Redefining Transitional Housing For Homeless Families

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The future directions of policies designed to aid homeless families should be based on a deep understanding of the causes of homelessness. Unfortunately, systematic data are lacking. Instead, biases and opinions have shaped the debate about the origins of homelessness and its solutions. Some experts argue that widespread construction of low-income housing will solve the homelessness problem. Attractive as such a proposal might be, it overlooks the contribution of noneconomic factors to homelessness, as well as the quality of life of the families involved. The provision of decent, affordable housing is an essential element of a comprehensive plan; but such a plan must also address the social, emotional, medical, and educational needs of homeless parents and children.

In his recent book, Rachel and Her Children,[1] Jonathan Kozol advances a deceptively simple economic analysis of family homelessness. He fails to recognize that many homeless persons have significant problems that could not be alleviated solely through the provision of housing. Kozol portrays the desperate plight of homeless families living in the Martinique, a dilapidated, rodent-infested welfare hotel in New York City. Laura, one of the Martinique's tenants who is the mother of three boys and an infant girl, is described by Kozol as a "broken stick," a woman so fragile that he finds it hard to start a conversation with her. Laura asks him to read a letter to her from the hospital.

> Her oldest son has been ill for several weeks. He was tested in November for lead poisoning. The letter tells her that the child has a dangerous lead level. She's told to bring him back for treatment. She received the letter some weeks ago. It's been buried in a pile of other documents she cannot understand.[2]

Laura then points to her four-month-old baby and says that she has a rash. Laura tells Kozol:

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1. J. Kozol, Rachel and Her Children: Homeless Families in America (1988). *See also* Bassuk, Book Review, The Atlanta Constitution, Feb. 21, 1988, at J8.
2. J. Kozol, *supra* note 1, at 102.

> "The carpets, they was filthy from the stuff, the leaks that come down on the wall. All my kids have rashes but the worst she has it. There was pus all over. Somewhere here I have a letter from the nurse. . . ." She finds the letter. The little girl has scabies.
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> "I been living here two years. Before I came here I was in a house we had to leave. There was rats. Big ones they crawl on us. The rats, they come at night. They come into our house, run over my son's legs. . . .
>
> "I was living here when I was pregnant with Corinne. No. I didn't see no doctor. I was hungry. What I ate was rice and beans, potato chips and soda. Up to now this week we don't have food. . . .
>
> "I can read baby books—like that, a little bit. If I could read I would read newspapers. I would like to know what's going on. My son, he tells me I am stupid. 'You can't read.' . . . I don't understand. People laugh. You feel embarrassed. On the street. Or in the store." She cries. "There's nothing here."[3]

Kozol later reports that Laura's situation has deteriorated even further: she abandoned her children to become a prostitute.[4]

The title of the book's first chapter, "Ordinary People," reflects Kozol's analysis of the causes of homelessness. He implies that the tragedy of homelessness could happen to anyone at any time. Throughout, Kozol describes the severity of the low-income housing crisis, inadequate welfare benefits, and indifferent and callous bureaucracies. His long-term solutions focus entirely on the provision of housing. "Only a multi-billion-dollar federal program can create the millions of new units that are needed, and only a sense of national emergency can render allocations on this scale politically conceivable."[5] Undoubtedly so, but does Kozol's analysis tell the entire story? Would Laura's problems disappear with the provision of permanent housing?

Kozol argues that systemic economic inequities account for family homelessness and that constructing enough low-income units would solve the problem. Strictly speaking, he is correct; Laura would not lack shelter if she were housed in a stable residence. But Kozol does recognize that homelessness is more than the lack of shelter. He repeatedly asks the question of what constitutes a home and concludes, "Only a home allows a family to flourish and to breathe."[6] He acknowledges that, in addition to the lack of shelter, homelessness reflects a person's profound disconnection and

3. *Id.* at 104-5.
4. *Id.* at 111.
5. *Id.* at 203.
6. *Id.* at 50.

alienation from supportive relationships and caretaking institutions. However, he does not ask several critical questions: why are many poor families able to find and maintain housing, while others must turn to the emergency shelter system for help? How did Laura's problems interfere with her ability to maintain a stable residence? Is society responsible for teaching Laura how to parent more effectively? Should we be concerned about the quality of life enjoyed by Laura and her children once they are housed? The answers to these questions have important policy implications. If family homelessness is due solely to economics and bad luck, as Kozol suggests, then we only need to construct low-income housing units and not look further.

Based on a literature review, including clinical studies of sheltered Massachusetts families,[7] this Article contends that in many families psychological and support system factors contribute to the origins of homelessness. Therefore, only a comprehensive, long-term plan that addresses those factors can successfully combat homelessness. This plan should include permanent housing, adequate income maintenance programs, case management services,[8] available and welcoming community resources, and assistance in creating and re-establishing supportive relationships. Homeless families should be offered necessary support and rehabilitative services such as crisis intervention, life skills, child care, psychological counseling, special

7. Systematic research describing the characteristics of homeless families is relatively sparse and has numerous methodological limitations. Much of the documentation is based on the following studies of Massachusetts sheltered homeless families: Bassuk, Rubin, & Lauriat, Characteristics of Sheltered Homeless Families, 76 Am. J. Pub. Health 1097 (1986) [hereinafter Massachusetts Study]; Bassuk & Rubin, Homeless Children: A Neglected Population, 57 Am. J. Orthopsych. 279 (1987); Bassuk & Rosenberg, Why Does Family Homelessness Occur? A Case Control Study, *forthcoming in* Am. J. Pub. Health (June 1988). These studies describe 80 homeless mothers and 151 homeless children in 14 Massachusetts family shelters. The Bassuk & Rosenberg study describes 49 homeless mothers and 86 homeless children in 6 family shelters in Boston and 81 housed mothers and 134 housed children living in low-income housing in 20 census tracts in Boston. Despite the methodologic limitations of these studies (e.g., small sample size, may not be generalizable to other locales) some generalizations can be made using these data, other reports, and anecdotal information.

8. The need for intensive case management for the homeless mentally ill has been described. "Intensive case management has been defined as an aggressive, comprehensive approach to accessing basic health and mental health services . . . for those who lack both an adequate support system and independent living skills, and who either cannot or will not access services on their own." Rog, Adranovich, & Rosenblum, Executive Summary, Intensive Case Management for Persons Who Are Homeless and Mentally Ill: A Review of Community Support Program and Human Resource Development Program Efforts 2 (1987). This Article proposes a similarly intensive case management approach as one aspect of a comprehensive plan to aid homeless families. Case management services include assessing clients, service planning and linkage, monitoring service delivery, and providing outreach and advocacy.

education, and job training. Such a coordinated system of care will help formerly homeless families to maintain their homes during difficult times. The overall goal is to create a network that will serve as a safety net during times of personal and economic crisis.

If housing and appropriate services were available, many homeless families could move directly from shelters into independent living situations with intensive case management and extensive supports. Certain homeless families, however, have difficulty coping with stress-filled environments, and their problems sometimes interfere with their ability to maintain stable independent housing. Referred to as "multi-problem families,"[9] they have multiple and chronic difficulties functioning. Because these families have special needs, they may be unable to move immediately from being homeless to living independently, even with intensive support services. They may require a form of transitional housing that offers on-site support and supervision, links to community agencies, and special programs for children.

The term "transitional housing" has been applied to various facilities for the homeless, including emergency shelters, church and community hospices, welfare hotels, and specialized housing. The Stewart B. McKinney Homeless Assistance Act (McKinney Act)[10] defined transitional housing as a type of supportive housing "that has as its purpose facilitating the movement of homeless individuals to independent living within a reasonable amount of time. . . ."[11]

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9. The term "multi-problem family" was used for the first time in the late 1950s to describe chronically dysfunctional families who used a disproportionate amount of social services with little demonstrable benefit. *See generally* E. Pavenstedt, The Drifters: Children of Disorganized Lower Class Families (1967); L. Kaplan, Working With Multiproblem Families (1986).

10. Pub. L. No. 100-77, 101 Stat. 482 (1987). The McKinney Act authorized the expenditure of $80 million in 1987 and $100 million in 1988 for "supportive housing." *Id.* at § 428(a). Overall $20 million was earmarked for homeless families with children. *Id.* at § 428(b)(1). The Act provided additional consideration for "deinstitutionalized homeless individuals and other homeless individuals with mental disabilities." *Id.* at § 428(b)(2). Although the McKinney Act is far-reaching, additional funds must be targeted to prevent family homelessness and to ensure the reintegration of homeless families into the community. Funds should also be devoted to increasing the supply of low-income housing units.

11. *Id.* at § 422(12). This section of the Act describes the supportive housing demonstration programs. "The term 'supportive housing' means a project assisted under this subtitle that provides housing and supportive services for homeless individuals. . . . All or part of the supportive services may be provided directly by the recipient or by arrangements with other public or private service providers."

The best solution to the homelessness problem was an issue raised before Congress when it considered this legislation. Representatives McKinney, Leach, Ridge, and McMillan gave the following testimony:

Transitional Housing

Transitional facilities have generally sprung up in response to urgent local needs and not as the result of long-term planning. Although transitional housing programs provide much-needed services to many homeless families, they are used extensively to cope with the lack of permanent housing, the dearth of comprehensive community services and health care, and the inadequacies of shelters as human service organizations.[12] Little distinction has been made among types of transitional programs, the client population they might best serve, and their place in the current system of care for homeless families. A comprehensive long-term system should be developed. At its core should be an adequate supply of decent, affordable housing that is locally controlled and state and federally funded. It should also include the following three coordinated, overlapping elements:[13] (1) shelters or "short-term" transitional programs that offer support services to help families move back into the community;[14] (2) case management and various services that provide a therapeutic environment in the community for formerly homeless persons who are independently housed; and (3) long-term transitional housing programs for a subgroup of chronically dysfunctional or "multi-problem" families. This Article focuses primarily on the third element, long-term transitional housing for multi-problem families.

> Our commitment to meet the needs of the homeless does not mean, however, that the House has won the war. Within our Committee we have seen extensive debate over the best methods of providing this assistance. As we know, the role of the Banking Committee on this legislation is limited to authorizing housing and shelter funding. But we all know that the people living on the street need much more than a roof. We need to help the people who are homeless today with a place to live, food and medical attention, and a way to get back into society. We need to reach out to people who may be homeless tomorrow so that they never get to this point.

H.R. Rep. No. 10(I), 100th Cong., 1st Sess. 55, *reprinted in* 1987 U.S. Code Cong. & Admin. News 362, 393.

12. Emergency shelters were originally created to provide shelter, food, and clothing. They were developed based on the belief that homelessness was a short-term crisis. Some shelters have evolved into human service organizations that provide an array of support services while others have not.

13. Although preventive programs are not described in this Article, they potentially form an essential part of a long-term plan. Researchers have not yet defined with certainty those factors associated with increased risk of homelessness. *See* Bassuk & Rosenberg, *supra* note 7, at 1.

14. Most existing transitional facilities, including those referred to in the McKinney Act, fall into this category.

I. Characteristics of Homeless Families

An estimated 2.5 million Americans are homeless.[15] Included among the homeless are adult individuals (of whom 25% to 50% suffer from chronic mental illness), families, and runaway or homeless youth.[16] Homeless families are the fastest growing subgroup. They constitute approximately one-third of the overall homeless population.[17] Nationwide, more than three-quarters of America's homeless families are headed by women with two or three children, usually preschoolers.[18] Perhaps reflecting employment patterns, the composition of homeless families varies regionally. Women head about 90% of homeless families in large eastern cities.[19] In the South and Southwest, approximately 70% of homeless families are headed by women; 30% are headed by women whose male partner has lost his blue-collar job.[20]

The typical homeless mother is in her late 20s, is single or divorced, and has had some high school education. She has been unemployed for several years or has never worked and has received Aid to Families with Dependent Children (AFDC)[21] for longer than two years.[22] Compared to the overall population of Massachusetts AFDC recipients, homeless mothers are disproportionately repre-

15. *See* Bassuk, The Homelessness Problem, 251 Sci. Am. 40 (1984).

16. *Id.* at 40-45; Arce & Vergare, Identifying and Characterizing the Mentally Ill Among the Homeless, in The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association 88 (H. Lamb ed. 1984).

17. *See* U.S. Conference of Mayors, A Status Report on Homeless Families in America's Cities: A 29 City Survey (1987).

18. Estimates of the composition of homeless families are available from New York City, Boston, and Los Angeles. *See* Dumpson, A Shelter is Not a Home: Report of the Manhattan Borough President's Task Force of Housing for Homeless Families 16 (1987); Bassuk, Rubin, & Lauriat, *supra* note 7, at 1098; K. McChesney, New Findings on Homeless Families, 1 Family Professional 3 (1986) (Los Angeles homeless families).

19. Dumpson, *supra* note 18, at 16; Bassuk, Rubin, & Lauriat, *supra* note 18, at 1098; McChesney, *supra* note 18, at 3.

20. Dumpson, *supra* note 18, at 16; Bassuk, Rubin, & Lauriat, *supra* note 18, at 1098; McChesney, *supra* note 18, at 3.

21. 42 U.S.C. § 601 *et seq.* (1982). The AFDC program was established "for the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each state to furnish financial assistance and rehabilitation and other services . . . to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to obtain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection . . . ." 42 U.S.C. § 601. The AFDC program involves both the federal government and those states that choose to participate by submitting a plan for aid and services to needy families with children. The purpose of the AFDC program is to provide financial assistance to needy dependent children who have been deprived of support of one of their parents. Rosen v. Hursh, 464 F.2d 731 (8th Cir. 1972).

22. Bassuk, Rubin, & Lauriat, *supra* note 7, at 1099.

sented among the small group of families who are persistently poor and dependent upon AFDC for long-term assistance.[23]

Although each homeless family has a distinctive route onto the streets, research suggests that homeless families share various common characteristics.[24] The lack of adequate support systems for a majority of homeless mothers contributes to both homelessness and the need for emergency shelter. Poor families who are precariously housed or who have lost their homes usually depend on family and friends to house them during times of crisis. Compared to the large numbers of families forced to double up, only a small number turn to the emergency shelter system for refuge.

The majority of homeless mothers have far fewer supports than poor housed mothers.[25] When asked to name three persons to whom they can turn during times of stress, one-fourth of the homeless mothers in the Massachusetts Study were unable to name even one; nearly one-fifth could name only one person, and within this group many mentioned a recent shelter friend or a professional contact. Overall, one-fourth named their minor child. Almost three-quarters of the mothers were unable to name three supports. If the interview had included questions about the quality of these relationships, the percentages of mothers unable to list such relationships would have been even greater.[26]

Why do homeless families have fewer supports than housed families? Although homelessness itself may stress and weaken relationships, many homeless mothers, unlike housed mothers, are already estranged from their families when they become homeless. In a study comparing 49 homeless female-headed families with 81 housed female-headed families in Boston,[27] housed and homeless mothers report similar rates of divorce, illness, and death in their nuclear families. However, homeless mothers experienced more family violence than the housed. Of the homeless women responding to the question, more than 40% reported having been abused as children. The violence continued into their adult lives: approximately 40% described abuse by their boyfriends or husbands. Also, more homeless than housed mothers were being investigated for abuse or neglect of their own children. The greater frequency of family violence suffered by the homeless mothers may explain, in

23. *Id.*
24. *Id.* at 1098-1099.
25. Bassuk & Rosenberg, *supra* note 7, at 3.
26. Bassuk, Rubin, & Lauriat, *supra* note 7, at 1097-1101.
27. *See generally* Bassuk & Rosenberg, *supra* note 7.

part, their difficulty forming and maintaining adequate supportive relationships.

In addition to physical and marital abuse, many sheltered homeless mothers interviewed in the Massachusetts Study reported that their boyfriends or spouses had poor work histories, substance abuse problems, and criminal histories.[28] Most of these men were unable or unwilling to provide child support.

Despite the nature and extent of homeless families' problems, few sustain contact with any support agencies. Citing "bad" experiences with workers, many homeless mothers refuse help because "it does no good anyway."[29]

Not surprisingly, the degrading experience of becoming homeless and the practical problems of living in emergency facilities exacerbate the long-term difficulties of these families. Shelters are frequently crowded and unsafe, and guests lack privacy. Families living in hotel rooms are often without refrigeration, accessible transportation, and relief from the constant demands of young children.[30]

A subgroup of homeless families, categorized as "multi-problem families," experience the problems described above[31] in greater combination and with more severity. "Their family relationships are disturbed or disrupted; their relationships to relatives, neighborhood, and community are marked by conflict or hostile detachment; and their handling of health, economic and household matters fails to meet the minimum needs of its members."[32] More than other poor and homeless families, multi-problem families seek help only during crises, use a disproportionate amount of social services, terminate contact when the crisis is over, and resist ongoing treatment. Unlike adult individual homeless persons, these families generally do not suffer from chronic mental illness.[33]

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28. Bassuk, Rubin, & Lauriat, *supra* note 7, at 1098.

29. Unpublished information from case reports of homeless mothers interviewed by the author in the Massachusetts shelter studies, *supra* note 7.

30. For a revealing account of the living conditions of the homeless, see generally Gallagher, No Place Like Home: A Report on the Tragedy of Homeless Families and Their Children in Massachusetts (Mass. Comm. for Children and Youth, Inc. 1986); Stone, Bastone, Hartmen, *et al.*, Heartbreak Hotels: A Special Section on New York's Homeless, The Village Voice, Apr. 1, 1986, at 16-25.

31. *See supra* text accompanying notes 25-30.

32. D. Kronenfeld, M. Phillips, & J. Middleton, The Forgotten Ones: Treatment of Single Parent Multi-Problem Families in a Residential Setting 3 (U.S. Dept. Health and Human Services Grant No. 18-P90705/03, 1978-80). This study of homeless multi-problem families was conducted at the Henry St. Settlement Urban Family Center in New York City where they have served these families since 1972.

33. Bassuk & Rosenberg, *supra* note 7, at 3.

Based on available data and clinical experience, this author estimates that 5% to 15% of homeless families can be categorized as multi-problem families. Usually, multi-problem families were isolated from the community before becoming homeless, have moved many times, and have inadequate supportive relationships. Although they find parenting difficult, experience high rates of family violence, and may have substance abuse or psychiatric problems, they oppose seeking help or becoming involved in ongoing treatment. In addition, the children of these families often have severe developmental, educational, emotional, and medical problems.[34]

These observations point to a real need for long-term transitional housing for multi-problem homeless families. Because many of these families have difficulty developing meaningful relationships and are distrustful of others, they are less likely to become involved with case managers while living independently in the community. Paradoxically, it is often the neediest families who do not receive follow-up, sometimes with dire consequences. It is likely that these families would benefit from transitional housing programs with lengths of stay of more than one year.

II. Policy Responses to Homeless Families

The initial policy response to the desperate plight of homeless families was to develop a system of emergency shelters. This effort was premised on the erroneous assumption that homeless persons were merely the victims of transient economic misfortune. It was thought that short stays of approximately six weeks to three or four months in emergency shelters would provide families the respite necessary to find housing. With AFDC payments well below the poverty level in many states[35] and the housing crisis worsening,[36] this expectation has proven to be ill-founded. On an economic basis alone, it is easy to understand why many poor families are precariously housed and many others are unable to find housing. The majority of homeless families double-up in overcrowded apartments

34. *See generally* Bassuk & Rubin, *supra* note 7, at 281-84; Bassuk, Rubin, & Lauriat, *supra* note 7, at 1099.

35. Because increases in AFDC payments have failed to keep pace with inflation, recipients currently find themselves well below the poverty level. In Massachusetts, for example, a family of three receives a monthly allowance of $442, 43% below the 1986 federally established poverty level. *See* Gallagher, *supra* note 30, at 76.

36. For a description of the housing aspect of homelessness, see generally Bassuk, *supra* note 15, at 41-42; Hartman, The Housing Part of the Homelessness Problem, in The Mental Health Needs of Homeless Persons 71 (E. Bassuk ed. 1986).

with relatives and friends. Only a relatively small percentage must turn to emergency shelters.

A. Emergency Shelters

As growing numbers of families have joined the ranks of the homeless, some communities have increased their numbers of family shelters at remarkable rates. In Massachusetts, for example, the number of family shelters has grown from an estimated three in 1983 to fifty in 1988. Unfortunately, in many parts of the country there are few specialized programs for homeless families; instead, parents and children are sheltered with adult individual homeless persons, sometimes in congregate and barracks shelters.[37] Congregate shelters include family centers where each family has an apartment with private sleeping accomodations; barracks shelters lack such provisions. Commonly, emergency shelters are rapidly filled to capacity, and the overflow is housed in dilapidated welfare hotels and motels.

The relative lack of affordable housing across the country contributes to a devastating cycle of instability and homelessness. Unable to find stable housing, some families move from shelters back to apartments of friends or family, often becoming homeless again. Others succeed in finding apartments, but due to some combination of economic and noneconomic factors, such as family dysfunction and interpersonal difficulties, they lose their apartments and must turn to the shelters. Because data are lacking, the exact numbers of such familes are unknown. A report from New York City suggests that almost one-third of formerly homeless families who had relocated in a housing project were unable to maintain their homes.[38] According to the Massachusetts Study, more than 50% of the currently sheltered families had moved to emergency facilities at some point during the previous five years.[39] The increasing length of stays in emergency facilities also reflects the severity of the housing crisis. It is not uncommon for families to remain longer than a year,

37. There is considerable regional variation in the types of shelters. In Massachusetts, there are approximately 50 small neighborhood-based family shelters (less than 20 families); the overflow is placed in welfare hotels. In New York City, 74% of families are housed in welfare hotels; 11% in barracks-type shelters without private rooms; 8% in family centers where each family has an apartment; and 6% in shelters with private sleeping areas. The estimated cost of providing shelter in New York City in fiscal year 1987 was $159 million. *See* Dumpson, *supra* note 18, at 21, 23.

38. *See* Dumpson, *supra* note 18, at 19.

39. Bassuk, Rubin, & Lauriat, *supra* note 7, at 1099.

and some families have stayed in welfare hotels for longer than two years.

B. Types of Transitional Housing

Transitional facilities are one essential component of a comprehensive long-term system of care for homeless families. The term "transitional" housing, as it applies to homeless families, generally refers to a range of facilities that attempts to bridge the gap between homelessness and permanent housing by providing support services and interim residence. The average length of stay, ranging from eight months to a maximum of two years, is longer than in most emergency shelters.[40] For the purposes of this discussion, "short-term" transitional programs will be contrasted with a "long-term" transitional housing model that this author suggests should be developed for multi-problem homeless families.[41] Although short- and long-term transitional facilities may overlap in program philosophy, characteristics, and even lengths of stay, the long-term transitional facilities adopt various programmatic elements from mental health models, offer more specialized services, and are more highly structured and supervised.

1. Short-term transitional housing. Short-term transitional housing generally includes most existing programs as well as those funded by the McKinney Act.[42] The purpose of these programs is to help persons overcome the crisis of homelessness. These programs attempt to provide families with enough time to find stable housing and to mobilize essential resources that will help make their transition into the community successful.[43] Goals include teaching the skills necessary for successful community reintegration and economic self-sufficiency, helping low-income women to parent effectively, and empowering mothers to take control of their lives. These goals are often achieved through an array of programs, such as educational and vocational training, parenting skills groups, and life-

40. Thus, the term transitional also can refer to those long-term emergency shelters that offer support services. Some of them provide an effective bridge into the community by offering comprehensive services and temporary housing.

41. Although many transitional facilities have specific admission criteria, such as teen-age motherhood, previous criminal history, and history of battering, few facilities limit their clientele to multi-problem families.

42. *See supra* note 10.

43. For an excellent description of the planning, development, and operation of short-term transitional facilities, see Women's Institute for Housing and Economic Development, A Manual on Transitional Housing (1986) [hereinafter Manual on Transitional Housing].

planning activities that include homemaking and budgeting. In addition, since most homeless families are disconnected from supportive relationships and caretaking institutions, mothers are encouraged to learn interpersonal skills, to mobilize new supports, and to re-establish old ones. Ideally, relationships formed during a family's stay in a transitional facility will continue after it moves into permanent housing.

In an ideal world, a family who became homeless would be rehoused rapidly in a stable residence in a community that offered comprehensive support services. The bleak realities of the housing crisis and lack of adequate supports, however, cause some families to turn to emergency shelters or transitional programs. Although many of these families could maintain independent housing, especially if offered case management services and appropriate community supports, they are forced to wait indefinitely until affordable housing becomes available. Short-term transitional facililities become an attractive option because the wait for permanent housing may be long and the communities to which families are returning often have sparse services. If the housing supply was ample and coordinated community services readily available, short-term transitional facilities would be a costly choice.

The House of Ruth in Los Angeles, California, represents a short-term transitional housing model. It serves a total of 10 women and children. The following statement describes the goals of the program:

> We strive to foster self-sufficiency in women who have been demoralized by poverty and homelessness. [They] may stay up to one year as they move toward independent living. [Because we offer] support services, such as job training, child care and mental health counseling, women are able to develop the skills they need to live independent and productive lives. By providing a supportive atmosphere where our guests feel both safe and respected, we help women and children realize again their dignity and self-worth.[44]

In many states, similar short-term transitional housing programs are springing up. For example, since 1985 the Connecticut legislature has allocated almost $8 million for housing both homeless families and adult individuals. In March 1988, $6.5 million had been committed to fund nine housing projects, of which five are multi-family residences. The legislators anticipate that four more transitional programs for homeless families will be approved this year;

44. Letter from Nancy Berlin, Coordinator of the House of Ruth (Dec. 17, 1987) (on file with author).

they are requesting an additional $8 million for both homeless families and individuals in 1989.[45]

2. Long-term transitional facilities for homeless multi-problem families. Homeless multi-problem families require the specialized services and intensive supports, supervision, and structure of long-term transitional facilities. To engage these families in a meaningful therapeutic process and to help develop trusting relationships, they must often stay in transitional housing longer than short-term programs permit.

This concept of long-term transitional housing has arisen from various residential models developed in a mental health context. For example, halfway houses provide a transition from the hospital to the community for the mentally ill. Historically, such specialized residential programs have provided disabled individuals with adequate housing and essential support services. For those disabled persons who cannot be rehabilitated, these residential programs offer safe and friendly permanent asylum in the community.[46] Similarly, transitional housing can be used to assist individuals and families who are socially disabled.

Many short-term transitional housing programs share a philosophical orientation both with residential programs that serve chronically mentally ill or mentally retarded citizens[47] and with the model for long-term transitional programs described in this section. All of these programs are designed to foster an individual's "psychological, psychosocial and behavioral" growth.[48] Characteristics of the program, staff size and level of supervision, and structure vary depending on the clients' special needs.

Long-term transitional programs that serve homeless multi-problem families should adopt various components from mental health

45. Telephone interviews with Marcy Levine-Holdowsky, Coordinator of the Regional Council for the Homeless, Bridgeport, Conn., and Fran Cubeta, Supervisor of the Homelessness Unit, Connecticut Department of Housing, Bridgeport, Conn. (Mar. 1988).

46. Grob, Psychosocial Rehabilitation Centers: Old Wine in a New Bottle, in The Chronic Psychiatric Patient in the Community: Principles of Treatment 265, 265-80 (I. Barofsky & R. Budson eds. 1983).

47. Budson, Residential Care for the Chronically Mentally Ill, in The Chronic Psychiatric Patient in the Community 281, 281-308 (I. Barofsky & R. Budson eds. 1983). "The entire [residential] program is organized with the recognition that it plays a central role facilitating the resident's development at different psychological, psychosocial and behavioral levels. It encourages individual psychological growth; it fosters socialization by creating an internal social system within the residential milieu; and it enables the resident to play meaningful roles in a variety of external systems—vocational, family, avocational and others." *Id.* at 281.

48. *Id.*

models. These facilities require staffing by mental health professionals, such as psychiatric social workers, psychiatric nurse practitioners, substance abuse counselors, family therapists, and child development specialists. Professionals can play an invaluable role in the process of engaging members of multi-problem families in long-term supportive relationships. In addition, these facilities should aim to provide the intensity and continuity of care required by multi-problem families.

To determine if a family needs placement in a long-term facility with specialized services, clinical staff should complete a multidisciplinary assessment of the family unit and individual family members and develop a case plan with specific short- and long-term treatment goals. In addition to determining psychological and medical needs, the assessment should focus on housing, income, educational, and job requirements. Special attention should be given to the developmental, emotional, medical, and educational needs of the children.

In general, these programs should adopt a multilevel (i.e., group, family, and individual) orientation that balances the need for structure, supervision, and interdependence with the need for independence and self-sufficiency. Most important, given the severely deprived backgrounds of many homeless mothers, the staff must view the process of engaging family members in supportive, nurturing relationships as long-term.

III. Drawbacks of Transitional Housing

Transitional housing programs offer many potential benefits to homeless clients, but they incur various costs as well, including financial costs to society and psychological costs to their residents. These costs may increase in programs that have longer lengths of stay.

One of the primary psychological costs of transitional housing involves restrictions placed upon the personal freedom of residents. In this and similar contexts, members of the legal community often refer to the "least restrictive alternative," the idea that "people should in general be free to live as they please."[49] This principle has prevailed in several judicial decisions regarding the involuntary commitment of severely mentally ill patients. Judges have ruled that caretakers must investigate the availability of less confining alterna-

49. Chambers, Community Based Treatment and The Constitution: The Principle of The Least Restrictive Alternative, in Alternatives to Mental Hospital Treatment 23, 23-29 (L. Stein & M. Test eds. 1978).

tives.[50] These alternatives may include "voluntary or court-ordered outpatient treatment, day treatment in a hospital, . . . placement in the custody of a friend or relative, placement in a nursing home, . . . and home health aide services."[51]

Although transitional facilities are far less restrictive than hospitalization, they do require some sacrifice of personal autonomy compared to independent housing. When a family enrolls in a transitional housing program, it must agree to conform to the general rules of the establishment and to the implicit requirements of the milieu. It is assumed that clients must actively participate in program activities to become successfully reintegrated into the community. Generally, the choice of activities as well as the therapeutic goals and treatment plan are negotiable, but staff and peers expect that all members will participate in the program to some degree.

The inherent restrictiveness of a transitional housing program also may be reflected in clients' emotions. Generally, clients are more likely to become dependent and regressed in highly structured and supervised settings. At the extreme are patients hospitalized for lengthy periods who develop a syndrome called "institutionalism," which may be manifested by apathy, withdrawal, submission to authority, and dependence.[52] In fact, the movement toward deinstitutionalization began partially in response to a growing awareness of the negative impact of long-term hospitalization. Transitional facilities do not involve the same risks as hospitalization. Policymakers, however, must recognize the fine line between independence and dependence, and structure carefully the use of a restrictive environment as a vehicle for growth rather than for regression. Ideally, policymakers should seek a means of providing intensive support and supervision in the least restrictive community setting.

Specialized residential facilities for disadvantaged people, including transitional housing, may unwittingly "ghettoize" their clients and contribute to a process of social stigmatization. Regardless of the extent of community linkages and attempts to mainstream clients into existing programs, the public generally remains hostile and antagonistic to homeless persons living next door. Public education has tempered some of these responses, but community resistance to zoning for transitional housing remains formidable and the stigma associated with homelessness has not significantly dimin-

50. *Id.* at 25-26.
51. Lessard v. Schmidt, 349 F. Supp. 1078, 1096 (E.D. Wisc. 1972).
52. *See generally* J. Wing & G. Brown, Institutionalism and Schizophrenia (1970).

ished.[53] Moreover, transitional housing that targets multi-problem families carries the risk of isolating and sequestering that group and heightening neighborhood resistance. A possible solution is to mix client groups, programs, and lengths of stay within a single facility.

It also must be recognized that, like many residentially-based programs, transitional facilities represent only an interim step toward reintegrating families into society. When a family's tenure in the program is complete, it must find stable housing, uproot itself from the community in which it has been living, and face the emotional stress of yet another relocation. Although the family will presumably have developed adequate supports by this point, a major move within the same geographic locale is unsettling for even the most stable family.

Finally, the cost effectiveness of transitional programs remains a critical issue. Transitional housing is extremely expensive to build and to operate, especially where 24-hour on-site staff is required.[54] However, if other less costly approaches cannot ensure the same positive outcomes, the long-term benefits justify the short-term investment, especially when young children are involved. For example, the additional cost involved in providing adequate assistance for young children in homeless families may be substantially less than the eventual societal cost incurred as a result of neglect or inadequate parenting. If some of the developmental, emotional, and medical needs of young children are initially met, the later costs of health care, special education, public assistance, and crime may be partially defrayed or even eliminated.[55]

IV. Case Study: A Multi-Problem Family

Who are these multi-problem families? It would be helpful to delineate criteria for determining which homeless families fit into this

53. *See generally* Homelessness in America: Hearing Before the House Subcomm. on Housing and Community Development of the Comm. on Banking, Finance, and Urban Affairs (Dec. 15, 1982).

54. The costs of transitional facilities vary according to location, size, staffing patterns, on-site programs, and clients' ability to contribute to rent. For a general discussion of development and cost issues, see Manual on Transitional Housing, *supra* note 43.

The estimated development cost of a transitional housing program in Boston is approximately $1 million. This figure is based upon the construction of a three-story apartment structure on a 10,000 square foot property, accommodating eight families (24 persons), and providing common spaces for staff, families, and children.

55. *See generally* Report of the Select Comm. on Children, Youth, and Families, in Children In Need: Investment Strategies for the Educationally Disadvantaged 6, 7 (1987) (a statement by the Research and Policy Comm. of the Comm. for Economic Development).

category and therefore require the specialized services offered by long-term programs. These criteria, however, should serve only as general guidelines. As with any complicated clinical problem, it is preferable to refer a family only after thoroughly assessing the current status and developmental history of each family member and evaluating how the family unit functions. Paradoxically, many multi-problem families who would benefit from long-term transitional housing are difficult to engage in this type of ongoing evaluation and treatment.

Nonetheless, there are certain characteristics and background experiences common to many multi-problem families. While no single family may be considered "typical," the following case study is instructive. It describes a multi-problem family that might benefit from participating in a long-term transitional housing program.

> Linda is a nineteen-year-old single mother of a three-year-old boy, Tommy. They have been living in a family shelter for six months. She is eight months pregnant and plans to return to the shelter after the delivery.
>
> During Linda's childhood, her mother was severely disabled by a chronic alcohol problem and manic-depressive illness. Linda remembers her mother calling her names, beating and biting her, and locking her in the closet. Unable to tolerate the abuse, she became a runaway at age eight. Until the age of 15, she wandered the streets, was temporarily placed in various Department of Youth Services (DYS) facilities, and in a foster home where she was sexually abused. She never lived anywhere for longer than two years. Feeling helpless and hopeless, she overdosed when she was 15. Shortly thereafter, her older sister took her in, but when Linda became pregnant and refused to have an abortion, her sister threw her out. Desperate and frightened, with no place to go, she lived on the streets and in abandoned, rat-infested buildings.
>
> Since Tommy's birth three years ago, they have lived in 12 different places—in the apartments of several sisters, her mother, casual friends, and a boyfriend in Florida; in abandoned buildings; and in three family shelters. Until recently, Linda disciplined her son by beating him, but she stopped when he seemed frightened most of the time. Linda told the interviewer that he often had nightmares and difficulty sleeping. On evaluation, Tommy seemed shy and manifested major lags in multiple developmental areas.[56]

56. *See generally* Bassuk & Rubin, *supra* note 7. In this study, preschoolers were evaluated using the Denver Developmental Screening Test. Almost half were found to have a major developmental lag in at least one of the four areas tested: language development, gross motor skills, fine motor coordination, and personal/social development.

> Without work skills or a high school education, Linda's future is bleak. Despite her son's urgent needs and the intensive help she has received from the shelter staff, she has not found stable housing or a day-care program for him. With the exception of the Department of Public Welfare, which gives her a check, she has no contact with any social service agency.[57]

Sadly, Linda grew up without the safety and sustenance of a stable home and understandably lacks many of the skills necessary to create a home of her own. The "homes" she knew were terrifying places, and the adults to whom she was exposed were unpredictable and abusive. The normative experiences of her young life were characterized by violation, chaos, and violence. She was unprotected in the most fundamental ways. Without any role models or supports, she is now unable to establish a home for herself and Tommy, or to form sustaining, nourishing, adult relationships.

Linda was so severely traumatized as a young child that she now allows no one to get close to her. Although she was cordial and polite during her interview, she maintained a cold and measured distance. When asked to whom she turns during times of stress, she adamantly insisted that she can only depend on herself. "People are unreliable," she said. "I don't want to see any of my family. They're all crazy and my sister drinks. I stopped caring a long time ago. I just feel numb." In reference to the shelter staff, she said, "I don't need the kind of help they are trying to give me."

What do Linda and Tommy need? Kozol's analysis implies that if Linda were given a home of her own, her problems would be greatly ameliorated. That is highly unlikely. Understandably, Linda has profound difficulty relating to other people and is unable to use supportive relationships to buffer the inevitable stresses of daily living. Furthermore, she does not have the skills to run a household or to parent effectively. It is also doubtful that Linda would be able to manage in independent housing even if a skilled case manager were available to serve both as a counselor and a service broker. Without a helping relationship, Linda's life would be isolated and chaotic, even within permanent housing. Tommy, who is already severely developmentally impaired, would also continue to suffer. Without housing *and* supports, the quality of life for Linda and Tommy would continue to be extremely compromised.

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57. Bassuk, Homeless Families: Single Mothers and Their Children in Boston Shelters, in The Mental Health Needs of Homeless Persons 45, 50-51 (E. Bassuk ed. 1986). Adaptation of case description used with Linda's written permission, with all identifying data altered.

Transitional Housing

A long-term transitional program would offer Linda and Tommy the best hope for a fulfilling future. Such a program could help Linda overcome her distrust of other persons, improve her self-esteem, and empower her so that she can control her life. Given the extent of Linda's early traumas and the lack of meaningful relationships, it is unlikely that a single year's stay in a transitional program would be long enough to accomplish these goals. Linda herself needs considerable mothering, role-modeling, and opportunity for developing various life skills. This author's clinical experience with women like Linda suggests that one year could begin the process of engaging her in a meaningful relationship, but that forming a sustaining ongoing relationship that she would "use" and depend on would probably take far longer.

Long-term transitional programs can also provide many benefits to children such as Tommy. A childcare program would offer Linda much needed relief from a preschooler's demands and would ultimately benefit Tommy. Parent aide programs and parenting groups, which are sometimes attached to a child's preschool program, might help Linda parent Tommy more effectively. For Tommy, participating in a preschool program (e.g., developmental day care, Head Start[58]) would offer him ongoing contact with stable, mature adults and opportunities for socializing with other children. These programs might also help him advance developmentally.

Would Linda agree to participate in such a program, given her bitter complaints about the restrictiveness of the shelter in which she had been staying? Currently she has little choice since housing is unavailable, but a properly constructed program need not be viewed by homeless families as simply the lesser of two evils. The initial stay in an emergency shelter prior to transitional housing may be used by a therapeutically skilled and patient counselor to help Linda overcome her resistance to help. Furthermore, the transitional program should allow Linda considerable freedom and privacy; it is clear from Linda's view of her previous experience with social service programs that only a long-term, flexible, and individually tailored approach would be successful.

58. The Economic Opportunity Act of 1964, Pub. L. No. 88-452, 78 Stat. 508, (codified at 42 U.S.C. §§ 2701-2996 (1982)). Project Head Start provides comprehensive developmental services for low-income preschool children and their families. For a discussion of the program's history and development, see Miller, Head Start: A Moving Target, 5 Yale L. & Pol'y Rev. 322 (1987).

V. The Need for a Long-Term Coordinated System

Ignoring the psychological component of the homelessness phenomenon can only invite misguided policy decisions. Only by acknowledging and addressing the psychological problems of homeless persons can we provide appropriate services, improve quality of life, and, for some persons, prevent homelessness from recurring.[59] Homeless families need stable housing and adequate income maintenance, reconnection to supports, and various degrees of educational, vocational, medical, and social welfare services.

Homeless families vary as to the amount and intensity of assistance they need to accomplish the difficult transition back into the community. Clinical experience and descriptive data about the characteristics of homeless family members suggest that many families would be able to maintain stable homes if they were provided independent housing in conjunction with case management services and supports. In addition to housing, these families require a therapeutic environment, including job training and support groups, that could be provided in the community.

Given the realities of the housing market and the availability of community services, a second category of families requires on-site support services for the short-term. Transitional programs with average lengths of stay approaching one year fulfill an essential function for families who are demoralized by poverty and homelessness and unable to move back to communities that have adequate services.

Even the level of care provided by short-term transitional programs, however, is insufficient for a third group, homeless multiproblem families. These families require longer stays in transitional facilities in order to develop trusting, supportive relationships and to learn the skills necessary to maintain a home in the community. Despite the availability of community programs and decent housing, longer-term residential programs are essential and potentially lifesaving for some families.

Transitional housing programs have sprung up not only in response to the real needs of many homeless families, but also in response to the serious limitations of the emergency shelter system,

59. *See* W. Wilson, The Truly Disadvantaged: The Inner City, the Underclass and Public Policy (1987). Wilson comments that "those who represent the traditional liberal views on social issues have failed to address straightforwardly the rise of social pathologies in the ghetto" because of concern about "blaming the victim" and emphasizes the importance of doing so. *Id.* at 12. *See also* W. Ryan, Blaming the Victim (1976).

the scarcity of community services, and the lack of available low-income housing. Consequently, transitional facilities generally serve several important functions: they provide interim housing; they provide the comprehensive support services that many emergency facilities are unable to provide; they offer various community services through their linkages with private and public agencies; and they help reconnect families to essential supports. Although the current system is complex, additional transitional programs would provide much needed services to homeless families and a place of refuge during the often lengthy process of finding a stable residence. Such programs are more humane than many emergency shelters and welfare hotels, solve the immediate housing problem, and provide a range of needed services. Given the stark realities of the housing crisis, as well as the limitations of our social welfare system, the drawbacks of transitional housing appear minor indeed.

Before expanding the current system by building more transitional programs, however, it is imperative that policymakers avoid repeating previous mistakes. They should not allow another system of care for homeless families to develop ad hoc without adequate long-term planning. Policymakers should develop long-range strategies that consider a family's needs at four stages in the homelessness cycle: (1) when a family is at high risk of becoming homeless; (2) when a family first becomes homeless; (3) during the transition back into the community; and (4) once stable housing has been found. The functions of emergency shelters must be coordinated with transitional programs and ultimately with community services once the family has moved into permanent housing. Such coordination will require evaluation of each family's need for stable housing, adequate income maintenance, and supportive relationships. Theoretically, society can provide a therapeutic environment in the community for most families. For the small subgroup of multi-problem homeless families, long-term transitional housing programs with intensive on-site services must also be developed.

While we must heed Jonathan Kozol's plea for an increase in the supply of affordable housing, it is clear that we must do more. We must introduce broad systemic changes that include the development and coordination of transitional housing programs and community services. Kozol's Laura and her children will continue to suffer unless they are offered intensive and specialized care. Regardless of whether they meet all the criteria defining a multi-problem family, they have complex social, medical, emotional,

developmental, and educational needs that must be addressed. Laura and her children must have far more than a roof over their heads if they are to successfully maintain a "home" in the community.