents identified a number of needs such as benefits, housing assistance and child protection, which did not fall within the direct remit of a specialist mental health professional.

For this reason, an alternative family support service model was developed in another UK city, Leicester, in partnership between the housing department and the health authority, initially through a 3-year, jointly funded family support worker (FSW) post. The broad objectives of the service were to provide assessment and identification of health and social care needs, liaison with specialist services, and parent training and support (Vostanis 2002). The aim of the present study was to establish: (1) the characteristics of homeless families referred to this service during its first phase; and (2) the users' perspectives and experiences of the service whilst residents at the hostel.

Subjects and methods

Setting and subjects

The service was established at the main local authority hostel for homeless families in Leicester, which accommodates approximately 20 families at any one time. The FSW has nursery nursing training, and past experience in parenting and child protection work through social services family centres. She coordinates services before and after re-housing, conducts individual and group parenting skills training (an adapted version of the Webster-Stratton parent training programme; Webster-Stratton & Hammond 1997), and supports the hostel staff. Her role is to: identify a broad range of needs (e.g. child protection, possible mental health problems, substance misuse, or school problems); provide different levels of support to the majority of families; organise activities at the hostel for toddlers, older children and parents; ensure children's school placement and attendance; and maximize the involvement of specialist (e.g. social services, health visitor, child or adult mental health service, educational welfare, or Sure Start) or non-statutory agencies (e.g. domestic violence or resettlement services). Local professionals attend a weekly multi-agency meeting, where information is corroborated and agency roles are established within the overall care plan, which is coordinated by the FSW (this should be distinguished from the statutory child protection role additionally held by social workers, where appropriate). The service is monitored by a multi-agency policy forum, with senior managers or practitioners from the above agencies. The FSW is based at the hostel. She is placed and line-managed within the housing department, and receives additional supervision on parenting work and mental health issues by a specialist mental health professional. Families were recruited from consecutive referrals to the FSW over a period of one year (between April 2001 and April 2002). The main carer, usually the mother, was interviewed at variable points in their stay, as soon as possible following contact with the FSW.

Measures

The families were assessed utilising quantitative and qualitative measures. The quantitative measures were used to establish parenting difficulties, and mental health problems among parents and children. Measures were completed by the mother or main carer. Children's measures referred to one child only, i.e. the child about whom the carer expressed concerns to the FSW.

Quantitative measures

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith 1983) is a standardised for validity and reliability, and widely used measure of anxiety and depression in adults. Each of the 14 items (seven for anxiety and seven for depression) is rated between zero

and three, depending on the severity of the symptom (range = 0-21 for each subscale). A cut-off total score of 11 or more indicates likely psychiatric morbidity, while a score of seven or more on either subscale indicates the likelihood of anxiety or depressive disorder.

The Parenting Daily Hassles Scale (PDHS; Crnic & Greenberg 1990) assesses the impact and frequency of 20 experiences that can be perceived as a 'hassle' by parents. The carer rates each item for frequency and intensity. The total frequency (range = 0-80) and intensity scores (range = 0-100) are obtained, with scores for challenging behaviour (range = 0-35) and parenting tasks (range = 0-40) being further derived from the intensity scale.

The Eyberg Child Behaviour Inventory (ECBI; Eyberg & Ross 1978) is a standardised measure of child behavioural (oppositional) problems. The items refer to 36 common childhood problem behaviours. Each item is rated: (1) as present or absent, the sum of which consists of the problem number score (range = 0-36); and (2) on its frequency (Likert scale = 1-7), the sum of which consists the problem intensity score (range = 36-252). Cut-off scores of 11 on the problem number score and 127 on the problem intensity score have been found to indicate behaviours that might require assessment and treatment (Eyberg & Robinson 1983).

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers *et al.* 1999a) include 13 clinical/psychosocial scales (Section A: disruptive/aggressive behaviour, overactivity and attentional difficulty, non-accidental self-injury, alcohol or substance/solvent misuse, scholastic or language skills, physical illness/disability problems, hallucinations and delusions, non-organic somatic symptoms, emotional and related symptoms, peer relationships, self-care and relationships, and poor school attendance), and two items on information about services (lack of knowledge-nature of difficulties and lack of information on services/ management). Each item is rated on a five-point severity scale between (0) 'no problem', (1) 'minor problem requiring no action', (2) 'mild problem but definitely present', (3) 'moderately severe problem' and (4) 'severe to very severe problem', with a detailed glossary for each point on the scale and item, standardised in clinical populations (Gowers *et al.* 1999b). All cases were independently rated by a researcher MY), who had previously completed the video and manualised training for the HoNOSCA.

Box 1 Semistructured interview guide

1. How did you become homeless?
2. How did you come to live here?
3. Do you have any family or friends in Leicester?
4. What is the hostel environment like?
5. What is it like to live in the hostel?
6. How long have you been in the hostel?
7. Have you any concerns about your children?
8. Do you need any help whilst at the hostel?
9. Have you had any help at the hostel?
10. What did you expect of the service?*
11. What happened when you saw the family support worker?
12. How many times have you seen her?
13. What difference has it made (if any)?
14. Is there any help you would really like now?
15. Have you seen any of the following in the past month: general practitioner, community psychiatric nurse, social services, midwife, health visitor. other nurse hospital service or solicitor?

*For those who only used the Family Support Service.

Qualitative measure

The clients were interviewed by an independent researcher (V.T.) within one month of admission to the hostel using a semistructured interview to explore their experiences and opinions of the hostel and family support intervention provided. This allowed the development of the emerging themes for further analysis (the interview guide is presented in Box 1). The interview was developed from themes that emerged from previous studies with homeless families on their perceptions of health and social care services (Cumella *et al.* 1998, Tischler *et al.* 2002). The initial part of the interview ascertained the reason for the admission to the hostel and any local support networks available. The clients' opinions of the hostel environment and experiences of living there were then sought, together with any concerns about their children's well-being (physical and emotional). The clients' expectations of the intervention were explored after discussing previous help received and the help they felt they required. Their experiences of the intervention and the difference it made were documented. The help the clients require in future was also explored (Box 1).

All interviews were conducted at the hostel. Parents provided informed consent to take part in the study. They were assured of confidentiality and that taking part in the research would have no impact on their housing application or the services they received. The study was granted approval by the local health research ethics committee.

Data analysis

The frequencies of categorical data are presented. Established cut-off scores were used to provide rates of problems likely to require specialist assessment and treatment. The relationship between parenting problems,

maternal psychopathology and child behaviour was investigated by Spearman correlation since the continuous scores were not normally distributed. The associations between parenting factors, maternal psychopathology and child behaviour were explored by linear regression analyses, with all variables entered together in each model. The ECBI and PDHS depression scores alternated as the dependent variable, with HADS scores as the covariate (independent variable). The findings of the regression analyses are presented as suggestive because of the moderate sample size. The SPSS Version 11.0 computer program was used in the analysis.

Qualitative data analysis was based on a thematic content coding (Flick 2002) with similar and identical responses to each question grouped into categories. This involved detailed consideration of the responses to each question, but also to the responses to other questions, to prevent repetition. Multiple responses to the same question were counted in different categories, but not more than once in the same category. This enabled the development of concepts relevant to the hostel residents. The relative strengths of each response could then be quantified. Examples in the participants' own words were used to illustrate their responses.

Results

Out of the 55 eligible families, 49 participated and six did not. No specific reasons were given for not participating, which would indicate that these families may have differed from the remaining sample. The majority of families consisted of mother and children *(n* = 33, 67%), with the remainder being couples with children *(n* = 14, 29%), and father and children *(n* = 2, or 4%). Families had a mean number of three children (range = 1-7). The ethnic status of the main carer was: White British *(n* = 30, 61 %), Asian *(n* = 7, 14%), White Irish *(n* = 5, 10%), Black African *(n=4,* 8%) and Middle Eastern (u = 1, 2%), while ethnicity was not recorded in two cases. The carers' mean age was 32.3 years [range = 1946 years; 95¹7, confidence interval (CI) = 30.4-34.3) and the children's mean age was 7.6 years (range = 2-17 years; *95*% CI = 6.5-8.7); the latter only refers to children seen by the FSW, for which reason no infants were included. There were 15 girls (31%) and 34 boys (69%.].

Quantitative data

These are presented in terms of frequencies of the main scales used, followed by the investigation of their potential relationship.

When a total HADS cut-off score of 11 was used, 38 carers (78%) were within the clinical range (total HADS mean score = 19.8, SD = 9.7, range = 2-40; 95% CI = 17.0-22.9). When a cut-off score of seven for each subscale was considered, 36 carers (74%) scored within the clinical anxiety range, and 33 *(67.3%)* within the depression scale. The HADS depression scores were significantly correlated with all PDHS subscales scores, but there was no significant correlation between HADS anxiety and PDHS scores (Spearman correlation; Table 1).

On the ECBI, 19 children (39%) scored within the clinical range of the intensity scale (mean = 98.7, SD = 42.9, range = 45-207; 95% CI = 85.5-111.8), and 10 (20%") within the clinical range of the problems scale (mean = 9.2, SD = 10.1, range = 0-36; 95% = CI 6.1-12.3). The ECBI intensity scores were significantly correlated with maternal HADS depression scores (rho = 0.30, P = 0.043), but not with HADS anxiety scores (rho = 0.17, P = 0.26), and with all PDHS scores: PDHS frequency scores (rho = 0.63, P< 0.001); PDHS intensity scores (rho = 0.66, P< 0.001); PDHS challenging behaviour (rho = 0,61, $P < 0.001$); and PDHS parenting tasks (rho = 0.63, $P < 0.001$).

The frequencies of children's HoNOSCA items and scores are presented in Table 3. Since 12 cases were missing, valid percentages are presented for 37 children. When scores of (3) 'moderate' and (4) `severe' were grouped together as potentially requiring assessment and treatment, the most frequently reported difficulties were: aggressive and disruptive behaviour *(n* = 8,21%); overactivity and attention deficit *(n* = 9, 24%); scholastic or language skills problems (n = 9, 247,,); emotional problems *(n* = 8, 21%); peer relationships (n = 9, *24*1k);

Table 1 Spearman correlation between Parent Daily Hassles Scale and Hospital Anxiety and Depression Scale scores *(n = 49)*

Parent Daily Hassles Scale	Hospital Anxiety and Depression Scale			
	Anxiety		Depression	
	Rho	P-value	Rho	P-value
Frequency	0.19	0.20	0.36	0.012
Intensity	0.13	0.37	0.39	0.006
Challenging behaviour	0.20	0.17	0.37	0.010
Parenting tasks	0.11	0.46	0.33	0.024

Table 2 Scores and frequencies on the Health of the Nation Outcome Scales for Children and Adolescents (n = 37)

	Severity				
Variable	None (0)	Slight (1)	Mild (2)	Moderate (3)	Severe (4)
Aggressive, antisocial and disruptive behaviour	15(41%)	9(24%)	5(14%)	6(16%)	2(5%)
Overactivity and attention deficit	9(24%)	14(38%)	5(14%)	5(14%)	4(10%)
Non-accidental self-injury	32(86%)	3(8%)	1(3%)	1(3%)	0
Alcohol, solvent and substance misuse	32(86%)	2(5%)	1(3%)	2(5%)	0
Scholastic or language skills problems	15(41%)	6(16%)	7(19%)	6(16%)	3(8%)
Physical illness or disability	27(72%)	4(11%)	5(14%)	1(3%)	0
Hallucinations, delusions and abnormal perceptions	33(92%)	3(8%)	0	0	0
Non-organic somatic symptoms	21 (57%)	3(8%)	8(21%)	4(11%)	1(3%)
Emotional and related symptoms	13(35%)	7(19%)	9(25%)	6(16%)	2(5%)
Peer relationships	14(38%)	8(22%)	6(16%)	5(14%)	4(11%)
Self-care and independence	24(68%)	6(16%)	3(8%)	2(5%)	1(3%)
School non-attendance	24(65%)	3(8%)	5(14%)	3(8%)	2(5%)
Problems with family life and relationships	17(46%)	6(16%)	7(19%)	4(11%)	3(8%)
Carer's knowledge and understanding of the young person's difficulties	23(62%)	4(11%)	7(19%)	2(5%)	1(3%)
Carer's lack of information about services and handling child's difficulties	21 (57%)	2(5%)	8(21%)	5(14%)	1(3%)

Table 3 Predictors of child behavioural problems (dependent variable: Eyberg Child Behaviour Inventory intensity score): (PDHS) Parent Daily Hassles Scale; and (HADS) Hospital Anxiety and Depression Scale*

		Ninety-five per cent confidence interval		
Predictors	Coefficient B	Lower	Upper	Level of statistical Significance (*P* value)
Parenting frequency problems (PDHS frequency score)	0.36	-1.87	2.59	0.75
Parenting intensity problems (PDHS intensity score)	1.38	-5.06	2.31	0.45
Parenting problems in dealing with behaviour (PDHS challenging behaviour score)	3.62	-1.75	8.98	0.18
Parenting tasks problems (PDHS tasks score)	3.25	-0.78	7.28	0.11
Maternal depression (HADS depression score)	0.33	-2.37	2.33	0.98
Maternal anxiety (HADS anxiety score)	0.23	-2.53	2.98	0.87

* $R^2 = 0.48$.

school non-attendance (n = 5,13%); family life problems *(n = 7,19%)*; and lack of information about appropriate services *(n = 6, 17%)* (Table 2).

The FSW addressed a number of family factors that are often interlinked in her intervention. For this reason, the present authors explored the potential associations between parenting skills, parental depression and child behavioural problems in two linear regression analyses. Initially, they wanted to explore which factors predicted child behavioural problems. The ECBI intensity scores were entered as the dependent variable, with PDHS and HADS scales scores as covariates (Table 3). None of these variables were significantly associated with ECBI intensity scores. When the variables were reversed, i.e. PDHS scores being the dependent variable, with HADS and ECBI scores as the covariates, parental tasks problems were predicted by the intensity of child behaviour and maternal depression (Table 4).

Qualitative data

The qualitative data is presented below, using headings to describe each theme. The themes are illustrated using examples where appropriate.

Reasons for being homeless and service contacts

Half of the families (n = 24, 49% had been homeless in the past. Their reasons for becoming homeless were: domestic violence *(n* = 6,12%); relationship breakdown (n = 15, 31 %) - on further questioning most of these mothers were also found to be victims of domestic violence; neighbour harassment (n = 13, 27%); eviction (n = 7, 14%); refugee status *(n* = 3, 6%); overcrowding (n = 3,6%); natural disaster *(n* = 1, 2%); and release from prison (n = 1, 2%).

The families had been in contact with the following services/agencies during the month prior to the interview:

Table 4 Predictors of parenting tasks problems (dependent variable: Parent Daily Hassles Scale tasks score): (ECBI): Eyberg Child Behaviour Inventory; and (HADS) Hospital Anxiety and Depression Scale*

Predictors	Coefficient B	Ninety-five per cent confidence interval		Level of statistical significance (P-value)
		Lower	Upper	
Child behaviour intensity (ECBI intensity score)	0.22	0.051	0.38	0.012
Child behaviour frequency problems (ECBI problems score)	0.20	0.48	0.88	0.56
Maternal depression (HADS depression score)	0.96	0.09	1.82	0.031
Maternal anxiety (HADS anxiety score)	0.44	1.43	0.56	0.38

* $R^2 = 0.49$

social services *(n* = 11, 22%); general practitioner *(n* = 25, 51%); health visitor *(n* = 12, 24%); community psychiatric nurse (adult service) *(n = 7, 14%);* other nurse (i*t* = 1, 2%); midwife *(n* = 4, 8%); hospital service (it = 12, 25%); and solicitor (it = 16, 33%). Out of the 49 families, *40 (82',",)* had friends or neighbours in the locality of the hostel.

Experience of living in the hostel

The comments regarding the hostel covered a wide range of issues related to both the physical environment and the context of their circumstances. The majority of general comments were positive; however, some residents were unhappy with different aspects of the accommodation:

[The hostel] is not as bad as its reputation.
[It] depends what you make of it.
[It's] like a prison, hell.

The locality of the hostel was not perceived as beneficial because of its distance from the city centre, family or schools, and also, because of incidents of racism in the area. The accommodation itself received hardly any praise with the complaints covering the facilities available, security, lack of privacy and hygiene levels. All statements regarding sharing facilities were of a negative nature; for example, 'dirty, disgusting, fleas', 'no lock on door, poor security' and 'not enough laundry facilities'.

Housing staff were mainly seen as helpful and friendly, although some residents felt that the staff did not respect their privacy; for example, 'friendly staff, supportive' and `treated like kids, staff barge in'.

There was a mixed picture with respect to the other residents. There were many examples of supportive relationships, but also of *intimidation* and even attacks by other residents; for example, 'made a lot of friends with other residents, like big community' and 'people abusive, stole food'.

Concerns regarding children's mental health and related needs

The majority of concerns were that the children's behaviour had deteriorated whilst being resident at the hostel. Parents also described children's distress or boredom as significant issues. A few commented on mental health or educational problems. Twelve parents reported no difficulties.

When asked what type of help the resident needed, there were multiple responses. The greatest subgroup was the need for practical help, mainly with re-housing and benefits, but there were virtually the same number of comments regarding child-care issues, housing, and counselling or mental health input:

Dr X[was] involved, dealing with flashbacks.

Expectations of the family support worker intervention

The expectations of the *intervention* were variable, and there were fewer responses to this question. Residents wanted information on services, help with schooling or letters of support for re-housing. Some residents wanted someone to talk to, while others were unsure of what was being offered. Six residents stated they did not want help. The assessment interviews with the FSW appeared to cover a wide range of issues. The residents felt that the support and counselling provided was an important part of the intervention. The majority of comments regarding the FSW were positive:

[H]elped with emotional problem, helped to get on feet, counselling.

Her advice on practical issues, *parenting,* and schooling, were also positively received:

[She] showed how to make bottles.
[She showed) how to discipline children.

Referrals were made to other agencies, and contact was enabled with community psychiatric nurses from the adult service, social workers, health visitors and general

practitioners. The majority of the residents felt that the FSW had made a positive difference, with a small number unsure, or reporting no change; for example, 'good difference, did not know where I was' and 'kept me going'.

Discussion

This designated FSW post was set up to address a number of objectives, i.e. to provide access and support to families during periods of crisis, improve the detection of social and health care needs, deliver individual and group parent training, and ensure access to specialist services whilst at the hostel and after re-housing. The post was broadly based on previous family support service models (Chaffin *et al. 2001,* Sanders *et al. 2002),* but adapted to the requirements of this vulnerable and highly mobile client group. Therefore, although there are similarities with interagency community services for children at high risk of behavioural and emotional problems (Barlow 1999, Window *et al. 2004),* the findings also need to be considered in the context of their differences, particularly the families' mobility and short stay in homeless accommodation.

The clients' characteristics appeared to be broadly similar to previous studies, with the principal cause of homelessness reported as domestic violence, and a range of health and social care needs (Bassuk *et al.* 1996, Webb *et al. 2001).* However, there were additional causes among families living in this large hostel, which made it even more difficult to provide appropriate interventions (e.g. the co-residence of victims of violence, and abusive residents or drug users). Clients seen by the FSW had a range of problems in parenting, maternal and child mental health, which are appropriate to be filtered by the FSW, with the less complex cases potentially benefiting from direct support and intervention, and the more severe ones (e.g. child protection or psychiatric disorders) being referred on to specialist services via a weekly multidisciplinary meeting. Of these factors, parenting difficulties were found to independently predict both maternal depression and child behavioural problems, which is consistent with previous research (Gopfert *et al.* 1996). Therefore, parenting interventions should be an essential component of FSW duties.

Although there was significant variation between their perceptions of the service, certain themes were evident. The living environment evoked a great deal of criticism and a negative reaction. Since the present study took place, there have been improvements in this area. On the whole, housing staff were positively perceived. Some clients expressed negative views concerning all aspects of their experience of the hostel, which may be a reflection of their mental heath or of their previous life experience, i.e. their perceptions of the environment and circumstances were closely linked with their adverse life events. Overall, parents had few or no expectations of the service, which may indicate the need for information not only at the time of admission, which occurs during emotional turmoil and a number of conflicting priorities for the families, but also throughout their residence. A FSW is well placed to undertake this role, which incorporates casework and care coordination.

The intervention dealt with a wide variety of problems, but it appeared that support was one of the major benefits to a group of people who often felt isolated and lonely. The majority stated that they benefited from this service. However, the FSW was only one of several agencies involved in their care (e.g. health, housing, education, social and legal services), often in an unclear or overlapping way. Since there were particularly high levels of contact with primary health care professionals, social workers and solicitors, it would be useful to increase multidisciplinary working and sharing information about clients in order to improve service provision. However, the sensitive nature of this group requires careful consideration of the balance between confidentiality and safety for vulnerable clients (e.g. when to instigate child protection procedures whilst attempting to engage the parents in therapeutic work). The FSW can provide a focal point in initiating appropriate and cost-effective specialist service involvement, and to act as advocate, if appropriate (e.g. parents and children may be apprehensive in meeting a psychiatrist). Parents clearly stated that practical help is at least as important to them as counselling and emotional support, and this should not be underestimated in designing similar services. For example, accessing non-statutory resources or specialist housing advice would be particularly valuable and engaging.

A number of difficulties may have affected clients' perceptions in this study. Being a new post, there was only one worker available, which limited her input to the client group. The families' characteristics indicate that, although this was a single post, the service and the findings could be generalized to other local authority and non-statutory hostels. There were also a number of limitations to the present study. Not all questions were answered in the semistructured interview, which may have biased the final analysis. However, the qualitative design of this study still enabled the identification of important themes. Furthermore, the authors did not describe or evaluate the specific components of the FSW's interventions, the therapeutic process and whether these were maintained after the families had been rehoused in the community. A larger sample size might have enabled such analysis. However, it was important

to establish a baseline of family needs and experiences of the initial service. This may also explain why clients were often unclear about the objectives of the intervention and the role of the FSW. Future evaluation should include children's views. In addition, the resource constraints (one FSW post) meant that she could not continue her involvement after re-housing, when families are most vulnerable and at risk of becoming homeless again (Walters & East 2001, Tischler & Gregory 2002). Since the completion of the present study, the housing department has identified funds to expand this post to a family support work team, consisting of five FSWs, who are now undertaking resettlement work in the community. This should be subject to further evaluation.

There are a number of implications for policy makers and providers across health and social care. The multiple and complex needs of families and children on the margins of existing community networks cannot be met by a single agency, nor by expansion of specialist services, without taking into consideration the characteristics of this population group. Recent policies in the UK such as the Green Paper Every Child Matters (Department of Education and Skills 2003) and the National Service Framework (Department of Health 2003) set the context for joint commissioning and service partnership through new organizational structures (i.e. children's trusts). The establishment of a central government directorate to oversee the provision of services for homeless people and the requirement that each local authority develops an interagency homelessness strategy are positive steps in addressing health and social care needs.

However, policies are not easily translated into implementation without clear objectives, local partnerships, commissioning and performance monitoring. For example, agreeing that all homeless children should be in education is not sufficient to free school places in the proximity of a hostel or after families have been re-housed. Access to mental health services, particularly for children, will not improve if services only follow 'stability' referral pathways through general practitioners. Similarly, primary care trusts facing a number of commissioning priorities will not automatically commission health services for homeless families without evidence of effective models and integration with the existing health agencies. Housing departments and associations are facing increasing demands for lower housing stock. The findings from the present study support the emergence of services tailored to the needs of a particular group (in this case, the FSW post), whilst maximizing access to existing community services (e.g. schools, health visiting or social work). Housing departments are ideally placed to lead and facilitate this process since this is the first agency in contact with families when they are most vulnerable.

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HOMELESS CHILDREN AND PARENTS: SHORT-TERM MENTAL HEALTH OUTCOME

KHALID KARIM, VICTORIA TISCHLER, PETER GREGORY & PANOS VOSTANIS

ABSTRACT

Background: Homeless families are an increasing but marginalised part of society. They have diverse and complex needs that have often not been addressed by the available services. There is some evidence that psychosocial factors continue to be detrimental to the mental health of these families even after rehousing.

Method: Thirty-five homeless families were assessed on their mental health (Hospital Anxiety and Depression Scale, Eyberg Child Behaviour Inventory Scale, Health of the Nation Outcome Scales for Children and Adolescents), parenting problems (Parenting Daily Hassles Scale), and service satisfaction (semi-structured interview) following admission to two homeless hostels, and four months later, when most families (69%) had been rehoused in the community.

Results: Children and their mothers continued to experience high rates of mental health problems whilst resident in the hostels and after rehousing. However, a proportion of parents expressed a subjective improvement, which was often associated with their housing and social circumstances. A diverse range of further needs was described.

Conclusions: There is a need to address the complex problems experienced by these families, with housing only forming one aspect of this provision. Inter-agency strategy, commissioning and services are required to meet the needs of this vulnerable group of parents and children.

INTRODUCTION

In recent years there has been a significant increase in the number of homeless families with children in both North America and Europe. The annual number of households defined as homeless by local authorities is above 100,000 in the UK (ODPM, Third Quarter, 2004) and of these households a significant proportion consists of homeless children and their families. Nineteen percent of all households in bed and breakfast accommodation are households with dependent children or expectant mothers. Of all households accepted as homeless by UK local authorities, 51 % have dependent children, and a further 11 % include a pregnant woman.

The reasons for homelessness are diverse: predominantly domestic violence, relationship breakdown, and neighbourhood harassment, with a recent increase in asylum-seeking and refugee families among the homeless population.

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These families often have complex and inter-related health, social and educational needs (Connelly & Crown, 1994). Homeless children have increased rates of physical and mental health problems when compared to the general population or those in stable housing (Vostanis *et al.,* 1997). Child mental health problems can be behavioural, for example, sleep disturbance, eating problems, aggression and over-activity; or emotional, such as anxiety. depression and self-harm. Homeless children are more likely to have delayed development, learning difficulties, and an increased incidence of accidents (Brooks *et al.,* 1998; Webb *et al.,* 2001). A frequent change of address reduces the accessibility to appropriate health care, with less access to preventative services. Educational achievement can also be affected, and has been related to the residential instability. Rubin *et al.* (1996) found that academic achievement was related to the repeated change in schools, although homeless children's actual cognitive ability was similar to the ability of housed children.

In addition to the difficulties facing the children, homeless mothers have reported high rates of previous abuse and psychiatric morbidity compared to those in stable housing (Vostanis *et al.,* 1998). Previous research with homeless mothers found a high incidence of depression and substance misuse, and reduced access to mental health services (Zima *et al.,* 1996). It is therefore not surprising that mental health problems in the parents and children are often inter-related (Zima *et al.,* 1996; Vostanis *et a/., 1997;* Holleman *et a/.,* 2004). A previous study on families resident in a homeless hostel also showed high rates of parenting difficulties and mental health needs among parents and children (Tischler *et al.,* 2004).

This relationship is particularly evident in families with pre-school children, i.e. maternal depression has been found to be a strong predictor of children's behavioural problems (Bassuk *et al.,* 1997). These problems are not specific to homeless families, and occur in other families subjected to chronic adversities and stressful life events. However, homeless families are relatively more disadvantaged, for example, they are more likely to be headed by a single parent, have higher exposure to domestic violence and lack social supports. It is these levels of social support that are important in predicting child and maternal psychopathology (Vostanis *et al.,* 2001).

There has been little previous research on the short- and long-term psychosocial outcomes of homeless children and their parents. Some evidence exists that these problems remain significantly elevated in both mothers and children after rehousing, and that families are not well integrated within their new communities when compared to families of low socio-economic status in stable housing (Vostanis *et al.,* 1998), leaving them at risk of future homelessness. The aim of this study was to establish the extent of mental health problems and parenting difficulties in homeless families at the time of becoming homeless and their short-term outcome after the standard period for rehousing. It was hypothesized that, in the absence of treatment, parents' and children's mental health problems and parenting difficulties would not decrease significantly, even following rehousing.

METHOD

Setting and subjects

The sample consisted of homeless families who had been consecutively admitted to two hostels for homeless families over a period of one year, and who participated in a follow-up assessment

four months after the admission. A total of 81 families were initially included in a baseline assessment of mental health and parenting problems (Tischler *et al.,* 2004). This study was conducted four months after the initial assessment. The four-month period was considered a reasonable period in which to assess short-term outcome following the usual rehousing process (the rehousing target is approximately two months). Families had already given consent to be contacted at follow-up and their new address had been sought from the Housing Department. At the time of follow-up, 35 families were contactable and agreed to be re-interviewed. Some families had left the hostel early without leaving a follow-up address, while others had already moved from the follow-up address by the time of the study. The difficulties of engaging homeless participants in longitudinal research have been identified elsewhere (Winship, 2001). However, the families lost to follow-up did not differ in their demographic factors or reasons for becoming homeless.

One hostel utilized a family support worker model to coordinate services before and after rehousing, whilst the other hostel utilized a key worker approach. Both systems provided assistance and support with families' housing and social care needs during their stay at the hostel. No follow-up or support arrangements were available after the families had been rehoused in the community. The majority of families who participated in the follow-up assessment were in new homes (22, or 69%). Ten families were still at their original hostel, one had moved to another hostel, and two had been rehoused but had subsequently returned to the hostel. Both of these families had experienced domestic violence, a risk factor for repeated and chronic homelessness (Bassuk *c t al.,* 2001). Of those families still in hostels, five had accepted new accommodation and were waiting to move.

MEASURES

The main carer of the family, usually the mother, was interviewed and completed the measures described below. The children's measures referred to one child, defined as `the child the parents were most concerned about', in relation to mental health problems.

- The Hospital Anxiety and Depression Scale (HADS - Zigmond & Snaith, 1983) is a standardized and widely used measure of anxiety and depression in adults. Each of the 14 items (7 for anxiety and 7 for depression) is rated between 0–3, depending on the severity of the symptom (range 0-21 for each subscale). A cut-off total score of 11 or more indicates likely psychiatric morbidity, while a score of 7 or more on either subscale indicates the likelihood of anxiety or depressive disorder.
- The Parenting Daily Hassles Scale (PDHS - Crnic & Greenberg, 1990) assesses the impact and frequency of 20 experiences that can be perceived as problematic by parents. The carer rates each item for frequency and intensity. The total frequency (range 0–80) and intensity scores (range 0-100) are obtained, with scores for challenging behaviour (range 0-35) and parenting tasks (range 0--40) being further derived from the intensity scale.
- The Eyberg Child Behaviour Inventory (ECBI - Eyberg & Ross, 1978) is a standardized measure of child behavioural (oppositional) problems. Items refer to 36 common child-hood problem behaviours. Each item is rated as (a) present or absent, the sum of

which consists of the problem number score (range 0-36); and (b) on its frequency (1-7 Likert scale), the sum of which constitutes the problem intensity score (range 36-252). Cut-off scores of 11 on the problem number score and 127 on the problem intensity score have been found to indicate behaviours which might require assessment and treatment (Eyberg & Robinson, 1983).

- . The Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA - Gowers et al., 1999a) includes 13 clinical/psychosocial items (Section A: disruptive/ aggressive behaviour, overactivity and attentional difficulties, non-accidental self-injury, alcohol or substance/solvent misuse, scholastic or language skills, physical illness/disability problems, hallucinations and delusions, non-organic somatic symptoms, emotional and related symptoms, peer relationships, self-care and relationships, poor school attendance) and two items on information about services (lack of knowledge on the nature of the child's difficulties, and lack of information on services/management).

Each item is rated on a five-point severity scale between 0 (no problem), 1(minor problem requiring no action), 2 (mild problem but definitely present), 3 (moderately severe problem), and 4 (severe to very severe problem), with a detailed glossary for each point of the scale and item, standardized in clinical populations (Gowers *et al.,* 1999b). The HoNOSCA was originally designed for completion by mental health practitioners. As this has also been used as a research outcome measure, in this study it was completed by the researcher from direct interviews with the carer.

In addition, a semi-structured interview on service satisfaction (housing needs and service access) was used to ascertain the family's current housing situation, their present and future needs, and satisfaction with services being accessed. The interview allowed the clients to discuss any mental health problems in themselves or their children, and their experiences of living in a hostel. The interview guides were developed from themes that emerged from previous studies with homeless families on family perceptions of health and social care services (Cumella *et al.,* 1998; Tischler *et al.,* 2002).

DATA ANALYSIS

Categorical data was initially presented as frequencies. Continuous scores at first and follow-up assessment were compared by non-parametric tests (Wilcoxon matched pairs), as the questionnaire data was not normally distributed. Established cut-off scores were used to provide rates of problems likely to require specialist assessment and treatment. The association between social and parenting variables and mental health outcomes (changes on the ECBI or HADS) was investigated by linear regression analyses. The SPSS version 11.0 was used.

Qualitative data analysis was based on a thematic content coding (Flick, 2002), with similar and identical responses to each question grouped into categories. This involved detailed consideration of the responses to each question but also to the responses to other questions, to prevent repetition. Multiple responses to the same question were counted in different categories, but not more than once in the same category. This enabled the development of concepts relevant to the clients. The relative strengths of each response could then be quantified. Examples in the participants' own words were used to illustrate their responses.

RESULTS

Of the 35 families, the majority (28, or 80%) consisted of a mother and children. The remainder were either couples with children, or a mother with her partner and children. The mean number of children was 3 (range 1-7). The ethnic status of the main carer was: white British 25 (71%), Asian 5 (14%), white Irish 2 (6%), black African 2 (6%), and other European 1 (3%). The main carer's mean age was 31.6 (range 19--46) and the child's mean age was 7.7 (range 2--17). Domestic violence (7, 20%), neighbour harassment (8, 23%), relationship breakdown (8, 23%) and eviction (6, 17%) accounted for the majority of reasons for homelessness.

MOTHERS' AND CHILDREN'S MENTAL HEALTH PROBLEMS AT THE TWO ASSESSMENTS

There was no significant change on the total HADS scores ($Z = -0.56$, $p = 0.58$). The number of clinical cases with a HADS score of 11 or greater remained at the same frequency at both assessments ($Z < 0.001$, $p = 1.00$). At the initial assessment. 28/35 cases (80%) scored above I 1 and at follow-up 23/30 cases (77%). Neither the HADS anxiety ($Z = -0.49$, $p = 0.62$) nor the HADS depression scores ($Z = -0.45$, $p = 0.66$) changed significantly. The parenting problems (PDHS) scores for frequency ($Z = -0.14$, $p = 0.88$) and intensity ($Z = -0.19$, $p = 0.85$) were not statistically different between the initial assessment and follow-up. Similarly, no change was found in PDHS scores for challenging behaviour ($Z = -1.61$, $p = 0.11$) and parenting tasks ($Z = -0.34$, $p = 0.74$).

There was no significant change on the Eyberg Child Behaviour Inventory number of behaviours ($Z = -1.28$, $p = 0.20$) or intensity scores ($Z = -0.11$, $p = 0.91$). Similarly, there were no statistically significant changes in the HoNOSCA subscales, except for disruptive behaviour, which was found to improve ($Z = -1.93$, $p = 0.05$). When scores of 3 and 4 were grouped together at follow-up, as those cases potentially require assessment and treatment, the most frequently reported difficulties were attention deficit 10 (43%) and disruptive behaviour 8 (35%). Scholastic and language, emotional, peer relationships problems, and problems in family life each affected 7 children (30%). Twelve cases of the 35 did not complete the HoNOSCA.

A new variable was created, as the change on ECBI scores between first and follow-up assessment. This was entered as the dependent variable in univariate linear regression analyses, with social variables (history of being homeless or reason for homelessness) as the independent variable. Experience of domestic violence was significantly associated with negative outcome on ECBI behaviour change scores (B = 31.15, 95% CI = -0.87 to 63.16, p = 0.05). A similar variable was created for changes on the HADS, but this was not predicted by either independent variable.

The impact of baseline maternal mental health and parenting on changes in child behavioural problems was tested by a multiple linear regression model, with changes on the ECBI as the dependent variable, and initial HADS and PDHS scores as the covariates. Changes in ECBI scores were predicted by two parenting problems subscale scores, but not by any of the HADS scores:

PDHS challenging behaviour: *B*=-6.98, 95% CI =-11.11 to -2.85, p = 0.002.
PDHS parenting tasks score: B = -5.09, 95% CI =-9.36 to -0.82, p= 0.021.

COMPARISON OF REHOUSED FAMILIES WITH THOSE STILL LIVING AT THE HOSTEL

Although the number of families still living at the hostel was small (N = 13), the impact of this variable on outcome was taken into consideration. There was no statistically significant difference in the baseline or follow-up HADS or PDHS scores between families who had been rehoused and families still living at the hostel (see Table 1). Children who had been rehoused showed no significant changes on the EBCI scores or on the HoNOSCA subscale scores (see Table 2), except for improvement on the HoNOSCA subscale for understanding the nature of their child's difficulties (Z = -2.27, p = 0.023). When children still living in the hostels were compared on behavioural and other mental health problems between the first and second assessment, there was no significant difference on the ECBI scores (number of problems score Z=-0.20, -*0*0.84; intensity score Z = 0.05, p= 0.96), but they were found to improve on the HoNOSCA subscales for emotional symptoms (Z =-L99, p= 0.046), self-care (Z = -2.00, *p* = 0.046) and problems in family life (Z = -2.1*1, p* = 0.035).

PARENTS' SERVICE SATISFACTION

The qualitative data is presented below, using subheadings to describe each theme. The themes are illustrated using parents' verbatim quotes, where appropriate.

Housing and related needs

Not surprisingly, perceptions of needs depended on families' housing status at follow-up. The majority of those families rehoused (16, 72%) were positive about their new home and satisfied with the quality of the new accommodation: `very comfortable, worth the wait'; `very happy with new home', 'like house, feels settled'.

Table 1
Comparsion between first and follow-up maternal HADS and PDHS scores(Mann-Whitney test)

Test compared pre/post	All mothers *(N = 35)*	Rehoused mothers *(N = 22)*	Mothers still in hostel *(N = 13)*
HADS anxiety score	*Z = -0.49 p = 0.62*	*Z=-1.84p=0.67*	*Z=-0.27p=0.79*
HADS depression score	*Z = -0.45 p = 0.66*	*Z = -0.63 p = 0.53*	*Z_=-0.18p=0.86*
HADS total score	*Z = -0.56 p = 0.58*	*Z = -0.52 p = 0.60*	*Z = -0.31 p = 0.76*
HADS score within clinical range	*Z = -0.38 p = 0.71*	*Z = -0.45 p = 0.66*	*Z=-0.00p= 1.00*
PDHS frequency score	*Z=-0.14p=0.89*	*Z = 0.05p=0.96*	*Z = -0.56 p = 0.57*
PDHS intensity score	*Z = -0.20 p = 0.85*	*Z=-0.54p=0.59*	*Z_=-0.44p=0.66*
PDHS challenging behaviour score	*Z=-1.61 p=0.11*	*Z.=-1.18p=0.24*	*Z = -0.97 p = 0.33*
PDHS parenting tasks score	*Z=-0.34p=0.74*	*Z=-0.18p=0.86*	*Z=-0.26p=0.80*

Table 2
Comparison between first and follow-up child ECBI and HoNOSCA scores (Mann-Whitney test)

Test compared pre/post	All children	Rehoused children	Children still in hostels
Eyberg behaviour score	Z=-1.28p=0.20	Z=-1.55p=0.12	*Z = -0.20 p* = 0.84
Eyberg intensity score	Z=-0.11p=0.91	Z=-0.15p=0.88	*Z = -0.51 p* = 0.96
HoNOSCA disruptive behaviour	Z=-1.93p=0.05	Z=-1.63p=0.10	Z=-1.08p=0.28
HoNOSCA attention deficit	Z=-1.53p=0.13	Z=-1.15p=0.25	Z=-1.00p=0.32
HoNOSCA non-accidental self-injury	*Z*=-1.19 *p*=0.23	Z=-1.13p=0.26	*Z*=-0.45 *p* = 0.66
HoNOSCA substance misuse	Z=-0.333p=0.74	*Z*=-0.45 *p* = 0.66	Z= 0.00 p= 1.00
HoNOSCA scholastic and language problems	Z=-0.03p=0.98	*Z* = -0.49 *p*=0.63	*Z = -0.41 p* = 0.68
HoNOSCA physical illness/ disability	Z=-0.07p=0.94	*Z* = -0.69 p = 0.49	Z= 0.82p=0.41
HoNOSCA hallucinations/ delusions	Z=-1.73p=0.08	Z=-1.41 p=0.16	Z=-1.00p=0.32
HoNOSCA somatic/non-organic symptoms	*Z* = -0.64 *p* = 0.52	Z=-O.55p=0.58	Z_=-0.27p=0.79
HoNOSCA emotional and related symptoms	*Z* = - 1.08p=0.28	Z=-0.12p=0.90	Z=-1.99p=0.05
HoNOSCApeer relationships	*Z* = -0.66 *p* = 0.51	Z=-*1.05*p=0.29	Z=-O.11 p=0.9
HoNOSCAproblems with self-care/independence	Z=-1.08p=0,28	Z=-0.37p=0.71	Z=-2.00p=0.05
HoNOSCAproblems in family life/relationships	*Z* = -0.99 *p*=0.32	*Z*=-0.04 *p* = 0.97	*Z*=-2.11 *p*=0.04
HoNOSCApoor school attendance	Z=-1.11 *p=0.27*	*Z* = -0.53 *p* = 0.60	Z=-0.96p=0.34
HoNOSCA nature of difficulties	Z=-1.81p=0.07	*Z* = -2.27 p = 0.02	Z=-0.00p= 1.00
HoNOSCA lack of services	Z=-0.47p=0.64	Z=-1.*10* p=0.27	Z=-0.71 p=0.48

Five families (23%) were unhappy with their accommodation, with three wanting to be rehoused again. Their dissatisfaction was mainly related to the locality of their home: `not happy here, feels like a prison'; `don't like (area), afraid of being burgled'; `hostel was a palace compared to this'.

Approximately a third of rehoused families (7, 32%) commented on the need for improvements to their accommodation: 'carpets, wardrobes, beds'; `needs bits and pieces'; `finish decorating'. Other needs included adult education and financial help; however, six families (27%) stated they had no further needs of any kind.

The families who were still resident in the hostels commented on a range of issues that affected their stay. As expected, the main expressed need of those still in hostels was for housing or help for rehousing (8 families, 62%). Other comments covered a range of issues, but help for their children, which encompassed the needs for schooling, childcare and help for the child's behaviour, were most requested (6 families, 46%). Residents also wanted information on financial and work problems: `a home, to get out of here'; `no other needs, just a house'; `privacy, better heating, housing'.

The majority of the hostel residents (8, 62%) found the staff helpful and supportive, although there were some complaints about privacy: `[staff] very supportive, very nice'; `gives moral support, very understanding how you feel'; `difficult to get privacy'.

The negative comments generally related to the lack of facilities, cleanliness and noise, and sharing with other residents: `only three washing machines . . . no fridge freezer'; `finding it boring'; `noisy, kids playing on the stair'.

Schooling

The majority of the families (24, 68.6%) had their children in either a full-time school placement or in a pre-school provision. Of these families, seven expressed negative comments regarding the schooling, with four of these no longer attending. Problems included racial abuse, bullying or difficulties with travelling. Four families had children too young for school: `stopped going to college, didn't like it'; `was attending ... but got racial abuse'.

Mental health

In the majority of rehoused families (13, 59%), the parents commented positively on their own mental health, with perceived improvement in mood symptoms, stress levels and substance abuse: `feel much happier, it was depressing and unpleasant'; 'I've changed for the better ... being sober': 'now off antidepressants, stopped one month after the hostel'.

A few parents (4, 18%) described either a continuation of mental health problems after rehousing, or problems relating to their current residence that were creating additional stress: `I've had enough, want to give up, hate new home'; 'don't feel good, need counselling for violence from ex'; `get anxious easily ... on medication'.

Significantly, two mothers commented that they felt more apprehensive in their new home and felt safer in the hostel. Five mothers requested psychiatric treatment for themselves or their children as one of their major needs: `counselling for child'; `counselling ... doesn't feel good in herself'; `psychiatric treatment for [child]'.

Parents' comments on the mental health of their children were virtually equally divided between those who commented positively after rehousing (11, 50%) and those who described difficulties (10, 45%). Some parents commented that the children appeared more relaxed and behavioural problems had improved: `[children] are a lot more relaxed since moving here'; `still difficult at times, but much better'; `since move, [child] has changed in a good way'. However, some parents (9, 41 %) described continued or worsening problems, particularly behavioural problems, including aggression: `being aggressive at school, breaking toys ... bites own hand'; `big change in [child], bad language, beats girls up'; '[child] more unsettled, lost weight recently'.

In contrast to the rehoused group, the majority of parents in the hostels (7, 54%) reported negatively on their mental health and often related it to their housing situation. Mood and anxiety problems were the most prevalent: `last few months have been very stressful ... feeling overwhelmed'; `calmer since prescribed by psychiatrists, recent panic attacks'; `talks about eating disorder, what has happened to the children, housing situation' (CPN). However, a few parents (3, 23%) were more positive about their mental health in the hostel. These residents described the support and help they received and the additional security of being in a hostel: `feel more settled'; `life sorted out since being at (hostel)'.

The majority of parents (9, 69%) commented that the mental health of their children was worse in the hostel environment, particularly with deterioration in their behaviour: `[child] keeps knives for protection, poor sleeper'; `kids unsettled, swearing, aggressive, in trouble with the police'; `[child] now very aggressive, older children encourage it'.

DISCUSSION

The findings of this study indicate further the increased and continuing levels of mental health needs among homeless families, even after their rehousing in the community. In the absence of substantial longitudinal evidence with vulnerable child and parent populations, these findings predominantly have implications for policy and service development. The underlying psychosocial factors which contributed to becoming homeless often persist after rehousing, thus remaining detrimental to the mental health of children and their parents. The characteristics of these families were similar to those in previous studies, with the main causes of homelessness reported as domestic violence, neighbour harassment and relationship breakdown (Vostanis *et al.,* 1997). The majority of the families had been rehoused at four months; however, a substantial proportion still resided in the hostels, while two families had been readmitted because of domestic violence.

Using standardized mental health outcome measures, there was no significant difference in the parents' mental health at follow-up, and this was not found to be related to their residential status at the time. However, this differed from the perception of the majority of the rehoused group who thought that their mental health and social situation had concurrently improved. This apparent contradiction between qualitative and quantitative data may reflect the small sample size available to follow-up. A proportion of those rehoused experienced deterioration in their mental health on leaving the sheltered environment of the hostels, and this may have negatively affected the results. The hostels provided a secure environment from the threat of domestic violence or harassment, and there was the facility to confide in and receive support from staff and other residents which would become unavailable once in the community. An alternative explanation was a real disparity between parents' global perceptions of their mental health well-being, which they associated with the overall housing and social circumstances, and their actual mental health status, at least at the time of moving to a new house and starting a new life with their family. Either explanation would, however, support the argument that housing only addresses the structural needs of these families, which does not completely alleviate the often complex stresses associated with mental health and other social problems.

The reduction in the children's disruptive behaviour may have been related to the stabilization in their home environment, with many families describing their children as being more settled. Nevertheless, a substantial number of children in rehoused families continued to have mental health difficulties, usually of a behavioural nature. This finding is consistent with a previous study of homeless children before and after rehousing in a different local authority (Vostanis *et al.,* 1998). In that study, 39% of children in rehoused families had significantly raised levels of mental health problems one year after becoming homeless, when compared to a group of children who were socioeconomically deprived but in stable housing. Even after rehousing, children remained vulnerable to risk factors such as family conflict and breakdown, domestic and community violence, and parental mental health problems, including substance abuse. The likelihood of further residential instability was indicated by the number of families in the earlier study who had moved at least once more since returning to the community.

Although a significant number of parents reported deterioration in the behaviour of their children in the hostels, there was some improvement in their emotional problems, self-care

and problems in relationships. The input from key-workers and the social support available in the hostels could be significant factors that would explain why these differences were absent after rehousing. It was positive to find that many of the children were in pre-school or full-time education. This is an improved finding to earlier research that established reduced school attendance rates among homeless children (Rubin *et a/.,* 1996; Vostanis *et al.,* 1997). Consistent schooling provides stability for children, and promotes protective factors such as academic attainment, friendships and self-esteem. This should therefore be a key component of the families' care plan.

A number of underlying mechanisms could explain the findings and could be explored in more detail by future research. Children could be affected directly through the continuation of vulnerability factors such as social and family disruption and exposure to violence. The impact of these adversities on parents' (usually the mother's) mental health and parenting capacity can further compound children's difficulties, in particular oppositional behaviour, which in turn adds a burden on the parent in the absence of support networks (Leverton, 2003; Ramchandani & Stein, 2003).

As one would anticipate, the needs of these families were diverse. A permanent home, as expected, was stated as their greatest need, but other practical issues were often perceived as equally or more important than mental health interventions for themselves or their children. This reinforces the need to consider multiple factors when coordinating services for this client group (Holleman *et al.,* 2004). The problems experienced by homeless families often do not conform to the models of care provided by organizations such as health, education, housing and social services, and in the past there has been little coordination between these different agencies (Page & Nooe, 2002). More recently, there have been initiatives to address this issue, for example, the family support model, to provide input in the hostel and after rehousing (Tischler *et al.,* 2004). The remit of family support workers is to provide parent training, detect a broad range of needs, and facilitate and coordinate the access to specialist services. An alternative service could be based on the adult outreach model, usually through community psychiatric nursing (Tischler *et al.,* 2000). This has been found to have a positive impact on children's behavioural problems (Tischler *et al.,* 2002), but is constrained if no agency co-ordinates services and deals with issues such as housing, child protection and school placements, which would otherwise overburden the specialist mental health professsional. Future research and service development should also consider the comparative costs of such models.

There were limitations to this study. The results may have been affected by the small sample size; however, the combination of quantitative and qualitative data addressed some of these limitations by providing the families' subjective evaluation of the situation and relations with services. Although not every family answered all of the questions on the semi-structured interview, themes were established for the whole sample. A larger sample size would help to address these concerns. It would have been useful to follow up the families for a longer period of time but, as discussed previously, the mobility of this group often results in their loss of contact with statutory agencies, consequently making it difficult to trace them for research purposes. The complex needs of these families, as established in this study, have implications for providers of health and social care on a local and national level. The range of needs implicated in the maintenance of mental health in both children and their parents has to be met by a co-ordinated strategy. It is positive to note the development

of a central government directorate in the UK to oversee the provision of homeless services, and that each Local Authority is required to develop an inter-agency strategy (O'Connell, 2003).

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Homeless Mothers: Is there a Relationship between Coping Strategies, Mental Health and Goal Achievement?

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ABSTRACT

This study examined the relationship between coping, mental health and goal achievement among homeless mothers. Seventy-two women took part and 44 were re-interviewed 4 months later. The Family Crisis Oriented Personal Evaluation Scales (F-COPES) were used to identify their coping strategies at the time of homelessness: the General Health Questionnaire (GHQ) measured mental health problems: and a semi-structured questionnaire identified their goals. Outcome measures at follow-up were goal achievement and mental health. A variety of coping strategies were used, with some differences ascertained according to reason for homelessness and age of respondent. Lower use of problem-focussed coping was associated with poorer mental health at the time of homelessness. Mental health problems improved over time, but levels of psychopathology remained high at follow-up. Most women had achieved their primary goal of resettlement, and this was associated with use of problem-focussed coping. Lower use of problem-focussed coping, in particular, acquiring social support, was associated with continuation of mental health problems at follow-up, however the greatest predictor of mental health at follow-up was mental health status whilst homeless. Despite exposure to major stressors and poor mental health, mothers experiencing homelessness can maintain their ability to cope effectively, in order to achieve their goals. Copyright 2007 John Wiley & Sons, Ltd.

Key words: adaptation; coping; goal achievement; homeless mothers; mental health

INTRODUCTION

Many women with children experience homelessness as a result of domestic and neighbour violence and relationship breakdown. It is accepted that the experience of homelessness is

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stressful and that the mental health of homeless women is often poor, yet little is known about how they cope, plan for their future and achieve re-housing.

Coping models and framework

Coping refers to a process which begins with appraisal (Lazarus & Folkman, *1984).* Primary appraisal occurs when an individual is confronted with a potential stressor and decides whether it is of concern. Secondary appraisal follows if the situation is considered stressful, and requires a response from the individual. This will in turn determine the types of coping strategies used (Lazarus, *1999).* There are a variety of conceptualisations of coping, however, the best known is that of Lazarus and colleagues. Coping is usually dichotomised into problem-focussed or emotion-focussed styles (Lazarus & Folkman, *1984).* Problem-focussed, externalising coping strategies aim to change an individual's relationship with their environment. Emotion-focussed, internalising coping refers to efforts to reduce the negative feelings associated with stress. Overall, most individuals will use both problem- and emotion-focussed coping in any one stressful encounter (Folkman & Lazarus, *1980).*

A number of authors have suggested that the theoretical framework underpinning coping requires further development. A distinction has been made between cognitive and behavioural coping styles (De Ridder, *1997).* Cognitive approaches indicate that an individual may, for example, reframe a stressor so that it appears more positive, whilst behavioural coping may involve some observable change in action. Others (Skinner, Edge, Altman, & Sherwood 2003) advocate a typology which describes different levels of coping. This includes higher order categories which encompass the adaptation functions of coping, and lower orders which classify the variety of coping skills and strategies.

Coping is a component of adaptation. This refers to the way in which an individual adjusts to their environment (Aldwin, *1994),* and which also includes defence and mastery. Individuals thus act to defend themselves from stressors, manage their circumstances, and attempt to master their environment. The most effective strategy is dependent upon context, yet emotion-focussed or disengagement coping has been associated with poor adjustment (e.g. Aldwin & Revenson, *1987;* Terry & Hynes, *1998).* Emotion-focussed coping can be beneficial in the short-term, particularly when an individual is confronted with a stressor over which they have little control. Some authors have suggested that emotion-focussed strategies, such as depressive symptoms can serve an adaptive function as they conserve energy and inhibit futile actions for individuals under severe stress (Brissett-Chapman, *1998;* Nesse, 2000). It has been argued that the experience of stress and trauma can be transformative as individuals develop self-reliance and healthier relationships with others, and experience change in life's meaning and priorities (Tedeshi & Calhoun. *1995).* It has also been suggested that traditional coping theories do not incorporate issues, such as power, gender and ethnicity, which are particularly relevant to marginalised groups such as women experiencing homelessness and domestic violence (Banyard & Graham-Bermann, *1993, 1998).* This suggests that vulnerable individuals may be more likely to report emotion-focussed coping strategies, hence be assessed as poorer 'copers'.

Coping with trauma and violence

A number of studies explored the coping strategies of women who had experienced abuse and trauma. A qualitative study by Davis (2002) reported that women subjected to

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domestic violence perceived themselves as survivors rather than victims, and used cognitive, inner strategies such as planning escape, hoping, and spiritual beliefs prior to utilising external resources like housing, welfare and legal services. Disengagement methods of coping such as denial and avoidance are common among women who experienced sexual abuse as children (Coffey, Leitenberg, Henning, Turner & Bennett 1996a; Leitenberg, Gibson & Novy, 2004). Minimising experiences of domestic violence, an emotion-focussed method of coping, has often been reported by women, a factor which contributes to victims feeling less motivated to leave the abuser (Arriaga & Capezza, 2005). In contrast, a number of inter-related, protective factors for women victims of domestic violence include decreases in appraised vulnerability within an abusive relationship, positive social relations, access to socio-economic resources such as employment, self-esteem, and lower rates of depression (Carlson. 1997; Nurius et al., 2003: Waldrop & Resick, 2004). These are important in bolstering a women's ability to cope with violence and thus break the cycle.

Coping and mental health

Many psychosocial factors influence the relationship between coping and mental health. including the type of problems faced, the degree of stress experienced (Pearlin & Schooler. 1978: Menaghan, 1983) and the environment in which the interaction takes place (Aldwin, 1994). A number of studies support the relationship between emotion-focussed coping and psychopathology. In particular, poor mental health has been found to be associated with disengagement strategies such as escapism (e.g. Aldwin & Revenson, 1987). A comparison of coping styles between healthy individuals and those diagnosed with depression established that chronic strain and emotion-focussed coping were more common in the depressed group. Healthy individuals were instead more likely to use problem-focussed coping when confronted with negative life events, but this capacity declined if exposed to chronic strain (Fondacaro & Moos, 1989). Individuals experiencing depression are also reported to be vigilant, thus `locked into' emotional aspects of the problem (Krohne. 1993). Coping may play an important buffering role in vulnerable individuals, for example, those who experienced abuse in childhood (Runtz & Schallow, 1997). Qualitatively derived coping strategies such as self-healing, receiving social support and finding meaning have been reported to be associated with recovery from depressive illness (Skarsater, Dencker, Bergbom, Haggstrom, & Fridlund 2003).

Further evidence supports the association between emotion-focussed coping and poor mental health in individuals exposed to violence and trauma. For example, suppressing childhood sexual abuse has been associated with low self-esteem in women (Perrott, Morriss, Martin, & Romans 1998). Disengagement coping strategies have been found to predict different types of psychopathology, particularly depression and post-traumatic stress in women subjected to domestic violence (Arias & Pape, 1999; Clements & Sawhney, 2000; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002). These methods of coping were often generated in other adverse life circumstances (Coffey, Leitenberg, Henning, Bennett. & Jankowski, 1996b). Homeless women experiencing both sexual and physical violence were more likely to use drugs and alcohol as a method of coping, compared to those subject to physical abuse only (Wingwood, DiClemente, & Raj 2000).

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Homelessness as an outcome of multiple adversities and traumatic events

Homelessness is the result of an accumulation of acute and chronic stressors, and has been described as an end point on a continuum of poverty and residential instability (Sosin, 1992). Evidence indicates that homeless women had been subject to multiple prior stressors such as poverty, domestic violence, employment problems, unstable housing, and lack of social support (Bassuk & Browne, 1996; Bassuk & Rosenberg, 1988; Bassuk, Rubin, & Lauriat, 1986: Milburn & D'Ercole, 1991; Vostanis, Cumella, Briscoe, & Oyebode 1996). Homeless women with dependent children were reported to be even more vulnerable socially than single homeless women (Smith & North, 1994), as they tended to be younger and poorer, and were more likely to have been the victim of a physical assault (Roll, Toro, & Ortola 1999). Women subject to violence in childhood and adulthood were also more likely to become homeless repeatedly (Bassuk, Perloff, & Dawson, 2001).

The experience of homelessness has significant and far-reaching effects on family relationships and dynamics (Herth, 1996). In trying to cope with the stress of physical, psychological and social aspects of living in sheltered or temporary accommodation, a mother may find that she unintentionally neglects or underestimates the needs of her children. The experience of stress may lead to a range of parenting problems such as inconsistent discipline (Ghate & Hazel, 2002); loss of parental authority, which can be exacerbated in shelters where staff or other mothers are seen to be interfering with parenting duties or `public parenting' (Kissman, 1999); and concerns about the impact of homelessness, particularly exposure to violence on their children (Carpiano, 2002; Fogel & Dunlap, 1998; Sheppard, 2004).

Nevertheless, individuals can experience both negative and positive psychological states when under severe stress (Folkman, 1997). Thus, some authors described homelessness as a psychological trauma (Milburn & D'Ercole, 1991) that provokes feelings, such as fear, loss, distress and anxiety (Banyard & Graham-Bermann, 1998); while other studies (e.g. Banyard, 1995; Styron, Janoff-Bulman, & Davidson, 2000) identified positive outcomes such as the respite and escape from violence that homelessness can bring to some families.

It is well established that homeless women have high levels of emotional disorders, mainly depression (Banyard & Graham-Bermann, 1998; Goodman, Saxe, & Harvey 1991; Holzer, Shea, Swanson, & Leaf 1986). These levels of mental ill health have been found significantly higher than matched socioeconomically deprived but housed groups (i.e. living in stability-Connelly & Crown, 1994; Conway, 1988; Vostanis, Grattan, & Cumella 1998; Zima, Wells, Benjamin, & Duan 1996). Toro et al. (1995) suggested that psychopathology was both cause and effect of homelessness.

Mediating the impact of homelessness: social support and goal achievement

Social support can be defined as `the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us' (Sarason, Levine, Basham, & Sarason. 1983). Further, it refers to social interactions which facilitate coping (Pierce, Sarason, & Sarason, 1990). The process of acquiring social support is in itself a problem-focussed coping strategy. Social support provides specific benefits to the individual and also acts together with coping, for example, significant others may provide feedback about the suitability of appraisal and coping strategies used (Aldwin, 1994). Social support acts as a buffer against mental and physical ill health by influencing cognitions, emotions and behaviours. For example, it can help to prevent mental health

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problems through practical assistance and engagement with services (Nyamathi, Leake, Keenan, & Gelberg, 2000; Rayburn et al., 2005). Levels of social support have been found to mediate the relationship between mental health and coping. In a study of women subject to domestic violence, problem-focussed coping was associated with depressive symptoms when social support was low, but not when social support was high (Kocot & Goodman. 2003).

The concept of goal setting refers to `the wish to perform an action associated with anticipation of some kind of outcome' (Carver, 1996). Goal setting is a self-management technique which involves self-reinforcement, that is, some reward for achieving a goal (Stroebe, 2000). Goal directed behaviour is related to a number of factors which include internationalisation of cultural values as well as interpersonal factors. Thus, socialisation combined with intrinsic human nature determines what may be a desirable future state, that is, what goals to aim for (Ryan, Sheldon. Kasser, & Deci, 1996). Previous research involving homeless young people reported that a reliance on reference to others' coping strategies, for example seeking professional help, was associated with achievement of self-defined goals (Dalton & Packenham, 2002), others suggest that it is particularly difficult for vulnerable groups of the population to set goals, with consequently reduced internalised standards and motivation ('Taylor, Lydon, Bougie, & Johannsen, 2004).

The influence of coping strategies as a means of managing and overcoming homelessness has been little explored, with the exception of a few US studies (Banyard, 1995; Banyard & Graham-Bermann, 1998; Wagner & Menke, 1991). Previous research findings may have been affected by conceptual, measurement and sampling issues. For example, most participants were drawn from shelter or hostel environments, indicating that these women may have been help-seekers, therefore not necessarily representative of all women subject to abuse. In addition, most data is drawn from cross sectional studies which tell us little about outcomes and the process of coping (Waldrop & Resick, 2004). This was the rationale for this study.

METHODS

Aim

The aim of this study was to establish the association between coping strategies, mental health outcome and goal achievement among homeless mothers.

Setting and participants

The participants were 92 homeless mothers from Birmingham, UK. All had been accepted as statutorily homeless1 and were residents consecutively admitted to council-run temporary accommodation for homeless families, known as homeless centres. All three council-run centres for homeless families in Birmingham took part in the study. All homeless mothers with children aged 3 and over were approached to take part (n=138).

[1]According to the Housing Act 1996 (the research was completed before the Homelessness Act 2002 came into force).

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This age restriction was due to criteria for a service evaluation running alongside the primary study, the results of which are reported elsewhere (Tischler, Vostanis, Bellerby, & Cumella, *2002).* The average length of stay in homeless centres was *4-6* weeks. Most families were then re-housed by the Local Authority, referred to another authority, or instructed to return to their previous address if it was found that they had no connection with the local area.

Measures

- The *Family Crisis Oriented Personal Evaluation Scales* (F-COPES) were developed by McCubbin, Olson, & Larsen (1981) to identify coping behaviours of families experiencing crises. These measure emotion-focussed and problem-focussed strategies in five sub scales: acquiring social support (range: 36, mean=26.51, SD=6.45, alpha=0.78), refraining (range: 32, mean=30.42, SD=491, alpha=0.61), mobilising the family to acquire and accept help (range: 16, mean= 11.82, SD=3.28, alpha-=0.78), seeking spiritual support (range: 16, mean= 15.96, SD=3.1 4, alpha=0.95), and passive appraisal (range: 16, mean=8.48, ,SD=-2.95, alpha=0.75). All sub-scales are problem-focussed, apart from passive appraisal, which represents emotion-focussed coping.

The F-COPES consist of the following items: Reframing a cognitive strategy where difficulties are managed by being evaluated in a positive way; Acquiring Social Support which refers to attempts to overcome problems by engaging with others; Mobilising the family which refers to attempts to acquire help from community resources and other agencies; Passive Appraisal which refers to coping strategies that minimise a respondent's response to difficulties, and Seeking Spiritual Support identifies efforts to get help via prayer or religious and spiritual beliefs. The F-COPES have demonstrated good construct validity and acceptable levels of test-retest reliability (McConachie & Waring. 1997*).*

- The *General Health Questionnaire (GHQ-28)* is a brief screening questionnaire designed to identify mental health morbidity (Goldberg. *1978).* Respondents are asked to rate symptoms experienced over the past few weeks. It has four sub-scales: social dysfunction *(alpha=0.80),* anxiety and insomnia *(alpha=0.88),* somatic symptoms *(alpha=0.83),* and severe depression *(alpha=091).* The GHQ-28 has no population norms but uses a recommended threshold score of *4/5,* with scores of four or above indicating the need for clinical assessment (Goldberg, *1978).* This measure has been used widely and has satisfactory validity and reliability (Bowling, *2005).*
- Goal achievement was established by a semi-structured interview. At first interview participants were asked to list the primary goal they wished to achieve. Goal achievement was measured at follow-up by reminding participants of their defined goal and asking if this had been achieved.
- The *intensity of violence* experienced by the participating women prior to becoming homeless was rated on a Likert scale. A score of `1' indicated minor/occasional violence such as verbal insults and pushing, *`2'* indicated moderate violence such as slapping or shoving, *`3'* indicated serious violence which led to physical injuries and bruising, and *`4'* indicated that extreme violence had occurred. This included rape, abduction, attack with a weapon or attempts to kill.

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Research procedure

All participants were interviewed at the homeless centre within 3 weeks of admission. Standardised measures were initially left with participants to complete and return to the homeless centre office. Twenty women did not return data or returned incomplete data, therefore these cases were excluded. Where the participants were a couple, the mother completed the measures. Approval for the study was granted from the local research ethics committee. Respondents were assured that their participation would not affect their prospects for re-housing or access to services. All were offered an inconvenience payment of £ 10 in exchange for their time, £5 at first interview and £_5 at the conclusion of the second interview. At follow-up, participants were contacted by post or telephone to arrange visits. The GHQ, F-COPES and interview were measured at first meeting. The GHQ and goal achievement were completed at 4-month follow-up. This time period was selected, as it was anticipated that the majority of women would have been re-housed by this stage, that is after the central government target of 4-6 weeks at the hostel.

Data analysis

The data was analysed using the Statistical Package for Social Scientists (SPSS Version 1 LS). Non-parametric tests were used where data was not normally distributed. Pearson's and Spearman's rank correlations were used to test for association between variables. T-tests were used to compare mean scores between groups. One-way ANOVA and Kruskal-Wallis tests were used to examine differences in groups on demographic variables. Binary logistic and linear regression were used to establish associations between covariates and dependent variables.

RESULTS

Characteristics of homeless mothers

Complete data was collected on 72 mothers at first interview (T 1) and 44 at follow-up (T2), giving response rates of 52 and 61%, respectively. Although relatively low, these rates compare well with other studies of homeless people (e.g. Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann 1993; Vostanis et al., 1998). Most participants were single parents (TI: 59, 81.9%; T2: 34, 77.3%), of UK White ethnicity (TL 43, 59.7%; T2: 22, 50°I-), reliant on Income Support (T 1: 51, 71%, T?: 29, 65.9%), with a mean age of 35 at T1 and 36 at T2. The mean number of children was two (demographic data is presented in Table 1). There were no differences between those mothers who responded at the first interview and the 20 mothers who did not complete all measures. The follow-up sample (n=44) contained more respondents who were black than those who were not traced at second interview (n=28).

The average length of time being homeless was 14 days at the time of the first interview. Fifty-four percent (n=39) of participants had been homeless at least once previously. Most participants were homeless following domestic violence (44, 61.1%). Of those who described the violence they had been subjected to, most women (36/52, 69.2%) revealed that they had been attacked physically and 10 (19.2%) described a combination of physical, emotional and sexual abuse in the month prior to becoming homeless. A further four

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Table 1. Demographic characteristics

	First interview *(n = 72)*	Follow- up *(n = 44)*
Family type		
Female single parent	59, 81.9%	34, 77.3%
Couple	13, 18.1%	10,22.7%
Ethnicity		
UK White	43, 59.7%	22, 50%
Afro Caribbean	13, 18.1 %	8, 19.2%
Asian	8, 11.1%	8, 18.2%
Other*	8, 11.1%	6, 13.6%
Mean age of mother	35 (range- 33)	36 (range- 27)
Mean number of children	2 (range- 6)	2 (range- 6)
Reason for homelessness		
Domestic violence	44, 61.1%	27, 61.4%
Neighbour harassment	16, 22.2%	10, 22.7%
Relationship breakdown	1, 1.4%	1,, 2.3%
Natural disaster	1, 1.4%	0
Eviction	6, 8.3%	3, 6.8%
Asylum seekers	4, 5.6%	3, 6.8%
Income		
Income support	51, 71%	29, 65.9%
Salary	5, 69%	5, 11.4%
Other**	16, 22.2%	10, 22.7%

*(includes Eastern European, White Irish and Middle Eastern).
**includes Child Support Agency maintenance, Disability Living Allowance, Social Services maintenance. sickness benefit, and none).

(7.7%) had experienced emotional abuse, and two (3.8%) stated that they had been sexually abused. Of those who rated the violence that they had experienced, most (43/5 1. 84.3%) women stated that it occurred regularly and was moderate (17, 33.3%), serious (18, 35.3%) or extreme (8, 15.7%).

Coping and mental health at the time of becoming homeless

A wide variety of coping strategies were used by respondents. Reframing and Acquiring Social Support were more frequently used (Table 2). There were some differences in coping strategies identified according to the reason for homelessness (Kruskall-Wallis test). Refugees were more likely to seek Social Support (X' =10.60 [3], p=0.01), and Spiritual Support (X2 =7.69 [3], p = 0.05) as compared to respondents who were homeless for other reasons. Those who had been evicted were more likely to use Passive Appraisal (X^=9.41 [3], p-0.02) as compared to those who were homeless for different reasons. There was no significant association between the number of children per family and mothers' coping strategies (Spearman correlation test). There were no differences in coping strategies according to whether the respondent had been homeless previously or not. Younger respondents were less likely to seek Spiritual Support (r, - -0.39, p < 0.01).

At first interview, about three quarters (56, 77.8%) of respondents reported total GHQ scores within the clinical range indicating the likelihood of mental health problems. There was no difference on GHQ scores according to reason for homelessness (One-Way ANOVA: F=L56 [3, 69], p=021). There was no association between GHQ scores and number of children per family (Pearson correlation test: r=-U.19, p=0.14). There was no

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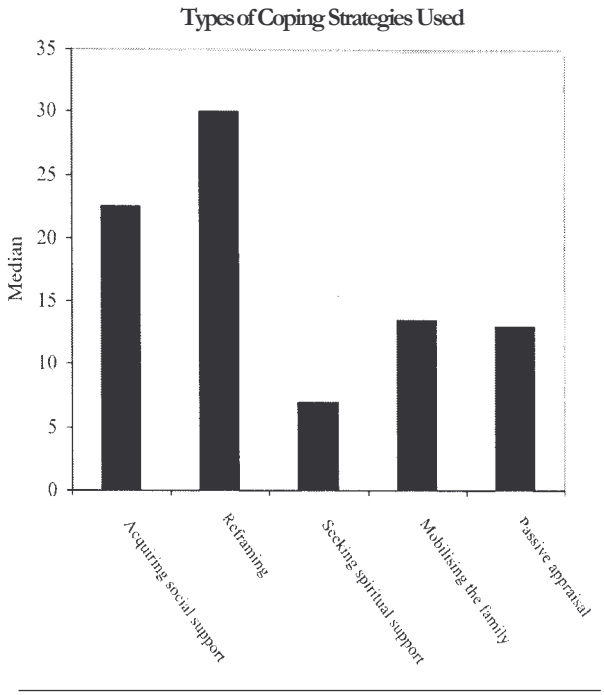
Table 2. Types of coping strategies used



difference in GHQ scores according to whether the respondent was a single mother or in a couple (independent samples t-test: *t=0.19 [70], p = 0.85).* Those who had been homeless previously were likely to have significantly higher GHQ scores than those who were homeless for the first time (independent samples t-test: *t-=2.05 [70], p = 0.04).* Higher total GHQ, Social Dysfunction and Severe Depression subscales scores were associated with lower use of the coping strategies Reframing and Acquiring Social Support, whilst higher Anxiety and Insomnia scores were associated with lower use of Acquiring Social Support (Table *3).*

Relationship between coping strategies and outcomes of homelessness

Coping strategies and mental health outcome. Mental health improved significantly from first interview to follow-up. All GHQ scales scores decreased significantly (Wilcoxon signed pairs rank test): GHQ total scores *(z=-3.41, p=0.001),* Somatic Symptoms (--2.57, *p=0.01),* Severe Depression *(z=-2.09, p--0.04),* Social Dysfunction (z.=-2.51, *p=0.01),* and Anxiety and Insomnia *(z=-3.22, p=0.001).* Despite this symptomatic improvement, more than half of the mothers *(26. 59%)* still scored at or above the GHQ total threshold score indicating the likelihood of mental health disorder.

The relationship between coping strategies and mental health outcome was investigated by a series of stepwise multiple linear regression analyses, with each coping strategy entered as the predictor and total GHQ score at follow-up as the dependent variable. Lower use of Acquiring Social Support accounted for 14%. of variance in the model (F= *6.83* [1, 42], p=0.01) indicating association with poorer mental health. The same result was found when demographic variables previously found to be independently associated with

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Table 3. Relationship between mental health problems and coping strategies at time of homelessness (Spearman rank correlation)

		Acquiring social support	Reframing	Mobilising the family to accept help	Seeking spiritual support	Passive appraisal
GHQ Total	r,	--0.33	-0.24	-0.14	0.05	0.03
	p	<0.01	<0.05	ns	ns	ns
Anxiety and Insomnia	r,	-0.29	-0.13	-O.13	0.06	0.08
	p	<0.05	ns	ns	ns	ns
Social Dysfunction	r,	-0.26	-0.25	-0.15	-0.01	0.06
	p	<0.05	<0.05	ns	ns	ns
Severe Depression	r,	-0.46	-.43	-0.14	0.01	0 00
	p	<0.01	G0.0 L	ns	us	ns
Somatic Symptoms	r,,	-0.18	-0.16	-0.17	0.13	-0.01
	p	ns	us	ns	ns	ns

either coping strategies or GHQ scores (that is age, reason for homelessness, and history of previous homelessness) were entered as covariates.
When GHQ total score at the first interview was also entered as a covariate, this became the only variable to be significantly associated with continuation of mental health problems at follow-up, accounting for 26*c*70 of variance ($F=14.84$ [1, 42], $p<0.005$).

Coping strategies and goal achievement. The majority of participants (48/72, 66.7%) cited resettlement as their primary goal at first interview. Examples of other goals specified were obtaining a school place for their children and gaining employment. When asked if their goal had been achieved at follow-up, 28 mothers (63.6%) gave an affirmative response. This was confirmed as most families (30, 68.2%) were resettled, that is had acquired permanent accommodation with a secure tenancy by the time of follow-up. The coping strategy Acquiring Social Support was associated with goal achievement (Binary logistic regression-Table 4). Finally, the relationship between mental health and goal achievement was explored by entering GHQ scores from the first interview as covariates in a logistic regression, with goal achievement as the dependent variable, but no significant association was established.

DISCUSSION

This study investigated the relationship between homeless mothers' coping, mental health and goal achievement. Findings suggest that respondents used a range of problem- and

Table 4. Goal achievement and coping strategies-logistic regression

Covariate	Significance	Odds ratio	95% C. I. for Odds ratio	
			Lower	Upper
Acquiring social support	0.02	1.14	1.026	1.268

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emotion-focussed strategies to cope with stress, which is consistent with other findings involving homeless mothers (Banyard, 1995); Banyard & Graham-Bermann, 1998; Wagner & Menke, 1991). This emphasises that homeless mothers use problem-focussed and cognitive coping strategies, in particular seeking social support and refraining, despite most having recent exposure to violence and trauma. There were some differences in coping styles according to reason for homelessness. Those who were homeless because of eviction were more likely to use disengagement methods of coping, which may suggest additional vulnerability in this group of individuals. Refugees were more likely to use social and spiritual support. Cultural differences in coping have been reported, particularly in the domain of spiritual or religious support (McConachie & Waring, 1997). This finding could be related to cultural differences in this sub-sample, as most were from Eastern Europe, where they may rely more on spiritual coping and `collective coping', for example, by involving extended family (Singh & Pandey, 1985).

High rates of mental health morbidity were reported in the current study, replicating previous findings with homeless families (Bassuk et al., 1986; Toro et al., 1995: Zima et al., 1996). These indicated that psychopathology may be related to exposure to previous adversities, such as violence and poverty rather than being homeless *per se,* although this mechanism could not be established as mental health had not been measured prior to becoming homeless. Although symptom severity decreased between first interview and follow-up, rates of mental health problems remained high following resettlement. This is also consistent with previous longitudinal studies with homeless families, which established the persistence or recurrence of risk factors, such as social isolation and abusive relationships, which in turn increase the likelihood of repeat homelessness (Bassuk et al., 2001; Vostanis et al., 1998).

The relationship between mental ill health and disengagement coping has been demonstrated in previous studies (Cohen, 2001; Franken. Hendriks, Haffmans, & Van-der-Meer 2001; Vollrath. Alnaes, & Torgersen 1996), including those involving women who experienced domestic violence (Clements & Sawhney, 2000; Coffey et al., 1996b). A number of studies (Fondacaro & Moos, 1989; Krohne, 1993), including those involving homeless mothers (Banyard & Graham-Bermann, 1998), report that use of emotion-focussed coping strategies, such as avoidance, denial and passive appraisal are associated with mental health morbidity. It has been suggested that coping strategies such as denial are often appropriate when a situation is beyond an individual's control (Lazarus, 1993) and that disengagement coping styles may represent symptoms of depression, for example, avoiding contact with others (Rayburn et al., 2005). Therefore, within a homeless population with poor mental health, it may be expected that disengagement coping would be common and perhaps an appropriate response to a situation over which one has limited control (Banyard & Graham-Bermann, 1998).

The current study adds to previous research on outcomes of homelessness. The findings indicate that most individuals achieved their goals, at least in the short-term. For most women, resettlement was their primary goal. The ability to acquire social support was a particularly important coping strategy in this respect. This concurs with previous findings (Dalton & Packenham, 2002) and underlines the importance of social networks and the ability to engage, for example seeking advice from others regarding housing services. Problems in seeking and receiving social support were also associated with the participants' poor mental health at follow-up. This emphasises the importance of this coping strategy in achieving goals (Aldwin, 1994) and the buffering role that social support can play in regard to mental health, concurring with previous findings (Kocot & Goodman,

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2003: Nyamathi et al., 2000). It was, however, the mental health of participants at the time of homelessness which was most predictive of continuing mental health problems at follow-up. This suggests that women's mental health during and after homelessness are important factors relating to future adjustment. Poor mental health impairs the ability to cope effectively (Coffey et al., 1996a), is associated with abusive and violent relationships (Arriaga & Capezza, 2005) and is likely to impair parenting (Ghate & Hazel. 2002), with adverse consequences for mothers and their children (Vostanis, Tischler, Cumella, & Bellerby, 2001).

Limitations of the study

The longitudinal aspects of this study and its focus on the process of coping and outcomes of homelessness are significant strengths of this study. Nevertheless, there are also limitations to acknowledge. The study had a relatively small sample size. Respondents were recruited from all council-run homeless centres in order to limit variance, so other types of hostels were excluded, for example centres run by charities. Although the inclusion of other centres may have generated further data, the different styles of management and services offered would have made comparison difficult. Twenty cases were disregarded due to incomplete data. Initially many of the standardised questionnaires were not returned when they were left with respondents to complete. This was probably due to the nature of life in the hostels, low motivation, or the variety of stressors that respondents were subject to.

The measure of mental health (GHQ) used did not assess substance abuse or post-traumatic stress disorder (PTSD). Given that many women had been subject to violence prior to becoming homeless, PTSD may have been a significant factor which was not detected in this study. Similarly, drug and alcohol abuse has been commonly reported in previous studies of homeless women (Nyamathi, Longshore, Galiaf, & Leake 2004) and thus important data on emotion-focussed coping strategies may have been missed. Coping was measured at first interview only. Changes in coping style from first to second interview could not therefore be ascertained. Measurement was also likely to have been affected by the proximity to the onset of homelessness and the experiences of violence before homelessness. Finally, this study focussed on mothers' individual needs, rather than in conjunction with those of their children.

Implications for practice and service development

The evidence of mental health difficulties combined with social and economic adversities in this and other studies argues powerfully for the development of designated services for this population. The significant number of mothers falling within the clinical range of psychopathology suggests an urgent need for mental health interventions. Even if mental health problems are not caused by homelessness, the residential facilities provided for homeless families provide an ideal opportunity to engage with this vulnerable population to optimise their chances of successful adaptation.

Services could be developed to empower homeless mothers by improving problem-focussed coping, for example social skills training could be offered to enhance engagement with others. Such interventions may shorten the length of the homeless period and help to prevent repeat homelessness. Simultaneously, family strengths can be identified and

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supported, thus promoting positive outcomes. Recognition of such strengths in families challenges the view of homeless people as victims (Alley, Macnee. Aurora, Alley, & Hollifield, 1998). A small number of services like resettlement teams and specialist interventions for homeless women utilise these principles. They work longer term with families within a holistic framework and address a wide range of issues, including tenancy problems, budgeting, childcare and education. The aim of these services is to maintain tenancies and prevent homelessness (Tischler, 2002; Walters, 2001). It is, therefore, crucial that services for this population involve inter-disciplinary approaches in order to meet the range of psychosocial problems and resources presented by families.

The importance of targeting psychosocial health is challenged by those who argue that provision of subsidised, high quality housing (Stojanovic, Weitzman, Shinn, Labay, & Williams, 1999) and employment (Shinn, Knickman, & Weitzman, 1991) are most important in maintaining resettlement and promoting self-efficacy. It is more likely that a dual approach is required. For example, over half the respondents in the current study had been homeless on at least one previous occasion. This suggests that the services offered are often not able to help these families to secure and maintain tenancies, and to break away from abusive relationships. Although not the focus of this study, this group is at high risk of disengagement from social networks and services, thus eroding resources that aid long-term adaptation. This population requires a coordinated and intensive response from health and social agencies to help families adapt and reintegrate into the community (Niner, 1999; Tischler. Karim, Rustall, & Vostanis 2004: Vostanis, 1999).

It is important to note that the shortage of affordable low-cost housing is a structural issue that, although not a direct cause (Ziefert & Strauch Brown, 1991), contributes to family homelessness (Bassuk et al., 2001; Shinn, Bawnohl, & Hopper, 2001). Therefore, any long-term solutions to family homelessness need to combine structural, social and clinical approaches.

A number of smaller initiatives have been developed recently in order to address the needs of homeless families in the UK. These include outreach services to address parents' and children's mental health. resettlement, and intensive long-term peer and professional support (Tischler, 2002; Tischler et al., 2002; Tischler, Cumella, Bellerby. & Vostanis 2000; Walters, 2001). Similar service developments in the US reported long-term benefits such as housing stability and prevention of homelessness (Taylor Gaubatz, 2001).

Future research

The relationship between coping, mental health and goal achievement has been explored. The results indicate that acquiring social support is a particularly valuable coping strategy and should be investigated further. For example, future studies should examine whether coping strategies change over time in this population, how they relate to a variety of outcomes, and what impact the availability and quality of social support may have on outcomes. Further studies should also establish the mental health of those mothers at risk of homelessness, for example, those who have been homeless previously or who are in an abusive relationship. This may help to identify factors which create mental distress in this population and would provide an opportunity to work with mothers to prevent homelessness.

More detailed exploration of goals in this population would be valuable. Whilst most of the families in the current study achieved resettlement, there is a need for future

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longitudinal research to examine their ability to sustain resettlement over time, particularly in light of evidence from other studies (Bassuk et al., 2001), who highlighted the risk factor of violence in repeatedly homeless families. Finally, studies should address the impact of parenting factors on children, and evaluate interventions that could protect children's emotional well-being within multiple adversities.

CONCLUSIONS

This study adds to the growing body of research involving women who experience homelessness, in particular, on the underlying relationship between coping strategies, mental health and goal achievement. Despite poor mental health and experiences of significant adversity, most women perceived that they had achieved their goals, at least in the short-term. However, their high rates of continuing psychopathology indicate that they remain vulnerable and that their ability to cope is likely to be impaired, stressing the need for intervention, before and after re-housing. Larger longitudinal studies are needed to examine the coping strategies and mental health of homeless women and women at risk of homelessness to examine which factors promote sustained adaptation.

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Mothers experiencing homelessness: mental health, support and social care needs

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Abstract
Little is known about the experiences of mothers who become homeless. The numbers of women with children in this situation are growing, most becoming homeless following domestic or neighbour abuse, or the breakdown of family relationships. This qualitative study aimed to describe mothers' experiences of homelessness in relation to their mental health, support and social care needs. Twenty-eight homeless women with dependent children residing in hostels were interviewed. The experience of homelessness was stressful, but viewed as a respite for many of the participants because they had experienced violence and harassment prior to their stay in the hostels. Many described poor mental health, which they related to the conditions in hostels and traumas that they had experienced before becoming homeless. Their experiences and perceptions of the services available were mixed. Some valued the support offered by staff and other residents, but the majority felt that there was a lack of resources to address their needs. Many women had difficulty coping with homelessness, and several said that support from other homeless women was an important source of help. Services need to work together to meet the multiple health, social, psychological and housing needs of these women.

Keywords: coping, homelessness, mental health, mothers, parenting, services

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Introduction

The most visible subsection of the homeless population is undoubtedly that made up of rough sleepers. More concealed, but just as vulnerable, am homeless mothers and their children. This subpopulation have received little consideration in research, but they make up a significant group: in the USA, homeless families account for approximately 40% of the total homeless population (National Coalition for the Homeless 2005). In the UK, the figure is even greater: 53% of the homeless population are families with dependant children, whilst a further 10% include a pregnant woman (National Statistics 2002/2003). It has been suggested that 'single-parent families headed by mothers [are] one of the fastest growing segments of the homeless' (Banyard 1995). A report submitted to the Council of Europe described a trend of increasing numbers of mothers and their children who were homeless throughout Europe in the 1990s (Avramov 1998). A review of the family homelessness literature reveals that most homeless parents are women in their 20s (Haber & Toro 2004).

Much of the existing literature is US in origin, and deals with the causes, consequences and characteristics of family homelessness. There is little qualitative research looking at the impact of homelessness on mothers' mental health, and what their care and support needs are.

Causes of homelessness

The road to homelessness is often complex and multi-faceted. It is rarely attributable to one factor or event, but a combination of issues that may be grouped into five categories: housing issues; drugs and alcohol; mental health; relationship breakdowns; and individual choice (Boyd 1999). Binding these issues, homelessness

is often associated with chronic poverty (Milburn & D'Ercole 1991, File 1996).

It is widely reported that homelessness follows a cycle that often repeats itself, and therefore, families may find themselves homeless on more than one occasion (Centre for Housing Policy 2003). A study looking at predictors of shelter applications and subsequent housing stability in the USA discovered that two-thirds of families who moved from a shelter into subsidised housing were still in the same property 18 months later; the stability rate was lower for those in private accommodation (Shinn *et al.* 1998). Another study reported that women who had been emotionally and sexually abused in childhood were at risk of repeat homelessness, as were those who had been homeless once and experienced subsequent domestic violence (Bassuk *et al.* 2001).

The experience of homelessness

A mother's experience of homelessness will reveal much about her need for support and service provision. Several studies have highlighted the feelings of powerlessness and loss experienced by mothers who are homeless (Walters & East 2001, Meadows-Oliver 2003). Others have stated that homelessness provokes distress, fear and anxiety (Banyard & Graham-Bermann 1998). The experience of loss is a major theme, covering issues from physical loss of housing to loss of privacy and freedom within the hostel setting. Mothers often experience an additional loss of parental authority - this is sometimes termed 'public parenting[1] - when shelter staff or other mothers are seen to be interfering with the discipline of a child (Kissman 1999). Mothers may feel undermined and parent-child relationships may be disrupted as a result.

Family relationships and dynamics are significantly affected by the experience of homelessness (Herth 1996). Mothers are often made homeless following a relationship breakdown with a spouse or partner. Relationship difficulties have an inevitable impact on family resources and can cause considerable psychological distress. This stress can often lead to parenting problems (Ghate & Hazel 2002). Subsequently, in trying to deal with the stress of physical, psychological and social aspects of living in sheltered or temporary accommodation, a mother may find that she unintentionally neglects or underestimates the needs of her children (Kissman 1999). This may lead her to question her parenting skills and add to the pressures that she already faces. Parenting itself brings many challenges and pressures that a woman has to cope with. Mothers who are homeless and already facing many different stressors may inadvertently display inconsistent parenting, leaving their children confused and unsure of their worth (Sheppard 2004). This can lead to problem behaviour in a child, which, in turn, causes more stress for the mother.

Mental health of homeless mothers

A growing body of research has considered the mental health and emotional well-being of mothers experiencing homelessness. High rates of mental health problems have been reported (Zima *et al.* 1996), and homeless mothers consistently report worse mental health compared to low-income but housed mothers (Bassuk *et al.* 1998, Vostanis *et al.* 1998). Depression and anxiety disorders are particularly prevalent (Banyard & Graham-Bermann 1998, Tischler *et al.* 2004). Maternal mental health plays a key role in parenting difficulties. Mothers with poor mental or emotional health are more likely to have difficulties with parenting and their relationship with their child compared to mothers with no mental health problems (Ghate & Hazel 2002). In addition, child behaviour problems have also been associated with parenting difficulties in this population (Tischler *et al.* 2004).

Support needs

Support from others is a key aspect of coping with a stressful situation such as homelessness. Social support refers to both the number of people available to offer assistance, i.e. a social network and also, the strength of support offered by those individuals (Schaefer *et al.* 1981). A number of studies have suggested that individuals become socially isolated and that their relationships break down on becoming homeless (Kissman 1999, Munoz *et al.* 1999). Despite mixed findings regarding levels of social support available in this population, most suggest that women feel estranged from sources of support (Meadows-Oliver 2005). These results have led researchers to suggest that the perceived availability of social report is more important than the actual support received (Ghate & Hazel 2002, Anderson & Rayens 2004).

Social care needs

It has been reported that homeless families find it difficult to access health, social and educational services (Cumella *et* a1.1998). Whilst many hostels provide some form of support for mothers who are homeless (e.g. from key-workers), there is little research exploring mothers' views about the type of care they would value.

[1] Note that the terms 'shelter' (US) and 'hostel' (UK) are used interchangeably.

In comparison to the USA, where specialised services for homeless families are well-established (Taylor-Gaubatz 2001), there are few organisations in the UK addressing the complex health and social needs of families who are homeless. Recent evidence suggests that family support services have an important role to play in engaging families and involving specialist teams (Tischler *et al.* 2004).

The present study aims to describe the experience of homelessness in relation to the mental health, care and support needs of mothers. This is an important area of research given the scale of the problem of homelessness, the paucity of European research, and the current lack of understanding and appropriate service provision for these women.

Subjects and methods

Setting

The present research was carried out at three local authority-run hostels, called 'homeless centres', in Birmingham. Approval for the study was granted by the local research ethics committee. The hostels house homeless families exclusively. Each hostel accommodates up to 40 families and 90 children. The average length of stay is 3-6 months, although many stay only a few weeks.

Each family is provided with basic accommodation in self-catering units. Bedding, crockery and cooking utensils are provided. Stores of food and clothing are available in an emergency, and are supplied by charitable organisations. Kitchen, bathroom and living areas are shared with other homeless families unless the family is particularly large, in which case they are allocated sole tenancy of a unit.

Hostels are staffed by a team of house managers who provide 24-hour cover. Most of these staff have no social care or housing qualifications. Their duties cover all aspects of hostel management, including admitting and discharging families, liaison with and referral to other agencies, administration, and cleaning duties. Housing support officers are employed by the Housing Department and visit the homeless centres on a weekly basis to assess housing need, allocate housing, assist with welfare benefits, and offer advice regarding housing and tenancy matters.

Participants

The participants were mothers, defined as being responsible for a child, aged 3 years or over, resident in the hostels. The age restriction was a result of the criteria for an evaluation study that ran in parallel to the present work and is reported elsewhere (Tischler *et al.* 2002).

Box 1 Topic guide

1. Events leading to homelessness
2. Experience of homelessness - environment /staff/ other residents
3. Mental health
4. Social network and support
5. Coping with homelessness
6. Service needs

The study was part of longitudinal research investigating the coping strategies, mental health and goals of homeless mothers (Tischler & Vostanis, in press). All mothers with children in this age range were invited to participate in the present study.

Instruments and approach

Qualitative semi-structured interviews were used to encourage the participants to share their own thoughts, feelings and perceptions (Clare Taylor 2005), in order to gain an understanding of homelessness. The topic guide (see Box 1) was derived from themes identified in the literature with a view to obtaining a narrative account of the events leading to homelessness, the mothers' experiences of homelessness, and in particular, issues related to their mental health and support needs.

Procedure

Preliminary visits were made to the hostels. These aimed to gather key information about how they operated, the services offered to residents and the impressions of residents about those services. Subsequent visits were made to hostels to minimise the Hawthorne effect, i.e. the likelihood of people changing their behaviour as a result of being studied (Bowling 2002), and to allow the researcher (V.TJ to become 'invisible' within the population of interest (Maykut & Morehouse 1994). In this way, the researcher was accepted into the participants' environment, and allowed an insight into the thoughts and feelings of those experiencing homelessness.

Staff working at the hostels were briefed individually at the commencement of the study. They received written information regarding the purpose of the study, the nature of the fieldwork programme, and they were updated on the progress of the study throughout the data-collection period. Introductory letters inviting the residents to take part in the study were supplied to all staff. These letters were included in a 'welcome pack' given to each resident on admission to the hostels. Interviews took place in a private meeting room or in the participant's accommodation within the hostel.

The interviews were audio-taped initially; however, because of noise in the hostels, subsequent interviews were manually recorded.

Data analysis

Interview transcripts were analysed using the NVivo, Version 2.0, qualitative analysis software (QSR International, Doncaster, Victoria Australia). Thematic analysis was used, applying both deductive and inductive coding (Joffe & Yardley 2004). This method systematically identifies themes or patterns within the data. Several broad themes were identified in the existing literature and applied to the data (deductive coding), and these were refined and subdivided using themes identified within the data. Another member of the research team (S.C.) re-coded the data in order to ensure inter-rater reliability. Names were omitted in order to protect anonymity.

Results

Participants

Of those who provided data at both time points *(n* = 44), 28 mothers agreed to be interviewed in detail about their experiences (64%). They ranged in age from 24 to 49 years, with a median age of 36. The median number of children was two, with a range of one to six. The ethnicity of most women was Caucasian (n = 14,50%), the remainder were Afro-Caribbean *(n* = 7,25%), Asian (n = 4, 14.3%) or Middle Eastern *(n* = 3, 10.7%). The majority were single mothers *(n* = 21, 75%), while the others had partners *(n* = 7, 25%). Most were reliant on Income Support 01 = 17, 60.7%).

Causes of homelessness

Most women had experienced violence prior to becoming homeless, with many not reporting the incidents to the police. For the majority, domestic violence at the hand of a male partner was the most commonly cited reason for homelessness. The violence was often sustained or repeated over a lengthy period. Many women were traumatised and suffered regular flashbacks. The extracts below illustrate the types of domestic violence experienced:

My husband has been emotionally and physically violent towards me. He has tried to kill me, once he pushed me over and kicked me repeatedly in the back, I blacked out and was in so much pain, I stayed in bed for several days, I was badly bruised. (C25)

My ex husband was regularly violent to me and the kids. He broke my wrist, my teeth, ribs, cut my head with a glass, I was too scared to leave him. lie then tried to abduct the kids and take them to Ireland. (C8)

Harassment by neighbours was another common reason for homelessness. Incidents included racial harassment, threats or actual violence, and damage to property. For example:

He [neighbour] came round and punched me in the face and sprayed tear-gas in my eyes. I was beaten with all sorts of things, like a baton, a rake, a spade; he jabbed me with a knife. This was someone who lived in the same road. He had attacked other people, it went on for an hour and a half, he kept tormenting me. My arms, knees, back, head were injured. It seemed he was really enjoying it. He kept going in the garden and coming back, dragging me around. He turned on the iron and put it in my face, and I resisted. (C9)

Experience of homelessness

The mothers' experiences of the hostels were mostly negative. Lack of control and poor facilities were the most common complaints. A minority described positive attributes associated with being homeless, such as support from staff and other residents, and feelings of safety.
Many respondents reported feelings of powerlessness and loss. Conditions in the hostels were perceived to be coercive and institutional.

Many respondents referred to rules and regulations within the hostels that inhibited their independence. A number described the experience as akin to imprisonment. As one respondent described:

It's so restrictive, so many rules here. You can't go out, I've been left home [sic] for years, but it's horrible knowing you can't go out; you feel restricted, it's not nice. I need my life back. (C2)

Many respondents related feelings of anger and despair associated with poor facilities in the homeless centres. This was not only attributed to loss of home and possessions. Loss of privacy was a significant issue because families were compelled to share often limited and basic facilities with other families. This had a negative impact on respondents, as illustrated in the following extracts:

I found sharing difficult, especially as food went missing and other things out of Hannah's [daughter) room. The other family never bought toilet rolls and it got to the point where I hid them in my [bed] room. (C3)

I feel isolated ... It is awful having to share the toilet and kitchen. (C22)

There is nothing for the kids to do, they get bored easily ... There's no play area for the kids. (C18)

A number of respondents valued aspects of homelessness, such as the sense of personal safety they felt as

a result of the presence of closed-circuit television in the hostels, and the support that they received from staff and other residents. For others, homelessness offered a respite from past traumas. For example:

I like the other residents, we've all the same problems, so we talk about it. (Cl)

It is good to have time with the kids and find out what their problems are. (C23)

Mental health

When asked about their mental health, many mothers described being depressed and stressed, as the excerpts below demonstrate:

My mood, I feel like I have a black cloud over me; I've lost my appetite, I've lost weight. I just pick at my food. I have a black feeling, it feels like the Prozac is just sticking -plaster. (C8)

I am very stressed, I'm not sleeping well. (C 12)

Several women admitted having experienced severe mental distress, including suicidal thoughts in their recent past. For example:

I feel depressed, and I have thought about committing suicide but not tried it because of the children (C25)

A small number of respondents reported that their mental health had improved on becoming homeless because they had escaped from a traumatic situation. For example:

I feel better now than I ever have done. It is the first time I have felt in control. I am sleeping better than I have done for years; if the kids are fine, then so am I. Leaving him [husband] has been the best tonic for my mental health ... I have felt depressed before, and I felt I was worthless and life was hopeless, but I don't feel like that now. (C5)

Lack of social and family supports

Some respondents felt let down by the lack of support received from hostel and housing department staff. This appeared to exacerbate feelings of isolation since many had exhausted their social networks prior to homelessness. Such lack of social and professional support was likely to have a negative impact on the mental health of respondents and their ability to cope whilst homeless. As one participant stated:

I thought it would be warm and supportive, but the staff are cold and selfish towards me; they don't understand the needs of homeless people. I thought I'd be treated right. I feel very bitter towards them. (C8).

The data revealed high levels of social isolation in this sample. Most reported that their relationships with friends and family had been under severe strain or were non-existent. Some respondents had become wary of forging new relationships following negative experiences with friends and neighbours. Many complained that they had difficulty maintaining contact with friends and family whilst homeless. A positive outcome related to homelessness was that a number of respondents described developing friendships and support networks with other residents whilst in the hostel, and that this interaction with other homeless parents was an important source of support.

Social isolation was categorised into three themes: estrangement, overstaying and geographical isolation. These are presented below.

Those estranged from their family and friends comprised the largest group of respondents. This group commonly related a history of family dysfunction, including child abuse, rejection, and family conflict. A small number recalled periods of homelessness from their own childhoods. Whilst this was not examined specifically, it may indicate that, for some, homelessness becomes a perpetuating cycle. One woman described the process of estrangement from social networks:

I had no support from family and friends. I became estranged from them when I got pregnant for the first time `cause of racism. I went with a black man and I'm Asian. My mum said I was dead to her. (C23)

Those described as 'over-stayers' had had adequate social support prior to homelessness, but became homeless following a breakdown in relationships with family or friends immediately preceding homelessness. For example, one respondent described staying with her five children in her sister's one-bedroom flat. Homelessness was a last resort for this group after exhausting alternative sources of accommodation. For example:

I moved in with a friend, but they got weird with me and kicked me out. (C22)

Geographical isolation relates to the displacement of family and friends, either because of repeated moves or because the subjects had no support locally. A number had moved away to escape from violence or to seek asylum:

I've got no support; my parents live in Scotland, my partner did not let me have friends and my sister lives in Northampton. (C11)

Coping with homelessness

Many mothers talked of their struggle to cope with the stresses associated with homelessness. In many cases, mothers felt that they were surviving rather than coping, as one mother explained:

I'm not coping, I'm surviving day to day. (C27)

Many women described emotional or disengagement coping strategies: they kept their feelings and worries to themselves in order to avoid upsetting their children or looking foolish in front of others. As one mother said:

I feel lost and run down, very hopeless. I try to suppress my distress. I don't feel able to talk to others, everyone has troubles of their own. (C3)

Many women coped by seeking social support from others. Supportive relationships were often formed with other homeless mothers. For example:

J. [another resident] is the most help to me. She's been depressed herself, so she can cheer me up. (C26)

Another explained:

There are other residents to help, they're a great support to one another, we share our experiences. (C28)

Some women refrained their problems by comparing their situation favourably to that of others. For example:

I cope by looking at other people's problems - mine didn't seem as bad. (C19)

Another said:

I cope by trying to remember that there are people worse off than me, and I write things down; that helps me. (C17)

Experiences of services

Respondents reported that very few services were available to meet their needs and those of their children. A few women had heard about available services through other residents, as one mother described:

I didn't see [a] nurse at the hostel, it wasn't offered to me; I didn't even find out that the health visitor came until nearly 4 months into my stay. (C13)

Another stated:

There is no support worker to deal with people who have been raped and subject to violence. (C17)

Several complained about the lack of services available for children. For example:

I think the hostels could help out a bit with the kids. I had so much to do and I had to drag them around the social, housing, etc..; it's not nice for the kids. (C9)

Several mothers suggested that an improvement to the hostel service would be for the staff to communicate better, so that they were aware of services available; for example, by publicising them in a resident's welcome pack.

Discussion

The aims of the present study were to examine the experiences of homelessness from mothers' perspectives, and to describe the perceived mental health of these women, and their attendant support and service needs.

The results indicate that the participants are comparable to samples used in previous research in that the main cause of homelessness was found to be violence and relationship breakdown (Vostanis *et* a1.1998, Tischler *et al.* 2004). As has been discussed in previous work, mothers often described the experiences of homelessness in negative terms (Vostanis *et al.* 1996, Cosgrove & Flynn 2005), but also suggested that it was a respite from their chaotic and often traumatic pasts (Styron *et al.* 2000). This is reflected firstly in the finding that many mothers experienced serious violence or abuse before becoming homeless, and most were poor. For many, it was their responsibility to their children that forced them out of those situations and into the hostels. however, their descriptions of the hostels were, on the whole, negative, with complaints about poor facilities and feelings of lack of control common.

The experience of homelessness tends to be associated with outcomes such as poor mental health (Banyard 1995, Banyard & Graham-Bermann 1998, Vostanis *et al.* 1998), which was supported by the findings from this study. Women's reports of depressive symptoms were especially common, and these were related to both the hostel environment and traumas preceding homelessness.

Social support has been reported to act as a buffer against mental health problems (e.g. Brown & Harris 1978). The findings indicated that mothers consistently felt unable to approach friends or relatives for help, either before becoming homeless or since arriving at the hostels. This would compound the sense of isolation felt by these women. This concurs with previous research concerning mothers' perceptions of the availability of social support (Ghate & Hazel 2002, Anderson & Rayens 2004). This has implications for service provision before and after homelessness. Service providers should endeavour to assist homeless mothers to maintain contact with their support network. This may prove challenging since many woman are moved away from their previous address for safety reasons; for example, following violence or harassment. It has also been reported that women who experience homelessness rely on support from partners with significant health problems (e.g. drug abuse), thus limiting the quality of assistance given (Nyamathi *et al.* 2000). Resettlement services may play an important role as they can provide help with reintegration into the community by offering budgeting, tenancy and educational assistance (Walters 2001, Tischler 2002).

The women's descriptions of how they coped concur with previous observations that mothers who are homeless employ a variety of coping methods (Wagner & Menke 1991, Banyard 1995). Examples of various types of coping were identified in the data. It appeared that mothers avoided problems or thought things through more often than actively dealing with problems. It has been suggested that individuals who are depressed may be conserving energy (Nesse 2000) in order to employ active problem-solving at a later stage. It is also possible that active problem-solving is impaired by poor mental health (Folkman & Lazarus 1988). It is evident that support from others is an important avenue by which the respondents coped with homelessness. The identification with others who were in the same situation was valuable for many. This might suggest that more formal peer-support systems within the hostels would be beneficial. This may be difficult to implement because some hostels have a policy of actively discouraging peer contact since it is thought that women may influence each other in a negative way. Counselling and therapy services offered within the hostels may also benefit many women by helping them to manage their problems in healthy ways. Such services have been used with some success in hostels for homeless women (Tischler *et al.* 2000, Walters 2001). These services should be flexible and integrated into the care programme to ensure that women are engaged with staff, and therefore, less likely to drop out of treatment. The Care Programme Approach (CPA) may benefit these families. The appointment of a CPA coordinator would ensure that vulnerable women receive a multi-agency review at regular intervals, that their mental health needs are assessed and that clear objectives are set (Mental Health Care 2006).

The strength of the present study lies in its utilisation of qualitative data to gather rich, detailed information about mothers' experiences of homelessness. The use of semi-structured interviews allowed the women to convey their experiences in their own words. Mental health measurements were not included in the present study, but were used in another paper (Vostanis *et al. 2001)* that supports the level of need that was reported by the present participants.

The study is limited by its relatively small sample size; however, this design was chosen to provide a better understanding of the phenomenon of family homelessness. Additionally, the sample itself was self-selected. This may have excluded some mothers, and therefore, the participants may not be representative. Furthermore, most interviews were not audio-taped so that nuances of communication may have been lost. Every effort was made to counteract this, since the participants responses were recorded verbatim.

The findings described in the present study have implications for both policy and practice concerning mothers who are homeless. The importance of promoting healthy support networks has been noted, as has the role of resettlement services to ensure that mothers and children are able to reintegrate into the community following homelessness. The dissatisfaction with hostel facilities indicates the need for improvements, especially in terms of play areas and other facilities for children. This would benefit children directly and could also improve parent and child interactions. The prevalence of mental health problems suggests the ongoing need for outreach mental health services. This would help to address the risks to children in these families since serious abuse and child fatalities have occurred where parents have had mental health problems (Falkov 1995, 1996). Outreach mental health services have been reported to operate successfully in hostels for homeless families (Tischler *et al.* 2002, Tischler *et al.* 2004). It is important to note the multiple roles that such services play, addressing mental health, social integration and other issues, such as parenting skills. This requires skill and flexibility from staff involved, and demands a multi-agency approach incorporating health, psychological, social and housing input.

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Resettlement and Reintegration: Single Mother's Reflections after Homelessness

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Resettlement and reintegration: Single Mother's Reflections after homelessness

Abstract

Previous research has identified that most families who become homeless are women with dependent children. Homeless families are reported to have a variety of complex needs however little is known about the experiences of families once they are re-housed. The aim of this study was to explore psychosocial issues related to the resettlement experiences of single mothers following a period of homelessness. Qualitative semi-structured interviews were used to gather data from twenty one women living in a UK Midlands city. Thematic analysis was used to draw conclusions from the data. Findings indicated that despite exposure to major stressors most women had begun the process of resettlement by improving their physical surroundings. Women had achieved personal growth as they had managed to escape violence, overcome homelessness, and create new opportunities for themselves and their children. Suggestions are made for future research and improvements to services which would promote resettlement in this population.

Keywords

adaptation, homelessness, mothers, reintegration, resettlement

Resettlement and reintegration: Single Mother's Reflections after homelessness

Introduction

Family homelessness is a major social problem. Previous research regarding the characteristics of homeless families has found a history of adversity (e.g. Bassuk *et al*, 1997; Bassuk *et al*, 2001), mental health problems among mothers and children (Vostanis *et al*, 1998; Anooshian, 2005), and limited access to services (Cumella *et al*, 1998). Very little attention has been given to the experiences of families following their exit from homelessness. The current study focuses on psychosocial issues related to homelessness and resettlement as much previous UK research in this field has concentrated on structural issues such as housing policy (Christian, 2003).

Substantial numbers of families experience homelessness in the UK and worldwide. Families as a proportion of the total homeless population comprise 41% in the United States and 50% in Britain (US Conference of Mayors, 2002; Office of the Deputy Prime Minister, 2004). Overwhelmingly, homeless families are women with dependent children who are roofless or who live in unstable or temporary accommodation, most of whom are fleeing domestic violence or relationship breakdown (e.g. Vostanis *et al*, 1998). The majority of these women conform to Schein's (1982) 'ABC' factors

which characterise economically poor single mothers. 'A' represents the absence of education and training, 'B' denotes betrayal by a partner and 'C' refers to negative childhood experiences. Schein argues that factors 'A' and 'B' precipitate a single mother's decline into poverty and 'C' undermines her efforts to escape from poverty.

Recent UK figures show a year on year increase in the number of homeless families: 39, 810 in 2002, 53, 070 in 2003, and 64, 340 in 2004 (Department of Work and Pensions, 2004). Latest figures report that 69 790 homeless households contained children and/or a pregnant woman (National Statistics, 2006). Others suggest that the official figures are underestimates and that 100 000 families are currently homelessness in the UK (Woods, 2006).

What is already known about Family Homelessness?

Homelessness arises through a combination of structural and individual factors. Structural factors include the lack of low-cost housing (e.g. Stojanovic *et al*, 1999) and individual factors include time spent in care (e.g. Bassuk *et al*, 1997). Homelessness is acknowledged to be a stressor (Goodman, 1991). Whilst a number of studies have examined the characteristics of homeless women and children (e.g. Bassuk *et al*, 1996) and narrative descriptions of homelessness (Banyard, 1995), the experiences of resettlement and reintegration into the community have largely been neglected. This

is important as women who have childhood experiences of violence, sexual abuse or experience of partner violence following re-housing are at risk of repeated homelessness (Bassuk *et al*, 2001).

One qualitative study was identified which explored the life histories of formerly homeless single mothers. The findings indicated that the loss of home represented a turning point for many respondents and that specialist services were needed to address the multiple difficulties that these women face whilst homeless and afterwards (Styron *et al*, 2000). These findings suggest that mothers experiencing homelessness have needs that persist after re-housing and that resettlement is a long term process.

Resettlement

Resettlement includes a number of proximal components; permanent accommodation, house-keeping skills, and a subjective sense about whether people are in the right place (Rivlin and Moore, 2001). These factors emanate from a person's concept of 'home' (Moore, 2000a) which has been described as a fluid construct that relates not only to a physical structure, but to a process which is closely aligned with a person's sense of personal growth (Horwitz and Tognoli, 1982). Further, housing that promotes factors such as independence, control and privacy can contribute to positive well-being (Moore, 2000b) including reintegration into the

wider community. As Shrubsole states, housing provides "roots, identity, security, a sense of belonging and emotional wellbeing" (Shrubsole, in Riddell, 2006, p. 1). The sense of home as a place of safety and security will be absent for many women experiencing homelessness after fleeing violence (Tomas & Dittmar, 1995). The importance of providing secure housing for women and children escaping violence has been identified as a key factor in helping them rebuild their lives (Malos & Hague, 1997).

A sense of home may relate to the wider context of community. This is characterised by factors such as shared identity and common activities (Fulcher & Scott, 2003). Communities may also develop neighbourhood features. This occurs when individuals within the community exhibit 'giving' and 'sharing' behaviours (Doyle, 1992) such as inviting neighbours to visit, thus providing opportunities for social networking. Integration in these contexts may be more difficult for previously homeless families who can be placed in the worst accommodation on marginalized estates due to the limited social housing stock available (Collard, 1997). Women escaping violence may also be moved to a geographical area far from their previous home potentially isolating them from support networks. This suggests that homelessness and resettlement are not simply housing problems but involve often complex interactions between individual, social and economic factors (Taylor-Gaubatz, 2001) thus

recommending an ecological approach to investigation (Toro *et al*, 1991).

A number of micro and macro factors influence resettlement. Some authors, for example, Lindsey (1998) stress the importance of psychological resources, such as the motivation and attitude of homeless mothers in achieving re-housing. Others argue that the housing stability is promoted by the availability of affordable, good quality accommodation (Shinn, 1997). This is aligned with the Government's promotion of sustainable communities which should contain 'decent, affordable' housing (Communities and Local Government, 2006). Housing is only one component of resettlement. Economic factors such as employment strategies are also critical according to Shinn *et al* (2001). Rivlin and Moore (2001) argue that in addition to permanent accommodation, quality of life and lifestyle must be promoted. This includes diverse variables such as social support, security, comfort and cultural requirements which aid reintegration. Studies examining resettlement in US formerly homeless populations suggest that it is a long-term process, often hampered by lack of resources, such as finance and education (Dunlap & Fogel, 1998; Rog, 1999).

Resettlement services which target both accommodation and support needs (Seddon, 1997; Tischler, 2002) are increasingly

being used to assist vulnerable individuals who struggle to maintain their tenancies. In the US, 'housing plus' services have been established to promote resettlement. These integrate housing and services to enhance social and economic well-being (Cohen *et al*, 2004). Other programmes have moved families into more prosperous neighbourhoods where respondents report psychological improvements such as an increased sense of self efficacy (Rosenbaum *et al*, 2002). Such services are yet to be widely developed in the UK although there is some evidence that provision such as Shelter's 'Homeless to Home' can help to sustain tenancies (Jones *et al*, 2002). Research identifying the experiences of resettling families and their needs relating to that process will inform further development of appropriate services for this population.

Aims of the study

This study aimed to investigate the experience of resettlement in a group of single mothers with dependent children who had experienced homelessness. A number of issues related to resettlement were explored. These were: satisfaction with new accommodation, their feelings about their home compared to their feelings whilst homeless, what they had learnt from their experiences of homelessness, and their hopes for the future.

Method

The 21 participants were drawn from a wider, longitudinal study of family homelessness, the results of which are reported elsewhere (Tischler *et al*, 2002; Tischler & Vostanis, in press). The women had been recruited consecutively over a period of 12 months from 3 Local Authority managed hostels for homeless families and had agreed to be interviewed again at four month follow-up. Of the 44 families traced at follow-up, 21 single mothers agreed to discuss their experiences in more detail. Families headed by single fathers or couples were excluded from the analyses as evidence from other studies indicates that these family-structures become homeless for different reasons, for example eviction (Vostanis *et al*, 2001), compared to single mothers whose reason for loss of home is usually domestic violence. It was also hypothesised that single mothers would have different needs and resources available compared to adults in alternate family-structures.

All participants were interviewed by the author in their homes following resettlement. A qualitative, semi-structured questionnaire gathered reflections on the period of homelessness, feelings about their new living arrangements, and explored respondents' hopes for the future. This method includes open-ended questions which allow respondents to reply in their own words and to raise other relevant issues (Carter & Henderson, 2005). Qualitative research has been

used previously to investigate sensitive issues including the experiences of single mothers living in poverty (e.g. Brodsky, 1999) and to understand the phenomenon of domestic violence from women's perspectives (e.g. Lutenbacher *et al*, 2003). Such methodologies have been noted to help validate women's experiences and hence promote empowerment (Davis, 2002). The transcripts were analysed using thematic analysis. This is an inductive process which involves systematically extracting and counting themes from the data (Joffe and Yardley, 2004). Demographic information was also collected from participants, including views on satisfaction with their new homes.

Characteristics of participants

The participants were single mothers with a median age of 35 years, and one or more dependent children (median: 2, range 1-6). Almost half (10, 47.6%) were of White UK ethnicity, 6 (28.6%) were British Afro-Caribbean, 4 (19%) were British Asian and 1 (4.8%) was White Irish. The majority were homeless as a result of domestic violence at the hands of a male partner (16, 76.2%) or harassment by neighbours (3, 14.3%). All had been previously housed in temporary accommodation by a Local Authority in the West Midlands after being accepted as statutorily homeless[3]. New homes were either Local Authority council housing or Housing

[3] According to the 1996 Housing Act

Association properties. No data was collected on the length of stay at current address although most families had been re-housed for a short period of time, usually a few weeks.

Resettlement

All participants were re-housed with a permanent tenancy. Data revealed some ambivalence regarding satisfaction with their new home. Eight (38.1%) stated that they were satisfied, 6 (28.6%) were not and 7 (33.3%) expressed uncertainty. Ambivalence was related to the accommodation itself, concerns about the environment, and little choice over housing that they were offered as the excerpts below reveal:

> The area is quiet. I am not happy to be here but I had no choice, I felt obliged, pressured to take this property (36 year old mother of 2)

> I don't like it [accommodation] as the area is not safe, I don't feel safe here, the locals are rough. The kids are happy to be here though (33 year old mother of 3)

> The area has a bad reputation, it is worse than it actually is, it's still not nice, there are problems with drugs and in the past, riots. I am happy to be here, I like my house and the

> back area is secure for the children to play (29 year old mother of 2)

Despite these concerns women often described their circumstances favourably compared to the homeless period and focussed on positive outcomes such as improvements in mental health and children attending school as the following extracts reveal.

> I feel better now than when I was homeless. At the hostel I felt pretty low because of all the rules and having to manage the children confined within four walls (34 year old mother of 5)

> I have my own place so I can do what I want, when I want. There is nobody watching you, I hated those cameras at the hostel, it felt like you were being watched (25 year old mother of 1)

> Now I've got things to do in the house, decorating and stuff, I'm constantly doing something. In the hostel I just sat there waiting. (30 year old mother of 3)

Respondents' were asked to reflect on what they had learnt from being homeless. Three major themes were identified. These were

escaping violence, improving the system, and opportunities for growth.

Most respondents stated that escaping violence had been the most important outcome of the time spent homeless. This included leaving a violent partner or escaping from violent or harassing neighbours. A number suggested that they would strongly advise other women to leave violent partners in order to protect themselves and their children as the excerpt below illustrates.

> Come out of a violent relationship, it's hard but it's worth it and there is hope (41 year old mother of 2)

Many respondents were keen to see the homeless system improve. They were critical of the conditions in the hostels, poor treatment by staff, and the lack of facilities for children. A number of suggestions were made regarding improvements to hostel environments and the experience of homelessness. The services most sought after were counselling, practical support for parents, and childcare and play facilities for children as the extracts below reveal.

> There needs to be someone coming into the hostel to support and counsel women, and to help them gain self-respect (39 year old mother of 2)

> It [hostel] should provide better facilities, like child care for kids not in school. They should help you get kids into school and offer more opportunities for kids to play (43 year old mother of 3)

Following resettlement a number of respondents recognised that homelessness had offered them an important opportunity for personal growth. They identified personal achievements such as recognition of inner strength, the ability to seek help independently, and helping others. Some reframed their predicament and many expressed feelings of liberation and freedom. As one participant stated:

> I learnt that there are people worse off than me, this makes me feel stronger. When I see homeless people on the streets, I know how they feel (41 year old mother of 2)

Finally, respondents were asked what their hopes were for the future. The hopes described by respondents were straightforward and realistic and the key themes identified were stability and

wishing for a better life. This involved a variety of outcomes such as, a stable home, happiness for themselves and their children, education for their children, and employment, education and training for themselves. As one woman described:

> I just want to get settled with the kids. To get a nice big house and settle down without any hassle. We just want a bit of peace. (*37-year-old mother of 4*)

Conclusions

This exploratory study provides insights into the experiences of formerly homeless single mothers and the process of resettlement in this population. No other UK studies which have examined these issues were identified. Despite enduring serious trauma prior to losing their homes and the adversity associated with homelessness most women were able to reflect positively on their new circumstances. This supports findings in other studies of economically poor, single mothers (Brodsky, 1999) and indicates resourcefulness and resilience in this population.

Despite ambivalence about their new accommodation, most women described their circumstances favourably compared to the time they had spent homeless. Outcomes of homelessness were positive overall with women focussing on change at both micro and macro

levels. Women described feeling a sense of freedom and independence compared to the confined conditions in the homeless hostels. Many women had achieved personal growth and a new sense of mastery as they had overcome homelessness and escaped from violence thus creating a new life for themselves and their children. This supports previous qualitative findings in this population which suggest that homelessness can be a respite from previous traumas (Styron *et al*, 2001) and can help to improve skills, for example parenting (Kissman, 1999). The findings also support the concept of 'posttraumatic growth' which suggests that individuals can experience positive changes after experiencing traumatic events (Tedeschi & Calhoun, 2004). Despite these positive outcomes, many women were fiercely critical about the lack of resources available whilst homeless and suggested that system change was required, for example that services such as counselling should be made available in hostels.

It was not possible to establish that these women had resettled according to definitions which emphasise security, a sense of 'home' and integration into the wider community. The data did however confirm that the process of resettlement had begun as most of the women indicated that they had achieved independence and that they were starting to plan for the future by settling children in local schools and considering educational and employment opportunities

for themselves. This supports other findings in this population which emphasise the long-term nature of the resettlement process (Rog, 1999).

Many respondents raised concerns about the quality of the housing, deprivation and crime in the area to which they had moved. It was evident that women had made compromises in order to escape from homelessness, such as accepting a house in an undesirable area. This supports the findings of Collard (1997) regarding the poor housing stock that may be offered to families who have been homeless. Other findings suggest that women living in deprived or crime-ridden areas may make a positive choice not to get involved with neighbours (Brodsky, 1996). These factors may inhibit a family's reintegration into a community and their ability to feel safe and secure.

None of the participants were receiving resettlement or other specialist support to maintain their tenancy and to help them integrate with their new communities. Given the ambivalence expressed regarding housing and the surrounding environment, the risk of future housing instability seems high. Development of services to address tenancy and support needs is recommended given the risks of repeated homelessness, (Bassuk *et al*, 2001) and other findings stressing the importance of follow-up in this

population (Walters & East, 2001). Improvements to the services available to families in hostels are also warranted, such as provision of counselling and child care. These would build skills and resources in families and help them prepare for resettlement. Services could be based upon successful models developed in the United States such as 'Housing Plus' provision (Cohen *et al*, 2004).

The study had some limitations. Participants were interviewed soon following re-housing and this may have been insufficient time in which to establish whether resettlement had occurred. If the women were visited after they had been resident in their new homes for a longer period they may have reported outcomes related to resettlement such as making new friends in the area or gaining employment. Alternatively, they may have moved on due to dissatisfaction with their housing or further experiences of violence or harassment.

This research included women who had approached the Local Authority Housing Department for help. It has been suggested that women who utilise hostel services are 'help-seekers' (Waldrop & Resick, 2004) and therefore may not be representative of all mothers experiencing homelessness. The research focussed on mothers experiences. Thus the views of children may have been neglected although mothers reported that children were beginning

to resettle, for example, by attending school in the area. The study was however exploratory in nature and thus aimed to uncover key issues and to gather insights about an under-researched phenomenon (Dyer, 2006). In addition the use of qualitative data gives voice to a marginalised group of women who may be referred to as a 'hidden homeless' population.

Future research should incorporate the views of formerly homeless children as other studies have reported that children are able to appraise their environment, for example, the value of neighbourhood places such as designated play areas (Min & Lee, 2006). This would provide useful information related to family functioning in addition to the mother's perceptions of resettlement which were the focus of the current study.

Future research could also examine how race impacts on the process of resettlement. Previous studies have reported that cultural factors impact on women's experiences of domestic violence (e.g. Kumar *et al*, 2005). Cultural and gender issues may also impact on resettlement. For example, seeking social support has been reported to be an important form of coping for those from non-Western backgrounds (Aldwin, 1994) and for women (e.g. Felsten, 1998).

Future longitudinal studies should investigate whether resettlement is successful in the longer-term in this population and in other families who become homeless. Finally resettlement services should be evaluated in order to develop a model that effectively promotes the long term stability and welfare of these vulnerable families.

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"I'm not coping, I'm surviving": Understanding coping in vulnerable populations

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Abstract

This paper explores theoretical, conceptual and methodological issues regarding assessment of coping in vulnerable populations, in particular, marginalised women. Standardised measures of coping are critiqued and their limitations are discussed and issues impacting on coping in vulnerable and marginalised individuals are presented. Findings from a study involving homeless mothers illustrate the utility of qualitative methodologies in the measurement of coping. The use of qualitative methods in studies with vulnerable individuals is recommended as the data can reveal information about the context, meaning and process of coping.

Keywords: coping, homelessness, measurement, mothers, qualitative, vulnerable, women

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Introduction

Coping refers to "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Thus, transactional theories of stress and coping posit that coping is dynamic and changes over time in responses to changes in the situation and in an individual's appraisal of that situation (Lazarus & Folkman, 1984). A distinction is often made between the adaptive or maladaptive function of particular coping strategies, that is, what works well and what works poorly in terms of adjustment to the environment, yet it has been recognised that all coping strategies may be considered adaptive depending on the context (Lazarus, 1993; Skinner et al, 2003).

Standardised measures of coping

A plethora of standardised measures of coping have been developed, many of which have been tested in research using white and middle class populations, for example The Ways of Coping Checklist (WAYS) (Folkman & Lazarus, 1980).

The WAYS is perhaps the best known and widely used measure which differentiates between problem-focussed coping, emotion-focussed coping, and seeking social support. Problem focussed

coping is aimed at doing something to reduce stress, emotion-focussed coping aims to reduce the emotional distress associated with the stressor, and seeking social support involves engaging with others to share and solve problems. It has been reported that this framework is too simplistic and that measures should incorporate situational and dispositional coping styles (Carver et al, 1989; De Ridder, 1997) and active-passive and prosocial dimensions (Hobfoll et al, 1994). It has further been proposed that coping needs to be classified in terms of lower and higher order categories, representing coping actions and their adaptive functions respectively (Skinner et al, 2003).

Additional dimensions of coping such as meaning-focussed coping have been suggested (Folkman, 1997). This strategy involves positive emotions and the discovery of meaning through the experience of a stressful event, this has also been referred to as transformational coping (Ford-Gilboe & Cohen, 2000). For example, a study of HIV-positive women reported that their ill health fostered personal growth and brought a new sense of meaning to their lives (Mayers et al, 2005). These issues are aligned with the concept of 'post-traumatic growth' (Tedeschi & Calhoun, 2004).

Conceptual issues can confound measurement of coping. One such factor is the differentiation between coping resources and coping

strategies, for example, social support is a coping resource and engaging with social support is a coping strategy. Also, dimensions of emotion-focussed coping are often confounded with symptoms of emotional distress (Coyne & Racioppo, 2000). In a review of classifications of coping no less than 400 coping strategies were identified in 42 adult and 47 child-adolescent coping measures (Skinner et al, 2003). In a critique of coping instruments, it was reported that no one measure encompasses trait and state coping mechanisms and that there is a need for longitudinal research to understand the complexity of coping in real-life experiences (Schwarzer & Schwarzer, 1996).

The concept of coping has also been recognised to have multiple and imprecise meanings in lay usage which may confound its measurement. ‘Managing’ and ‘coping’ are often used interchangeably, yet coping suggests minimal success compared to managing which suggests a greater level of control such as overseeing or supervision (Keil, 2004).

Attempts have been made to incorporate situational and dispositional, active-passive and prosocial, and multi-level factors within measures of coping, for example the Mainz Coping Inventory-Revised (MCI-R) (Krohne et al, 2000), the Strategic

Approach to Coping Scale (SACS) (Hobfoll, 1998), and the Coping Strategies Inventory (Tobin et al, 1989) respectively. It is acknowledged however that problems are dynamic and represent a multidimensional process and that coping behaviours are diverse and complex and that these factors are not captured by many standardised measures of coping which rate its method or focus (Oakland & Ostell, 1996). This is in accordance with the view that "coping needs more detailed specification…because of the bewildering richness of behaviour relevant to it" (Pearlin & Schooler, 1978, p. 4). In a study of women's experiences of battering[1] it was noted that by focussing on a woman's behaviour in relation to abuse, "you have only a partial understanding of the phenomenon of battering" (Smith et al, 1995, p. 174). These concerns suggest that many standardised measures do not capture the process of coping and its complexity and, in particular, may rate vulnerable individuals as poorer copers. There could therefore be argued that there is a need to utilise alternative methodologies to measure the construct of coping.

Women with dependant children who experience homelessness are an example of a population who experience disempowerment and social exclusion. These families are often characterised by factors such as diversity, gender and culture, issues often neglected by

coping theory (Banyard & Graham-Bermann, 1993) which are discussed below. It has been suggested that marginalised women's coping options may be constrained by their limited access to power and resources (Lewis et al, 2006).

Gender

Older studies indicated that women were less able copers than men. This was because they were more likely to utilise emotion-focussed and avoidant coping which was associated with impaired functioning (Billings & Moos, 1981; Pearlin & Schooler, 1978). In one influential study Folkman and Lazarus (1980) reported that the increased use of problem-focussed coping strategies by men indicated that they were better able to persevere with difficulties compared to women. One possible explanation for this is the socialisation hypothesis which suggests that men are socialised to deal with stress instrumentally whereas women tend to be socialised to express emotion and to seek support from others (Ptacek et al, 1992). Also, the tendency for males to be self-reliant combined with their often higher status may mean that their coping efforts are viewed as superior to that of women (Hobfoll, 1998). The overall findings on gender differences in coping are inconclusive. Whilst some studies have reported that men and women use similar coping strategies (e.g. Korabik & Van Kampen, 1995; Krohne, 1993), it is still

recognised that women utilise more social support (Felsten, 1998; Gonzalez-Morales et al, 2006; Lengua & Stormshak, 2000) and disengagement coping (Matud, 2004) compared to men.

It may be that the categorisations of coping as adaptive and maladaptive do not take into account what is effective for women under stress making them unsuitable for studies of marginalised individuals experiencing poverty. It has been indicated that the simplistic dichotomy of adaptive versus maladaptive coping may underestimate the complex reality in the lives of women who are experiencing crises (Lewis et al, 2006).

Maladaptive coping strategies may be interpreted differently in studies of female populations. Strategies such as avoidance and denial, largely interpreted as maladaptive, may in fact be a survival strategy for some women who have been subject to violence or abuse and therefore appropriate at times of crisis (Banyard & Graham-Bermann, 1993). It has been suggested that depressive symptoms such as withdrawal and denial may be adaptive as they inhibit futile actions and hence conserve energy (Nesse, 2000). Others suggest that depression may be adaptive when an individual is confronted with an uncontrollable stressor such as homelessness (Brissett-Chapman, 1998). Further, Unger (1990) suggests that women may cope differently when in the company of other women

as opposed to a passive style often adopted when around males. This has implications for measurement of coping in all-female environments, for example hostels[2] for homeless women. Women's sense of connectedness to and responsibility for others leads them to attend to and nurture others, or to provide social support (Belle, 1991). Other studies such as that in a women's prison indicate the importance of the instrumental support provided by fellow inmates (Severance, 2005).

Feminist approaches recommend that issues including power relations, a commitment to the group being researched and a foregrounding of the participant's perspectives are incorporated into research methodologies (Watts, 2006). This approach concurs with philosophies underpinning qualitative methodologies as they avoid objectifying research participants and consider them as experts on the phenomenon under investigation (Lindsey, 1997).

Culture

Anthropological perspectives have defined coping as a function of an individual's culture (Aldwin, 1994) and the importance of the social context of coping has been recognised (Banyard & Miller, 1998; Berg et al, 1998; Hobfoll, 1998; Ibanez et al, 2004). Cultural contexts influence situational demands and individual resources which in turn affect stress appraisal (Folkman & Lazarus, 1984;

Lazarus, 1991). Norms also influence beliefs and values and emotional expression, for example, suppressing emotion may not culturally appropriate. For example, *ataque* is a Puerto Rican emotional response to bereavement or other uncontrollable stressors. It is characterised by extreme emotional expression, fainting spells and often self-destructive behaviour. (Aldwin, 1994). This contrasts with Western norms in which problem-focussed and rational approaches to coping are viewed as appropriate (Lazarus, 1993).

Coping in conjunction with others or 'collective coping' has been reported to be an important form of coping in non-Western cultures, for example engaging the assistance of extended family members (Cortina & Wasti, 2005; Singh & Pandey, 1985). Religious beliefs, seeking spiritual support and praying have been found to be commonly used strategies in other studies (Averitt, 2003; Baldacchino & Draper, 2001; Brodsky, 1999; Thabet et al, 2004). It should be recognised therefore that definitions of coping which prevent, avoid or control emotions such as that by Pearlin and Schooler (1978) may be appropriate only in a White Western context.

Homeless families- a marginalised population

Women with dependant children who experience homelessness are a significant yet hidden population. Many have experienced trauma including domestic violence, relationship breakdown, and harassment by neighbours. These individuals have been little considered in research and yet are a significant group, in the US homeless families account for 33% of the total homeless population (National Coalition for the Homeless, 2006). In the UK in 2004/05 57% of the homeless population were households with dependant children (ODPM, 2006). Although homelessness has been described as a stressful, traumatic event (Goodman et al, 1991), others suggest that it can be a positive occurrence due to the safety and support available in refuges or hostels (Styron et al, 2000). A small number of studies in the USA have explored coping in this population (Banyard & Graham-Bermann, 1998; Wagner & Menke, 1991) including some utilising qualitative methodologies (Banyard, 1995; Cosgrove & Flynn, 2005; Styron et al, 2000).

Using qualitative methodologies in vulnerable and marginalised populations

One way in which to address the shortcomings associated with the use of standardised measures of coping in vulnerable populations is to use qualitative methodologies. Such methods encourage individuals to relate ideas, experiences, thoughts, and behaviours in their own words and are recommended for use in the exploration of

sensitive topics (Bowling, 2002; Carter & Henderson, 2005) and in community psychology research which advocates an ecological approach to investigation emphasising the importance of context (Banyard & Miller, 1998). Other qualitative research with vulnerable individuals suggests that the findings allow us to understand the person-environment context, thus helping to identify risk and protective factors (Brodsky, 1999) and to challenge the status of participants as victims (Cosgrove & Flynn, 2005), thus avoiding disempowering participants (Banyard & Graham-Bermann, 1993) and presenting a more holistic view of the subject under investigation.

Further it has been suggested that "narration of difficult or even traumatic life experiences helps us integrate and surmount them" (Neimeyer & Levitt, 2001, p 64). This indicates that participation in qualitative research may have therapeutic value (Moyle, 2002). Some ethical problems have also been identified. These relate to the potential for harm caused to participants when asked to discuss distressing or traumatic events (Kavanaugh & Ayres, 1998), the blurring of researcher-health professional boundaries (Ensign, 2003), and the risk of further pathologising individuals who are already marginalised (James & Platzer, 1999).

It has been reported that when coping was explored qualitatively with women who had experienced childhood sexual abuse "the substantial complexity of the coping process" (Oaksford & Frude, 2003, p. 69) was revealed, and when used with homeless mothers, a multi-faceted and heterogeneous group of individuals was identified (Cosgrove & Flynn, 2005). This is in contrast to quantitative findings from studies of homeless women where high levels of disengagement and avoidant coping styles have been associated with psychopathology (Banyard & Graham-Bermann, 1998; Rayburn et al, 2005).

Understanding coping in homeless mothers

In order to explore coping in a population of homeless mothers mixed methods were used in a longitudinal study. Relationships between coping, mental health and goal achievement were examined quantitatively and are reported elsewhere (Tischler & Vostanis, in press). The variables chosen for study were guided by Lazarus (1991; 1993) who recommended that coping process and outcome should be measured independently. Qualitative data was collected with the aim of exploring the process, meaning and context of coping in a population of homeless mothers.

A semi-structured interview schedule was used with 21 women to help construct a narrative and chronological report of these

women's lives, before, whilst and after homelessness. Coping was investigated by asking the women how they were coping with being homeless and what they did in order to cope. The women and their children were resident in temporary accommodation provided by a Local Government Authority. Women were interviewed within the first three weeks of homelessness and again four months later, when most had been resettled.

The qualitative data were analysed using thematic analysis. This method systematically identifies themes or patterns within the data (Boyatzis, 1998; Braun & Clarke, 2006; Joffe & Yardley, 2004). Deductive coding was used where themes were identified in the existing literature and applied to the data and these were refined and sub-divided using themes identified inductively from the data. A colleague (SC) re-coded a selection of the data in order to ensure inter-rater reliability.

The qualitative data revealed the variety and complexity of coping strategies used whilst the stressor of homelessness was experienced. Two strategies in particular, cognitive reframing and engaging with social support were reported most often. The use of reframing indicates the importance of social comparison in this population, either identifying their good fortune compared to others,

or by relating to others who are also homeless as the excerpts below illustrate.

> It is stressful and emotional, I try to hang in there and remember there are people worse off, its only a few months of your life…you can see a tunnel in your mind and you wonder if you'll ever see the light at the end, you'll give up hope if you don't, it makes things harder for yourself. (C2)

> I learnt that there are people who are worse off than me. This makes me feel stronger. When I see homeless people on the streets, I know how they feel (C41)

Seeking social support was commonly reported by participants as the extracts below describe.

> I go to my sister for advice as she is down to earth and doesn’t judge me (C12)

> J [another resident] is the most help to me, she’s been depressed herself so she can cheer me up (C26)

Seeking support appeared to be an important coping strategy for many woman, in particular seeking help from other homeless

women suggesting that the all-female environment of the hostel may have influenced the coping strategies used (Unger, 1990) and identifying the importance of peer support as reported by Severance (2005). This reliance on others may also reflect homeless women's lack of power and access to limited resources (Lewis et al, 2006). This finding supports the notion that women's coping should be examined in the context in which it occurs, which often involves nurturing or attending to others (Banyard & Graham-Bermann, 1993; Belle, 1991). This is important as many women were vulnerable, expressed feelings of shame related to their homelessness, and had been subject to serious violence beforehand. It may also be that for some homelessness was a respite from past troubles and an opportunity to form new social networks with other homeless women. In this way, qualitative data can reveal the multi-dimensionality of coping, relating not only the coping strategy used, but the meaning of the stressor to the individual, and the expected outcomes.

The importance of reframing and seeking support is in accord with findings from previous studies such as Cosgrove & Flynn (2005) which suggests that homeless women are able to engage with others and focus on positive outcomes in order to cope. The data also provide insights into why certain strategies are used and in what circumstances. The context in which these strategies were

used helps to clarify the meaning of homelessness to these individuals. The importance of understanding the meaning of a stressful event was reported by Lazarus (1993) and Banyard and Graham-Bermann (1993). Whilst homelessness was perceived as a stressor, participants realised that it was time limited, would lead to improved outcomes such as permanent housing, and that others such as rough sleepers were in a worse predicament than them, thus they reframed the stressor. For these individuals homelessness was accepted as a route to a better life, or 'a means to an end', eliciting the construct of transformational coping (Ford-Gilboe & Cohen, 2000).

Disengagement strategies such as avoidance and diversionary tactics were reported by a small number of participants and this was commonly related to mental distress as the following extracts describe.

> I feel lost and run down, very hopeless. I try to suppress my distress. I don't feel able to talk to others, everyone has problems of their own (C3)

> I'm up and down, sometimes I get depressed, I like to help myself, I often do exercise to help (C41)

Although these women may appear to be coping poorly and may be rated as such by a standardised measure, the data again indicate that context must be considered before assessing efficacy. This reflects the views of Lazarus (1993) who suggests that the adaptational value of coping should not be rated without considering the context in which it occurred. This indicates that strategies which appear to be maladaptive, for example, the use of avoidance, may be appropriate in response to a stressor over which participants have little control such as homelessness.

A number of women expressed a lack of control over their predicament, and that they were unable to cope effectively as the excerpts below illustrate. These comments provide an insight into the lives of women who have survived trauma and are living in often cramped and high security conditions with their children.

> I'm not coping, I'm surviving day to day. I switch on a button and go on autopilot (C27).

> I'm not coping well but I pretend to be happy because of [son]. I don't feel in control, I feel trapped (C22)

Data revealed the interaction between poor mental health and coping as the excerpts below reveal. Some women expressed

serious mental distress, including suicidal ideas, which were often moderated by thoughts of their children's welfare. A number of women referred to mental illness, particularly depressive symptoms.

> I think I had a nervous breakdown, I couldn't cope. I usually cope well. I feel low sometimes, the situation is not my fault, everything was ok until those people moved in next door. I try to hide it from the kids. I do get tense when I go out around here, I feel threatened…sometimes it feels like life is dishing out unfairness, when I feel bad I just think of the kids (C23)

> Honestly, if it wasn't for the kids I wouldn't be here, I would have killed myself. They are the only thing keeping me going, they keep me alive (C18)

The following extract reveals that various coping strategies may be used simultaneously to deal with distress.

> I have been depressed…I thought I could cope but I couldn't so I took an overdose…I am much more tearful at the moment, but my friends really help, they cheer me up. I try to keep a good sense of humour too (C22)

The high level of mental distress reported was confirmed in other quantitative and qualitative findings from the study (Tischler & Vostanis, in press; Tischler et al, in press). Others have suggested that such distress may be a survival mechanism for women in crisis (Brissett-Chapman, 1998; Nesse, 2000). The participants' mental health is likely to have influenced the types of strategies used, and poor mental health is likely to impair active problem solving (Folkman & Lazarus, 1988).

Implications and Conclusions

This paper has explored some of the theoretical, conceptual and methodological issues related to the use of standardised measures of coping, limiting their use for assessment of coping in vulnerable and marginalised populations such as women with dependant children who experience homelessness. Qualitative findings revealed insights into the nature of coping in this population.

Problem-focussed coping, which is often rated as adaptive, for example, making a plan and sticking to it, was rarely mentioned by these respondents. This may be indicative of high levels of emotional distress in this population or it may suggest that other cognitive and engagement strategies are more beneficial to women experiencing a crisis. It may also be that some individuals do not

equate coping with the psychological concepts of appraisal and problem and emotion focussed strategies, rather they may view it as a cognitive, emotional concept. This would seem important to explore in future research, particularly in vulnerable groups in which standardised measures of coping have yet to be developed.

Further longitudinal studies are recommended as it could be that women report different strategies such as problem-focussed coping at a later stage or as the crisis resolves. It was also interesting that spiritual or collective coping strategies were rarely reported, despite the fact that a significant minority of participants were from ethnic minorities. This could be because these strategies are not be conceptualised by lay people as 'coping'. If the participants had been asked about how they 'managed' or 'got by' their responses may have been different. This reflects some semantic confusion regarding coping terminology which was revealed by the data. Responses indicated that for some, 'to cope' was to be managing a situation well, for example, seeking help from others, whereas a number felt they were simply surviving which they did not equate to coping. This supports what Lewis et al (2006, p. 350) terms "situationally responsive strategies to survive" but is in contrast with the view that coping be restricted to 'effortful' responses (Compas et al, 1997), and questions the sensitivity of some standardised measures. The possibility that the psychological

construct of coping is not being tapped accurately must be considered especially when some respondents indicated that they were not coping.

Qualitative data can be used to gain a more comprehensive understanding of the complex construct of coping. Its use ensures that vulnerable individuals are able to describe their coping efforts and their reasons for using particular strategies fully and using their own terminology. This goes some way to uncovering the 'bewildering richness of behaviour' that Pearlin and Schooler (1978) referred to. Future studies should aim to move beyond analysis of coping strategies to a qualitative exploration incorporating higher and lower order coping categories, plus state and trait dimensions. This would promote the holistic investigation of coping incorporating process, appraisal, individual differences and meaning as advocated by Lazarus (2000).

Qualitative methods are not a substitute for standardised measures but they can usefully elucidate and contextualise coping efforts and clarify the meaning of stressors for research participants. Qualitative research may be particularly appropriate for use with vulnerable populations when approached with sensitivity due to its empowering and therapeutic qualities. The rich data gathered embeds coping in contextual and process detail which can reveal

insights into coping in vulnerable groups and the interaction between coping and other psychosocial variables such as mental health.

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Endnotes

[1] US terminology for domestic violence

[2] Also referred to as homeless centres or shelters

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STATEMENT OF AUTHORSHIP OF PUBLICATIONS

On behalf of Victoria Allison Tischler

By Professor Panos Vostanis

I am registering for a PhD by published works. This statement confirms the contribution made by myself to jointly authored work. In our case the work is:

(1) **Tischler, V.,** Cumella, S., Bellerby, T. and Vostanis, P. (2000) A Mental health Service for homeless children and families. *Psychiatric Bulletin* 24, 339-341

I confirm that Victoria Tischler contributed 70% to the above publication

(2) Vostanis, P. **Tischler, V.,** Cumella, S. and Bellerby, T. (2001) Mental health problems and social supports among homeless mothers and children victims of domestic violence. *International Journal of Social Psychiatry 47 (4),* 30-40

I confirm that Victoria Tischler contributed 40% to the above publication

(3) Tischler, V., Vostanis, P., Bellerby, T. and Cumella, S. (2002) Evaluation of a mental health outreach service for homeless families. Archives of Disease in Childhood 86, 158-163

I confirm that Victoria Tischler contributed 70% to the above publication

(4) Tischler, V. and Gregory, P. (2002) A resettlement service for homeless and vulnerable parents. Housing, care and support 5 (4), 33-36

I confirm that Victoria Tischler contributed 80% to the above publication

(5) Thabet, A. A. M, Tischler, V. and Vostanis, P. (2004) Maltreatment and coping strategies among male adolescents living in the Gaza Strip. Child Abuse and Neglect 28, 77-91

I confirm that Victoria Tischler contributed 30% to the above publication

(6) Tischler, V., Karim, K., Rastall, S., Gregory, P. and Vostanis, P. (2004) A Family Support Service for homeless children and parents: users' perspectives and characteristics. Health and Social Care in the Community 12 (4), 327-335

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(7) Karim, K., Tischler, V., Gregory, P. and Vostanis, P. (in press) Homeless children and parents: short-term mental health outcome. International Journal of Social Psychiatry

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(8) Tischler, V. and Vostanis, P. (in press) Homeless Mothers: Is there a Relationship between Coping Strategies, Mental Health and Goal Achievement? Journal of Community and Applied Social Psychology

I confirm that Victoria Tischler contributed 80% to the above publication

(9) Tischler, V., Rademeyer, A. and Vostanis, P (in press) Mothers experiencing homelessness: mental health, support and social care needs. Health and Social Care in the Community

I confirm that Victoria Tischler contributed 70% to the above publication

Signature _____

Date _____

A statement about joint authorship

The presented work is based upon six years of research studying psychosocial issues in homeless families and the development and evaluation of services for this population. Most of the findings are based upon data collected in two separate longitudinal studies, one in Birmingham and the other in Leicester.

In respect of the papers where I am named as first author, I gathered data, reviewed literature and wrote the literature reviews, identified aims and objectives of the studies, wrote the method, analysed data, discussed results and drew conclusions.

I collected the vast majority of data presented. One exception to this was a study of coping in male adolescents in the Gaza strip (5) where the data was collected by Dr Thabet. In respect of that paper I reviewed the literature and wrote the literature review and wrote the method and discussion sections of the manuscript. Dr Gregory contributed to collection of data with regard to paper (4).

I analysed the quantitative and qualitative data presented in all jointly authored papers with the exception of papers (2), (5) and (7) where Professor Vostanis, Dr Thabet and Dr Karim analysed the data respectively. I contributed a review of social support literature to paper (2) and added to the discussion of findings related to this factor. For paper (7) I contributed to the discussion and literature reviews.

Professor Vostanis supervised the research programme and designed both the Birmingham and Leicester studies. He was Principle Investigator on the research grants which funded the service evaluation research.

Signature _____

Date 11-12-06

THE GENERAL HEALTH QUESTIONNAIRE

GHQ 28

David Goldberg

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1 – been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 – been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 – been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 – felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 – been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 – been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 – been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

---

B1 – lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 – had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 – felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 – been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 – been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 – found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 – been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

C1 – been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2 – been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 – felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4 – been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5 – felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 – felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7 – been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

---

D1 – been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2 – felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 – felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 – thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5 – found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 – found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 – found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A ☐ B ☐ C ☐ D ☐ TOTAL ☐

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Family Crisis Oriented Personal Evaluation Scales (F-COPES)

NFER-NELSON
INFORMING YOUR DECISIONS

The *Family Crisis Oriented Personal Evaluation Scales* are designed to record effective problem-solving attitudes and behaviour which families develop to respond to problems or difficulties.

Read the list of 'Response Choices' one at a time and decide how well each statement describes your attitudes and behaviour in response to problems and difficulties. If the statement describes your response *very well* then circle the number 5 indicating that you STRONGLY AGREE; if the statement does not describe your response at all then circle number 1 indicating that you STRONGLY DISAGREE; if the statement describes your response to some degree, then select a number 2, 3 or 4 to indicate how much you agree, or disagree, with the statement about your response.

When we face problems or difficulties in our family we respond by:

	Strongly disagree	Moderately disagree	Neither agree nor disagree	Moderately agree	Strongly agree
1. Sharing our difficulties with relatives	1	2	3	4	5
2. Seeking encouragement and support from friends	1	2	3	4	5
3. Knowing we have the power to solve major problems	1	2	3	4	5
4. Seeking information and advice from persons in other families who have faced the same or similar problems	1	2	3	4	5
5. Seeking advice from relatives (grandparents, etc.)	1	2	3	4	5
6. Seeking assistance from community agencies and programmes designed to help families in our situation	1	2	3	4	5
7. Knowing that we have the strength within our own family to solve our problems	1	2	3	4	5
8. Receiving gifts and favours from neighbours (e.g. food, taking in mail, etc.)	1	2	3	4	5
9. Seeking information and advice from the family doctor	1	2	3	4	5
10. Asking neighbours for favours and assistance	1	2	3	4	5
11. Facing the problems 'head-on' and trying to get a solution right away	1	2	3	4	5
12. Watching television	1	2	3	4	5
13. Showing that we are strong	1	2	3	4	5
14. Attending religious services	1	2	3	4	5
15. Accepting stressful events as a fact of life	1	2	3	4	5

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When we face problems or difficulties in our family we respond by:

	Strongly disagree	Moderately disagree	Neither agree nor disagree	Moderately agree	Strongly agree
16. Sharing concerns with close friends	1	2	3	4	5
17. Knowing luck plays a big part in how well we are able to solve family problems	1	2	3	4	5
18. Exercising with friends to stay fit and reduce tension	1	2	3	4	5
19. Accepting that difficulties occur unexpectedly	1	2	3	4	5
20. Doing things with relatives (get-togethers, dinners, etc.)	1	2	3	4	5
21. Seeking professional counselling and help for family difficulties	1	2	3	4	5
22. Believing we can handle our own problems	1	2	3	4	5
23. Participating in church activities	1	2	3	4	5
24. Defining the family problem in a more positive way so that we do not become too discouraged	1	2	3	4	5
25. Asking relatives how they feel about problems we face	1	2	3	4	5
26. Feeling that no matter what we do to prepare, we will have difficulty in handling problems	1	2	3	4	5
27. Seeking advice from a religious leader	1	2	3	4	5
28. Believing if we wait long enough, the problem will go away	1	2	3	4	5
29. Sharing problems with neighbours	1	2	3	4	5
30. Having faith in God	1	2	3	4	5

Note: In the use of this instrument the clinician/researcher may need to obtain more complete information about the instrument, its conceptualization and the total theoretical framework as well as standard scores, reliabilities and validities from the original source of the instrument.

Family Support Scale (FSS)
(Adapted from Dunst, Jenkins and Trivette)

NFER-NELSON
INFORMING YOUR DECISIONS

Listed below are sources of support that are often helpful to members of families raising a young child. This questionnaire asks you to indicate how helpful each source is to *your family*.

Please *circle* the response that best describes how helpful the sources have been to your family during the past *3 to 6 months*. If a source of help has not been available to your family during this period of time, circle the NA (not available) response.

	Not available	Not helpful at all	Sometimes helpful	Generally helpful	Very helpful	Extremely helpful
1. My parents	NA	1	2	3	4	5
2. My partner/spouse's parents	NA	1	2	3	4	5
3. My relatives/kin	NA	1	2	3	4	5
4. My partner/spouse's relatives/kin	NA	1	2	3	4	5
5. Partner/spouse	NA	1	2	3	4	5
6. My friends	NA	1	2	3	4	5
7. My partner/spouse's friends	NA	1	2	3	4	5
8. My own children	NA	1	2	3	4	5
9. Other parents	NA	1	2	3	4	5
10. Co-workers	NA	1	2	3	4	5
11. Parent groups	NA	1	2	3	4	5
12. Social groups/clubs	NA	1	2	3	4	5
13. Place of worship/religious organization	NA	1	2	3	4	5
14. My family or child's doctor	NA	1	2	3	4	5
15. Professional helpers (social workers, therapists, teachers, etc.)	NA	1	2	3	4	5
16. Professional agencies (public health, social services, mental health, etc)	NA	1	2	3	4	5
17. School/day-care centre	NA	1	2	3	4	5
18. Hostel manager	NA	1	2	3	4	5
19. Mental health outreach service	NA	1	2	3	4	5
20. _____	NA	1	2	3	4	5

Strengths and Difficulties

QUESTIONNAIRE

TO BE COMPLETED BY A MAIN CARER OF A CHILD AGED BETWEEN 3 AND 4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain, or the items seem daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name _____ Male/Female Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, downhearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things over before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Please complete questions on the next page...

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No difficulties	Yes – minor difficulties	Yes – more serious difficulties	Yes – severe difficulties
☐	☐	☐	☐

If you have answered 'Yes', please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1–5 months	5–12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	☐	☐	☐	☐
Friendships	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Leisure activities	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature _____

Date _____

Mother/Father/Other (please specify) _____

Thank you very much for your help

SF-36 HEALTH SURVEY

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Didn't do work or other activities as **carefully** as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

Not at all 1

Slightly 2

Moderately 3

Quite a bit 4

Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

None 1

Very mild 2

Mild 3

Moderate 4

Severe 5

Very severe 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all 1

A little bit 2

Moderately 3

Quite a bit 4

Extremely 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and low?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

All of the time 1

Most of the time 2

Some of the time 3

A little of the time 4

None of the time 5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get ill more easily than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

HOSPITAL ANXIETY AND DEPRESSION SCALE

Instructions: Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he or she will be able to help you more. This questionnaire is designed to help your doctor know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

I feel tense or 'wound up':	**A**	**I feel as if I am slowed down:**	**D**
Most of the time	3	Nearly all of the time	3
A lot of the time	2	Very often	2
Time to time, occasionally	1	Sometimes	1
Not at all	0	Not at all	0

I still enjoy the things I used to enjoy:	**D**	**I get a sort of frightened feeling like 'butterflies in the stomach':**	**A**
Definitely as much	0	Not at all	0
Not quite so much	1	Occasionally	1
Only a little	2	Quite often	2
Not at all	3	Very often	3

I get a sort of frightened feeling like something awful is about to happen:	**A**	**I have lost interest in my appearance:**	**D**
Very definitely and quite badly	3	Definitely	3
Yes, but not too badly	2	I don't take as much care as I should	2
A little, but it doesn't worry me	1	I may not take quite as much care	1
Not at all	0	I take just as much care as ever	0

I can laugh and see the funny side of things:	**D**	**I feel restless as if I have to be on the move:**	**A**
As much as I always could	0	Very much indeed	3
Not quite so much now	1	Quite a lot	2
Definitely not so much now	2	Not very much	1
Not al all	3	Not at all	0

Worrying thoughts go through my mind:	**A**	**I look forward with enjoyment to things:**	**D**
A great deal of the time	3	A much as I ever did	0
A lot of the time	2	Rather less than I used to	1
From time to time but not too	1	Definitely less than I used to	3

often					
Only occasionally		0	Hardly at all		2
I feel cheerful:	**D**		**I get sudden feelings of panic:**		**A**
Not at all	3		Very often indeed		3
Not often	2		Quite often		2
Sometimes	1		Not very often		1
Most of the time	0		Not at all		0
I can sit at ease and feel relaxed:		**A**	**I can enjoy a good book or radio or TV programme:**	**D**	
Definitely		0	Often	0	
Usually		1	Sometimes	1	
Not often		2	Not often	2	
Not at all		3	Very seldom	3	

Parenting Daily Hassles

SCALE

The statements below describe a lot of events that routinely occur in families with young children. These events sometimes make life difficult. Please read each item and circle how often it happens to you (rarely, sometimes, a lot, or constantly) and then circle how much of a 'hassle' you feel that it has been for you FOR THE PAST 6 MONTHS. If you have more than one child, these events can include any or all of your children.

EVENT	How often it happens				Hassle (low to high)
1. Continually cleaning up messes of toys or food	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
2. Being nagged, whined at, complained to	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
3. Meal-time difficulties with picky eaters, complaining etc.	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
4. The kids won't listen or do what they are asked without being nagged	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
5. Baby-sitters are hard to find	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
6. The kids schedules (like pre-school or other activities) interfere with meeting your own household needs	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
7. Sibling arguments or fights require a 'referee'	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
8. The kids demand that you entertain them or play with them	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
9. The kids resist or struggle with you over bed-time	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
10. The kids are constantly underfoot, interfering with other chores	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
11. The need to keep a constant eye on where the kids are and what they are doing	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
12. The kids interrupt adult conversations or interactions	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
13. Having to change your plans because of unprecedented child needs	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
14. The kids get dirty several times a day requiring changes of clothing	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
15. Difficulties in getting privacy (eg. in the bathroom)	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
16. The kids are hard to manage in public (grocery store, shopping centre, restaurant)	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
17. Difficulties in getting kids ready for outings and leaving on time	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
18. Difficulties in leaving kids for a night out or at school or day care	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
19. The kids have difficulties with friends (eg. fighting, trouble, getting along, or no friends available)	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5
20. Having to run extra errands to meet the kids needs	Rarely	Sometimes	A lot	Constantly	1 2 3 4 5

Questionnaire completed by *mother/father/adoptive parent/foster carer* (please specify)

EYBERG CHILD BEHAVIOR INVENTORY

Rater's Name: _____
Relationship to Child: _____
Date of rating: _____
Child's Name: _____
Child's Age: _____
Birthdate: _____

Directions: Below is a series of phrases that describes children's behavior. Please (1) circle the number describing how often the behavior currently occurs with your child and (2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

Never	Seldom	Sometimes	Often	Always	-	Is this a Problem Now?

	1	2	3	4	5	6	7	Yes	No
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has Poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Does not obey house rules on his own	1	2	3	4	5	6	7	Yes	No
9. Refuses to obey until threatened w/ punishment	1	2	3	4	5	6	7	Yes	No
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
13. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14. Sasses adults	1	2	3	4	5	6	7	Yes	No
15. Whines	1	2	3	4	5	6	7	Yes	No
16. Cries easily	1	2	3	4	5	6	7	Yes	No
17. Yells or screams	1	2	3	4	5	6	7	Yes	No
18. Hits parents	1	2	3	4	5	6	7	Yes	No
19. Destroys toys or other objects	1	2	3	4	5	6	7	Yes	No
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
21. Steals	1	2	3	4	5	6	7	Yes	No
22. Lies	1	2	3	4	5	6	7	Yes	No
23. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
24. Verbally fights with friends his own age	1	2	3	4	5	6	7	Yes	No
25. Verbally fights with brothers and sisters	1	2	3	4	5	6	7	Yes	No
26. Physically fights with friends	1	2	3	4	5	6	7	Yes	No
27. Physically fights with brothers and sisters	1	2	3	4	5	6	7	Yes	No
28. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No

29. Interrupts	1	2	3	4	5	6	7	Yes	No
30. Is easily distracted	1	2	3	4	5	6	7	Yes	No
31. Has short attention span	1	2	3	4	5	6	7	Yes	No
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
33. Has difficulty entertaining himself alone	1	2	3	4	5	6	7	Yes	No
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
35. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
36. Wets the bed	1	2	3	4	5	6	7	Yes	No

YOUR CHILD'S NAME_____ DATE_____

HoNOSCA PARENT'S ASSESSMENT (V1).

IN THE LAST TWO WEEKS, DO YOU THINK THAT:-

1. Your son/daughter has been troubled by disruptive behaviour, physical or verbal aggression

Not at all Insignificantly Mild but definitely Moderately Severely

2. Your son/daughter has suffered from lack of concentration or restlessness?

Not at all Insignificantly Mild but definitely Moderately Severely

3. Your son/daughter has done anything to injure or harm him/herself on purpose?

Not at all Insignificantly Mild but definitely Moderately Severely

4. Your son/daughter has had problems as a result of the use of Alcohol, Drugs or Solvents?

Not at all Insignificantly Mild but definitely Moderately Severely

5. Your son/daughter has experienced difficulties keeping up with his/her usual educational abilities?

Not at all Insignificantly Mild but definitely Moderately Severely

6. Your son/daughter has any physical illness or disability that restricts his/her activities?

Not at all Insignificantly Mild but definitely Moderately Severely

7. Your son/daughter has been troubled by hearing voices, seeing things, suspicious or abnormal thoughts?

Not at all Insignificantly Mild but definitely Moderately Severely

8. Your son/daughter has suffered from self induced vomiting, head/stomach aches with no physical cause, bedwetting or soiling?

Not at all Insignificantly Mild but definitely Moderately Severely

9. Your son/daughter been feeling in a low or anxious mood, or troubled by fears, obsessions or rituals?

Not at all Insignificantly Mild but definitely Moderately Severely

10. Your son/daughter has been troubled by a lack of satisfactory friendships or bullying?

Not at all Insignificantly Mild but definitely Moderately Severely

11. Your son/daughter found it difficult to look after him/herself or take responsibility for his/her independence?

Not at all Insignificantly Mild but definitely Moderately Severely

12. Your son/daughter has been troubled by relationships in your family or substitute home?

Not at all Insignificantly Mild but definitely Moderately Severely

13. Your son/daughter stopped attending his/her education sessions?

Not at all Insignificantly Mild but definitely Moderately Severely

HoNOSCA Score Sheet

Scale 0 –4 Rate 9 if not known

Name of Patient.....

Assessed by.....

Initial Assessment (Date:..../..../.....)

Section A

1.	Disruptive, antisocial or aggressive behaviour	☐
2.	Overactivity attention and concentration	☐
3.	Non accidental self injury	☐
4.	Alcohol, substance/solvent misuse	☐
5.	Scholastic or language skills	☐
6.	Physical illness or disability problems	☐
7.	Hallucinations and delusions	☐
8.	Non-organic somatic symptoms	☐
9.	Emotional and related symptoms	☐
10.	Peer relationships	☐
11.	Self care and independence	☐
12.	Family life and relationships	☐
13.	Poor school attendance	☐
	Section A Total Score	☐

Section B

14.	Lack of knowledge – nature of difficulties	☐
15.	Lack of information – services/management	☐
	Section A & B Total	☐

Coding Summary Report

Project Homeless

Generated: 24/05/2007 13:50

Nodes Coding

Tree Nodes\themes\child behaviour

Tree Nodes\themes\child behaviour\child health

Tree Nodes\themes\child behaviour\non school attendance

Tree Nodes\themes\coping\coping for children

Tree Nodes\themes\coping\reframing

Tree Nodes\themes\events leading to homelessness\eviction

Tree Nodes\themes\events leading to

Tree Nodes\themes\events leading to homelessness\physical

Tree Nodes\themes\events leading to homelessness\poor

Tree Nodes\themes\events leading to

Tree Nodes\themes\experience of homelessness\+ve

Tree Nodes\themes\experience of homelessness\+ve\safety

Tree Nodes\themes\experience of homelessness\+ve\staff

Tree Nodes\themes\experience of homelessness\previous experiences of homelessness

Tree Nodes\themes\experience of homelessness\-ve

Tree Nodes\themes\experience of homelessness\-ve\environment

Tree Nodes\themes\experience of homelessness\-ve\impact on

Tree Nodes\themes\experience of homelessness\-ve\lack of choice

Tree Nodes\themes\experience of homelessness\-ve\lack of privacy

Tree Nodes\themes\experience of homelessness\-ve\lack of services

Tree Nodes\themes\experience of homelessness\-ve\parenting

Tree Nodes\themes\experience of homelessness\-ve\physical illness

Tree Nodes\themes\mental health\depression

Tree Nodes\themes\mental health\drug dependence

Tree Nodes\themes\mental health\fear

Tree Nodes\themes\mental health\nervous

Tree Nodes\themes\mental health\panic

Tree Nodes\themes\services\advice

Tree Nodes\themes\services\children's

Tree Nodes\themes\services\CPN

Tree Nodes\themes\services\Doctor- GP

Tree Nodes\themes\services\employment

Tree Nodes\themes\services\housing

Tree Nodes\themes\services\lack of services

Tree Nodes\themes\services\police

Tree Nodes\themes\services\practical

Tree Nodes\themes\services\Social

Tree Nodes\themes\services\women's

Tree Nodes\themes\social support

Tree Nodes\themes\social support\estrangment

Tree Nodes\themes\social support\family

Tree Nodes\themes\social support\friends

Tree Nodes\themes\social support\geographical isolation

Tree Nodes\themes\social support\lack of support

Pergamon

Child Abuse & Neglect 28 (2004) 77–91

Child Abuse & Neglect

Maltreatment and coping strategies among male adolescents living in the Gaza Strip

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Abstract

Objective: To establish the nature and extent of maltreatment experiences, coping strategies, and behavioral/emotional problems, and their relationships, in a sample of Palestinian adolescents.
Method: A study of 97 male adolescents aged 15–19 years, and attending a vocational training center based in the Gaza Strip. Adolescents completed the Child Maltreatment Schedule and the Ways of Coping Scale (WAYS). The Strengths and Difficulties Questionnaire (SDQ) was completed by adolescents and by their teachers.
Results: Findings revealed high rates of emotional and physical maltreatment. Reliance on emotion-focused or avoidant coping strategies was associated with exposure to maltreatment. Use of maladaptive coping also predicted emotional difficulties in the respondents.
Conclusions: Coping strategies are an important indicator of psychosocial functioning in adolescents who have experienced maltreatment. Identification of coping styles can augment the assessment of at-risk adolescents. Emotion-focused strategies, in particular, appear to be widely used by young people from non-Western cultural backgrounds.

Keywords: Abuse; Maltreatment; Adolescents; Behavior; Coping; Mental health; Palestinian

Introduction

Unstable political and socioeconomic circumstances, inconsistent and rejecting child-rearing practices, and increasing family conflicts have all been cited as issues that render children more exposed and vulnerable to maltreatment (Cote & Allahar, 1994). Community attitudes and values can potentiate child

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abuse by considering physical punishment an appropriate child discipline method (Straus, 1980). During war and long-standing political violence, the use of violence as a problem-solving method is legitimated by the society (Jensen & Shaw, 1993). This may create generations of violence-oriented children who early in their lives participate actively in armed struggles to seek security, develop self-esteem, and gain group support. Further, a child's perception of such violence and military conflict is influenced by his or her ability to cope with it (Baker & Shalhoub-Kevorkian, 1999).

The definition of child abuse and neglect includes both qualitative and quantitative aspects. It consists of single or repeated events, or a pattern of interaction, that is, characteristic of the relationship between the abuser, in this case often a parent or primary carer(s), and the child. Whereas physical abuse refers to the nature of events, neglect and emotional abuse characterize the relationship between the carers and the child. Different forms of child abuse and neglect often coexist (e.g., Claussen & Crittenden, 1991; Ney, Fung, & Wickett, 1994).

Child maltreatment in Western and non-Western societies

Many studies have investigated the prevalence of child abuse in Western societies. There has been less reported on the nature and prevalence of child maltreatment and abuse in non-Western societies. Because of the substantial cultural differences in child rearing and attitudes between societies, we have particularly looked at previous research in Arab countries.

The relationship between parent and child is considered a private one in Arab culture. This factor may hinder reporting of child abuse cases (Haj-Yahia & Shor, 1995). In one of the few studies of child maltreatment in Arab societies, Haj-Yahia and Ben-Arieh (2000) studied 1640 Arab secondary school students in Israel. The authors reported that 39%, 40%, and 42% of the participants stated that their fathers, mothers, and siblings, respectively, had yelled at them and/or done something to insult them at least once during the same period. Furthermore, 17%, 15%, and 20% of the participants revealed that their fathers, mothers, and siblings, respectively, had attacked them continuously for several minutes with a stick, club, or other harmful object at least once during the 12 months preceding the survey. In addition, 17% of the participants had witnessed their fathers threatening to hit or throw something at their mothers, and 18% had witnessed their fathers attacking, grabbing, or shoving their mothers at least once during the 12 months preceding the survey. Regarding exposure to mother-to-father violence, the rates for the same acts were 4% and 3%, respectively.

Ayoush (1991), in a study of children living in the West Bank, found that 14.4% were emotionally abused by use of blaming and humiliation compared to 8.4% of children resident in the Gaza Strip. Overall, the rate of emotional abuse in Palestine is 12.6%. The abuse was higher among families living in refugee camps.

Child maltreatment and psychopathology

Over the last decade, evidence has continued to accumulate concerning the strong association between childhood maltreatment and social, emotional, and behavioral problems, both in later childhood and adult life (Cicchetti & Toth, 1995; Pillay & Schoubben-Hesk, 2001; Post, Weiss, & Leverich, 1994; Simeon, Guralnik, Schmeidler, Sirof, & Knutelska, 2001).

Those exposed to political and social unrest are placed at further risk. Allodi (1989) reported that victims of political persecution and torture experienced psychological distress up to 10 years following their

traumatic experiences. Arab adolescents living in war zones have demonstrated high levels of distress and behavioral problems (Al-Krenawi, Slonim-Nevo, Maymon, & Al-Krenawi, 2001). Children exposed to traumatic events during the Intifada in Palestine have been reported to suffer from higher levels of neuroticism, risk taking, poor memory, and low self-esteem. Such children are more likely to participate in political activity, especially boys who have been exposed to many traumatic experiences (Qouta, Punamäki, & El Sarraj, 1995). Further, a positive correlation between levels of political activity undertaken and psychopathology has been reported (Punamäki, Qouta, & El Sarraj, 1997a). Families living in adverse conditions, such as those in refugee camps, face additional difficulties. These include overcrowding, unemployment, and lack of social and educational opportunities, which affect parental and child mental health. Children exposed to these circumstances present with symptoms of emotional distress, aggressive behaviour, helplessness, low self-esteem, and learning difficulties (Abu Hein, Qouta, Thabet, & El Sarraj, 1993).

How do children and young people cope in adversity?

Coping is a psychological process used to manage difficulties, such as the abusive experiences described previously. The concept of coping is based on schema proposed by Lazarus and his colleagues in which it is conceptualized as a response to perceived stress and may be defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984). Lazarus and Launier (1987) described four basic modes of coping. Instrumental strategies are directed towards managing the threat or stressor itself. Intrapsychic strategies are aimed primarily at regulating or minimizing the accompanying emotional distress. Inhibition of action refers to the ability to resist taking action when such action would increase the likelihood of harm, danger, or conflict. Information seeking involves the instrumental activity of mobilizing support or investigating alternatives that can relieve emotional distress. Coping encompasses cognitive (emotion-focused) and behavioral strategies (behavior-focused) used to manage stressful situations and attendant negative emotions (Lazarus & Folkman, 1984).

Compas, Orosan, and Grant (1993) hypothesize a model of the role of stress and coping in the development of depression during adolescence. They suggest that biological changes coupled with interpersonal stress and coping styles may contribute to the development of depressive symptoms. Gender differences in prevalence of depressive outcomes may be influenced by use of particular emotion-focused coping styles, specifically, females' reliance on rumination whereas males are more likely to use distraction.

The sociocultural context in which coping occurs may influence the type of coping strategies utilized. This is of particular relevance in the current study. Few studies have examined cultural influences on coping, particularly amongst those from lower socioeconomic groups (Graham, 1992). A study of Israeli children subject to bombardment reported that they used a combination of information-seeking and emotion-focused coping strategies (Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman, 1993). Emotion-focused strategies, such as avoidance, were associated with less postwar stress reactions than those who persisted with problem-focused actions. This finding indicates the protective function of emotion-focused coping.

Two previous studies have reported the positive correlation between exposure to traumatic events and the use of active cognitive coping in Palestinian (Punamäki & Puhakka, 1997) and Israeli (Bat-Zion & Levy-Shiff, 1993) children. The adaptive role of active cognitive coping was challenged by Punamäki

et al. (1997a), who found that Palestinian adolescents who were involved in political activity had increased levels of psychological adjustment problems. Further, boys were more likely to engage in political activity in order to cope with trauma, a strategy encouraged by their fathers (Punamäki, Qouta, & El Sarraj, 1997b). In politically active children, parenting was perceived as more negative.

Age contributes to the styles of coping used. Individuals become increasingly adaptive around the age of 15 and adopt a larger range of strategies as they reach late adolescence. This period of development will influence how the individual deals with stress as they move into adulthood (Seiffge-Krenke, 2000). The experience of abuse during adolescence may affect the type of coping strategies that are utilized, as well as the subsequent psychosocial development (Shapiro & Levendosky, 1999). In their study of survivors of childhood sexual abuse, the use of an emotion-focused strategy, such as "acting out," may be perceived as an acceptable response to trauma in adolescence while being viewed as maladaptive in adulthood. Use of avoidant and cognitive coping strategies can act as mediating factors, for example, when abuse occurs, however, these types of strategies are consistently linked with risk of psychological dysfunction (Shapiro & Levendosky, 1999). The use of dissociation as a coping strategy has been reported to be particularly associated with sexual abuse where it acts as a mediator of symptoms, such as self-harming behavior (Kisiel & Lyons, 2001).

In a study of university students who had suffered childhood abuse, Runtz and Schallow (1997) reported that perceived social support and types of coping strategies at the time of abuse were found to be essential to an understanding of the relationship between later adjustment and the abusive event. This study also found emotion-focused, avoidance strategies, such as "trying not to think about what happened," to be associated with impaired psychological functioning.

Seiffge-Krenke's research (1998) on adolescent coping has established that adolescents diagnosed with drug or alcohol problems, depression or anxiety were more likely to utilize emotion-focused, avoidant coping styles. Similar findings were reported by Ebata and Moos (1991) in a study of adolescents where those suffering from depression relied significantly on avoidant coping styles. Avoidant coping has consistently been linked to poor adaptation, while cognitive or approach-oriented coping has been associated with positive adaptation (Seiffge-Krenke, 2000). It is important to note that avoidance may play a protective role in adapting to severe stress, such as abuse, however, this has not been fully investigated. The relationship between symptomatology and development of dysfunctional coping skills and those which are pre-existing has also yet to be established.

The impact of coping in adolescents who are at high risk of later psychopathology due to their experience of maltreatment is an area of research yet to be fully investigated. There were several reasons for opting to examine these variables in the context of the Palestinian society, as this is characterized by:

(a) Close nuclear and extended family relationships, and social support networks.
(b) Although not well researched, child-rearing practices may take a different approach, particularly in relation to physical punishment and children's emotional functioning.
(c) Exposure to socioeconomic adversity, such as poverty, unemployment, overcrowding, and limited housing (Thabet & Vostanis, 1998).
(d) Exposure to ongoing political unrest, violence, and war conflict, which may have some effect on coping strategies among children and adults, but also response to violence (Thabet, Abed, & Vostanis, 2002).

The aims of this study were to: (a) establish the nature and frequency of abusive experiences and coping strategies among Palestinian male adolescents, and (b) to investigate their relationship between abusive experiences, coping strategies, and mental health problems. We hypothesized that adolescents living in

poor communities, such as refugee camps and in large families, would be at risk of developing mental health problems and would be likely to use avoidant coping strategies.

Method

Sample

The sample consisted of young male Palestinians attending a vocational center. As it was ethically difficult to conduct a general population study, a representative group of young people recruited from the only training centre in Gaza city, but who also came from areas of socioeconomic adversity, was considered the most appropriate alternative. This prevented us from approaching young women, because of the cultural constraints of not attending similar community/education settings. Female students usually follow different training pathways, such as secretarial courses.

The study was carried out at the Near East Council of Churches (NECC) vocational training center in the Gaza city. The NECC was founded in 1952 in response to the immense human needs of the Nakba-Palestine disaster of 1948. Those who had been forced from their homes and land and who were separated from their families required assistance to rebuild their lives. The NECC began its work in partnership with the World Council of Churches by providing rations to help the new refugees and steadily added new projects, such as a computer and language center, a family health care center, vocational training, and a dressmaking center. The participants in this study attended the vocational training scheme. All adolescents completed the research measures with help and clarification from social workers based at the center. They were asked about their experiences during the time they had been attending the vocational training, that is, up to a 3-year period. The study was approved by the Ministry of Health Helsinki Committee (Research Ethics). Informed consent was given by the young people, following their teachers' approach with information about the study.

At the time of study, 98 adolescents were attending the center, and a 99% response rate was achieved as only one participant did not complete the Child Maltreatment Interview Schedule. Thus, 97 male adolescents participated in the study. Their mean age was 16.9 years ($SD = .82$, range 15–18); 62.9% were from Gaza city (urban area), 23.7% were from North Gaza (rural area), and 13.4% were from the middle area (refugee camp). Their fathers' employment status was: unemployed (11.3%), unskilled worker (28.9%), skilled worker (10.3%), employee (32.0%), merchant (6.2%), and other occupational groups (11.3%). Only two of their mothers were employed. The monthly family income was under $300 in 14.4% of families, between $300 and $500 in 54.6%, between $500 and $750 in 28.9%, and above $750 in 2.1%.

Measures

The Child Maltreatment Interview Schedule (Briere, 1992). This scale measures types and frequencies of child maltreatment. This is a combined clinical assessment and research instrument. It collects data on two subscales, physical maltreatment and emotional maltreatment, for the previous 3 years. The seven physical maltreatment items are rated as "yes" or "no." Seven emotional maltreatment items are rated according to reported frequency of occurrence (none, once per each year, twice per year, 3–5 times, 6–10 times, 11–20 times, or more than 20 times). In the analysis, emotional maltreatment was defined

as occurring at least three times per year for the last 3 years. Translation to Arabic and back translation was completed and the questionnaire was revised by a panel of experts, including five academics from Palestinian universities and the Gaza Community Mental Health Program, with no differences found between the two versions, in the validation of the instrument.

Ways of Coping Questionnaire (Folkman & Lazarus, 1988). This is a 39-item measure of three primary coping domains: emotion-focused, problem-focused, and seeking social support. The measure was developed using the cognitive-transactional theory of stress developed by Lazarus and Folkman (1984). A 4-point (0 = not at all, 1 = sometimes, 2 = a lot, and 3 = almost all the time) Likert-type format was employed to examine frequency. This scale was used and validated in the Gaza Strip on a sample of political prisoners (Qouta, Punamäki, & El Serraj, 1997).

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). This 25-item version for 11- to 16-year olds was used and was completed by teachers and by adolescents. The SDQ is an established and widely used measure of emotional, behavioral, and peer relationships difficulties. Scores are estimated for total difficulties, as well as for the subscales of conduct, hyperactivity, emotional, and peer relationships problems. The SDQ has been back translated and validated in a previous epidemiological study in the Gaza Strip (Thabet, Stretch, & Vostanis, 2000). In that study, population norms were established and tested for the likelihood of mental health disorders. Using the cutoff scores which were originally established in a UK sample (Goodman, 1997) and further tested in Palestinian children (Thabet et al., 2000) frequencies of young people likely to present with problems of clinical significance were estimated for each subscale, that is, conduct, emotional, hyperactivity, and peer problems, in addition to the total difficulties scores. Although the cutoff scores should be used with caution, the main questions on its validity in Arab populations were raised for preschool children. In contrast, it was found to operate satisfactorily with adolescents.

Demographic data form. This included locality, age, and socioeconomic factors, that is, parental employment status and income.

Data analysis

To examine differences on frequencies of reported maltreatment items ("yes"/"no") according to sociodemographic variables, χ^2 was used. Adolescents who had experienced each type of maltreatment were compared with those which had not, on coping strategies items, using one-way ANOVA with Bonferoni correction for multiple comparisons. The same test was used to compare these groups on SDQ scores. SDQ scores between areas of residence were compared by Kruskal-Wallis nonparametric test. The impact of coping strategies on SDQ scores was tested by linear regression analyses.

Results

Types and frequency of physical and emotional abuse

The most frequently reported physical abuse items were being pinched, beaten, or injured by an adult leading to injury (36.5%), and threats of death or injury by parents or brothers (32.0%). The most

Table 1
Frequencies of types of reported maltreatment during previous three years ($N = 96$)

	N	%
Physical maltreatment		
Pinched, beaten, or injured by an adult, to lead to bruises, fractures, or hemorrhage	35	36.5
Threatened with death or injury by parents or brothers	31	32.0
Threatened by parents or other adults to be abandoned at another place	14	14.4
Taken to hospital because of injuries induced by an adult	13	13.4
Threatened by parents or brothers to leave you at home alone, and them not to return	12	12.4
Locked in room or cupboard by parents or brothers	8	8.2
Tied by chain or rope by parents or brothers	6	6.2
Emotional maltreatment		
Shouted at by father or teacher	41	42.3
Humiliated by teacher or others	34	35.1
Blamed, criticized by teacher or others	33	34.4
Made to feel guilty in every thing you do	23	23.7
Made to feel a bad person	20	20.8
Embarrassed in front of friends	18	18.6
Humiliated and made fun of	15	15.5

frequently reported emotional abuse items were being shouted at by their fathers and teachers (42.3%), being humiliated by teacher or others (35.1%), and being blamed or criticized by teacher or others (34.4%) (Table 1).

Differences in experiences of maltreatment between areas of residence were examined. Young people living in the middle area (refugee camps) were significantly more likely to have experienced the emotional item "humiliated or being made fun of" ($\chi^2 = 5.73$, $df = 2$, $p = .05$), but there was no difference on the other items. There was no difference on maltreatment according to family income, although there was a trend for young people coming from the lowest income families to have been blamed and criticized ($\chi^2 = 7.16$, $df = 3$, $p = .06$).

Coping strategies

Table 2 shows the frequencies of coping strategies used. The coping strategies most commonly used in stressful situations were "acceptance of faith in God" (used almost all the time by 79.4%), and "searching for information on how to get help" (used almost all the time by 60.8%). The least commonly used strategies were "eating, drinking, or smoking" (never used by 79.4%), "being angry towards people who are not the cause of the problem" (not at all used by 59.8%), and "take risks to get what I want" (not at all used by 40.2%).

Type of maltreatment and coping strategies

Due to the measure used, it would not have been valid to dichotomize young people as maltreated or nonmaltreated. Therefore, their coping strategies were examined specifically for each maltreatment item/experience. Those who had experienced a particular type of maltreatment were compared with those

Table 2
Frequencies (%) of coping strategies in stressful situations ($N = 96$)

Coping strategy[a]	Almost all the time	A lot	Sometimes	Not at all
Accept it, because of my faith that this is what God wants (E)	79.4	10.3	8.2	2.1
Look for more information that can help me (P)	60.8	16.5	20.6	2.1
Express my feelings somehow (E)	55.7	10.3	29.9	4.1
Concentrate on what I have to do next, step-by-step (P)	50.5	19.6	23.7	6.2
I went over in my mind what I would say or do (P)	50.5	15.5	26.8	7.2
Accept the apology and conciliation of others (E)	49.5	20.6	24.7	5.2
Make a plan of action and followed it (P)	49.5	13.4	30.9	6.2
Double my efforts to make things work (P)	48.5	25.8	16.5	9.3
Prepare for a new beginning when the problem is over (P)	48.5	22.7	25.8	3.1
Pray (E)	47.4	15.5	30.9	6.2
Try to discover new faith or some important truth (E)	47.4	15.5	28.9	8.2
Become stronger than before (E)	46.4	22.7	27.8	3.1
Fight for my principles (P)	41.2	14.4	24.7	19.6
Change something about myself (P)	40.2	24.7	30.9	4.1
Remember what is important in my life (E)	38.1	23.7	35.1	3.1
Promise to myself that things will be better next time (P)	37.1	14.4	32.0	16.5
Face myself by remembering that other people have more problems (P)	36.1	17.5	39.2	7.2
Try to control myself in difficult situations, without responding quickly (P)	35.1	19.6	32.0	13.4
Ask for help from professionals (S)	35.1	19.6	38.1	7.2
I volunteer in any organization I feel I could help (S, P)	34.0	21.6	42.3	2.1
Take advice from relatives or friends (S, P)	28.9	11.3	55.7	4.1
Let my feelings out somehow (do not hide my feelings) (E)	25.8	11.3	55.7	7.2
Blame myself for things I have and have not done (E)	27.8	11.3	45.4	15.5
Recognize that I am the only one who can help myself (P)	24.7	16.5	45.3	13.4
Blame myself for the situation (E)	23.7	22.7	37.1	16.5
Take risks to get what I want (E)	22.7	9.3	27.8	40.2
Talk to someone to find out more about the situation (S)	22.7	18.6	49.5	9.3
Try to forget the whole thing (E)	20.6	12.4	42.3	24.7
Talk to someone about how I feel (S)	16.5	21.6	36.1	25.8
Try to keep my feelings to myself (E)	15.6	16.7	50.0	17.7
Try to be funny (E)	15.5	22.7	46.4	15.5
Do not respond, even if I feel it is not fair s(E)	14.4	13.4	45.4	26.8
Avoid being with people in general (E)	14.4	9.3	46.4	29.9
Express my feelings to the one who caught the problem (E)	13.4	10.3	47.4	28.9
Daydream or imagine a better time or place (E)	12.4	12.4	38.1	37.1
Refused to believe what has happened (E)	11.3	11.3	50.6	26.8
Think I was unlucky and nothing could help me (E)	8.2	14.4	58.7	18.6
Become angry towards other people, who are not the cause of my problem (E)	6.2	4.1	29.9	59.8
Try to feel better by eating, drinking, smoking, using drugs, or medication (E)	3.1	4.1	13.4	79.4

[a] E denotes emotion-focused strategy; P denotes problem-focused strategy; S denotes seeking social support strategy.

Table 3
Maltreatment and coping strategies

Type of maltreatment	Coping strategy	Difference (one-way ANOVA) F and p values
(a) Significantly more used by children who experienced certain types of maltreatment		
Made to feel bad	Fight for my principles	6.6; .012
	Take risks to get what I want	17.1; <.001
	Can only help myself	5.6; .020
	Feel better by eating and drinking	5.5; .022
Made to feel guilty	Fight for my principles	4.7; .033
	Take risks to get what I want	23.5; <.001
	Daydream or imagine	4.6; .035
Frequently criticized	Take risks to get what I want	15.4; <.001
	Became stronger than before	14.2; <.001
	Blame myself	4.4; .039
	Daydream or imagine	7.9; .006
Humiliated	Fight for my principles	6.4; .013
	Volunteer to help	9.9; .002
	Take risks to get what I want	27.3; <.001
	Daydream or imagine	8.8; .004
Beaten up	Take risks to get what I want	6.3; .003
	Keep feelings to myself	6.3; .003
	Refuse to believe it has happened	4.5; .013
(b) Significantly more used by children who did not experience these types of maltreatment		
Made to feel bad	Go over in my mind what to say or do	5.6; .021
Frequently criticized	Think over in my mind what to say or do	4.5; .038
Humiliated	Think over in my mind what to say or do	4.2; .043
Threatened with injury or death	Taking advice from relatives	17.6; <.001
	Talk to someone to find more about the situation	4.5; .036

Bonferoni corrections for multiple comparisons were used.

who had not, using one-way ANOVA with Bonferoni corrections for multiple comparisons. The significant differences between types of coping strategies used and whether types of maltreatment were experienced are presented in Table 3: Table 3a describes the coping strategies which were significantly more used by young people who had experienced each type of maltreatment; in contrast, Table 3b describes the coping strategies which were significantly more used by young people who had *not* experienced each type of maltreatment. Interesting patterns were established. Young people who had suffered different types of maltreatment (Table 3a) were significantly more likely to use coping strategies, such as "taking risks," "fighting for their principles," "volunteering to help," "daydreaming or imagining they were in a better place," and "eating or drinking to feel better." Two of these strategies (daydreaming/imagining, and drinking/eating) were not frequently used by the total sample, that is, they were not the cultural norm for this population. In contrast, young people who had not experienced the different types of maltreatment (Table 3b) were more likely to use coping strategies, such as "going over in my mind what to say or do," and "taking advice from relatives."

Table 4
Maltreatment and emotional/behavioral problems (SDQ) (self- and teacher-rated) (problems significantly more reported by children who experienced certain types of maltreatment)

Type of maltreatment	SDQ Problems Scale score	Difference (ANOVA) F and p values
Made to feel bad	Conduct (teacher)	13.1; <.001
	Peer problems (teacher)	6.5; .012
	Total problems (teacher)	21.0; <.001
	Emotional (self)	12.4; .001
	Hyperactivity (self)	4.2; .044
Made to feel guilty	Conduct (teacher)	6.7; .011
	Hyperactivity (teacher)	5.6; .019
	Total problems (teacher)	4.5; .037
	Emotional (self)	7.1; .009
Frequently criticized	Emotional (self)	4.9; .030
Humiliated	Conduct (teacher)	15.2; <.001
	Emotional (teacher)	4.4; .039
	Hyperactivity (teacher)	5.3; .024
	Total problems (teacher)	11.2; .001
	Emotional (self)	7.5; .007
Beaten up	Total problems (teacher)	5.2; .007
	Conduct (self)	5.4; .006
	Emotional (self)	7.5; .001
Threatened with injury or death	Emotional (self)	6.5; .013

Bonferoni corrections for multiple comparisons were used.

Emotional and behavioral problems

Overall, 8.3% of young people reported likely clinical problems, contrasted to 13.5% as reported by teachers. These findings indicate that the likely rates of total psychiatric morbidity were relatively low. Specific self-rated scores included hyperactivity (5.3%) and emotional problems (4.1%). Teacher-rated scores indicated conduct problems (3.1%), hyperactivity (3.1%), and emotional problems (3.1%). The Kruskal-Wallis test indicated that there were no significant differences on SDQ scores between areas of residence.

Maltreatment, coping strategies, and emotional/behavioral problems

Young people were compared on each SDQ subscale and total score, according to whether they had or had not experienced each type of maltreatment using one-way ANOVA with Bonferoni corrections for multiple comparisons. Young people exposed to maltreatment scored significantly higher on a number of SDQ teacher- and self-rated scales, the most consistent being self-rated emotional problems (Table 4).

In order to establish the impact of coping strategies and environmental exposure (area of residence) on emotional and behavioral problems, a series of multiple linear regression analyses were conducted. As there were 39 coping strategies items, only those which were significantly more likely to be used by adolescents who experienced the most frequent types of maltreatment (i.e., the 10 coping strategies listed in Table 3a), as well as the area of residence, were entered as covariates. In each regression analysis,

an SDQ total or subscale score was entered as the dependent variable (total, conduct, emotional, peer relationships, or hyperactivity), that is, five regression analyses. The emotional problems subscale in self-rated SDQ scores were strongly predicted by the use of "trying to feel better by eating, drinking, smoking, using drugs or medication" ($R^2 = .40$; $B = .62$, $p = .05$). Teacher-rated total SDQ scores were best predicted by two coping strategies ($R^2 = .61$): blaming oneself ($B = 1.49$, $p = .023$) and refusing to believe what happened ($B = 2.00$, $p = .002$).

Discussion

The aim of this study was to establish levels of maltreatment and coping strategies used among male Palestinian adolescents, and their relationship with emotional and behavioral problems. The research uncovered high reported frequencies of emotional and physical maltreatment, although the findings should be interpreted cautiously, as cultural norms influence the acceptability of types and severity of abuse. In the Palestinian culture, community attitudes and values may potentiate child maltreatment, as physical punishment is considered an appropriate method of child discipline reflected in the high rates of physical maltreatment reported. In particular, the long-standing political violence in the Gaza Strip, has led to the legitimacy of use of violence as a problem-solving method, among both children and adults in the society.

A large number of the respondents relied on emotion-focused coping styles, particularly faith in God. A very few cross-cultural studies on adolescent coping styles exist, therefore, reliance on spiritual coping styles and the implications for mental health warrant further investigation. In view of past research linking emotion-focused coping to later psychopathology, the identification of emotion-focused coping, particularly withdrawal and avoidance could be used to monitor adolescents at risk. In addition, cognitive and information seeking strategies were widely used and are linked to positive adaptation which may help to counteract the negative effects of emotion-focused strategies.

Differences in styles of coping were identified between groups exposed and not exposed to maltreatment. Those exposed to maltreatment were more likely to use avoidant and emotion-focused strategies, such as self-blame and denial. In contrast, those who had not been exposed to types of maltreatment were more likely to use active-cognitive and adaptive coping strategies, such as seeking advice and information. These findings are consistent with the literature on adolescent coping and abuse, for example, Seiffge-Krenke's (2000) study reporting the association between abuse and increased use of avoidant coping styles.

The relationship between emotional maltreatment and emotional and behavioral problems indicates the high levels of distress experienced by the respondents. This is consistent with previous research (Cicchetti & Toth, 1995). In addition, they are more vulnerable due to the ongoing political unrest and violence to which they are exposed (Abu Hein et al., 1993).

Certain emotional problems, as rated by the SDQ, were associated with coping strategies items that might suggest underlying denial (refusing to believe what happened) coping style, or self-blame (blaming oneself). Previous studies have found high use of avoidant coping places among adolescents at increased risk of later psychopathology (Runtz & Schallow, 1997; Shapiro & Levendosky, 1999). Use of emotion-focused coping does, however, serve a protective function in the short term. While it was not the focus of this study, political activity, a type of active cognitive coping strategy, has been associated with psychological dysfunction (Punamäki et al., 1997a). Active cognitive strategies cannot therefore be assumed to serve an adaptive role, particularly in non-Western cultures.

This study indicates that identification of coping strategies serves a clinical function. Coping profiles reveal adolescent strengths and difficulties and can therefore assist in planning appropriate services. They can be used to monitor mental health or to reveal potential maltreatment. The strengthening of young people's adaptive coping strategies and other factors, such as support in their family relationships, should be provided in order to help them cope with trauma (Baker & Shalhoub-Kevorkian, 1999). Such strategies could guide service development, particularly in an educational setting. They could also guide the provision of individual and group therapeutic interventions, such as psychodynamic, cognitive-behavioral, or solution-focused therapy, all of which aim to some extent, albeit using different underlying theoretical models and different techniques, at enhancing young people's coping in the face of adverse experiences.

The study has also revealed relationships between child maltreatment, mental and behavioral problems, and use of coping strategies in an adolescent Arabic population. Cultural norms suggest the high rates of child maltreatment reported should be interpreted cautiously. Cultural sensitivity issues are also important in studying and eliciting abusive experiences across different cultures, such as the Arab culture in general and the Palestinian society in particular, because of the distinction from what are considered appropriate parenting methods. Nevertheless, it was established that Palestinian adolescents are at high risk of psychopathology due to exposure to maltreatment and other adversities. Their reliance on emotion-focused coping may increase their vulnerability to disorders in adult life.

Limitations of the study

The selection of the sample which included only male adolescents attending a particular service, that is, vocational training, the relatively small sample size, multiple comparisons, and the use of instruments previously developed in Western populations were limitations of this study. However, previous general population epidemiological studies by the authors on different types of mental health problems, such as post-traumatic stress and anxiety disorders (Thabet & Vostanis, 1998, 2000) found similar rates of psychopathology, including emotional problems in children and adolescents from the Western societies. Undertaking research in the volatile environment of Gaza presented further difficulties. In addition, social desirability issues may have been a factor as social workers helped the adolescents to complete the measures and may therefore have influenced their responses. Limitations regarding the reliability and validity of scales developed in the West but used in the Arab culture, also need to be taken into consideration. We also need to consider the possibility of young people under-reporting experiences of maltreatment, because of fear of informing their parents or teachers. The assessment of coping strategies would require a more detailed research instrument applied in larger and representative samples, before conclusions could be generated for similar cultural groups.

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Résumé

Objectif: Définir la nature et la dimension des expériences de mauvais traitements parmi un échantillon d'adolescents palestiniens, ainsi que la façon dont ils y ont fait face, les difficultés émotionnelles et du comportement qu'ils ont connues et la relation entre ces éléments.
Méthode: L'étude s'est penchée sur 97 adolescents âgés de 15 à 19 ans qui fréquentaient un centre de formation au travail situé à Gaza. Ils ont complété un questionnaire, le Child Maltreatment Schedule et le Ways of Coping Scale, tandis que le Strengths and Difficulties Questionnaire a été complété par les jeunes et leurs enseignants.
Résultats: L'étude révèle des taux élevés de mauvais traitements psychologiques et physiques. On note que d'avoir été victimes de mauvais traitements tend à mener à des réactions émotives ou d'évitement pour faire face aux difficultés de la vie. Le recours à des stratégies de mauvaise adaptation prédit des difficultés émotives chez les adolescents.
Conclusions: La façon dont les adolescents victimes de mauvais traitements font face aux difficultés de la vie constitue un baromètre de leur fonctionnement psychologique. Bien identifier leur capacité de faire face aux mauvais traitements améliorera l'évaluation qu'on fera des adolescents à risque élevé. Il semble que les jeunes qui ne sont pas issus de milieux occidentaux sont portés à utiliser des stratégies axées sur l'émotion.

Resumen

Objetivo: Establecer la naturaleza y el alcance de las experiencias de maltrato, estrategias de afrontamiento, y problemas de conducta/emocionales, y sus relaciones, en una muestra de adolescentes palestinos.
Método: Se llevó a cabo un estudio con 97 jóvenes adolescentes (varones) de edades comprendidas entre los 15 y los 19 años; estos jóvenes acudían a un centro de formación profesional en la franja de Gaza. Los adolescentes completaron el *Child Maltreatment Schedule* y el *Ways of Coping Scale* (WAYS). Los adolescentes y sus profesores completaron el cuestionario de puntos fuertes y dificultades.

Resultados: Los hallazgos revelan las altas tasas de maltrato emocional y físico. La confianza en estrategias de afrontamiento centradas en la descarga de la emoción y en la evitación fueron asociadas a la exposición al maltrato. El mal uso de afrontamiento no adaptativo también predijo dificultades emocionales en los entrevistados.
Conclusiones: Las estrategias de afrontamiento son un indicador importante de funcionamiento psicosocial en adolescentes que han experimentado maltrato. La identificación de estilos de afrontamiento puede mejorar la evaluación de adolescentes en riesgo. Concretamente, las estrategias centradas en la emoción parecen más utilizadas por jóvenes de origen cultural no occidental.