Homeless Mothers and Depression: Misdirected Policy*

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This paper is a critique of recent service-intensive shelter programs for homeless mothers and the policies that underlie these shelters. We first document the process by which mental health problems and family homelessness became so closely but mistakenly linked. We then demonstrate empirically that shelter programs for homeless families nonetheless presume that mental health problems are part of the causal nexus of family homelessness and indiscriminately deliver mental health services to homeless mothers. Simultaneously, shelter programs encourage the isolation of their residents from what they presume to be their "problematic" social networks. We show that, while mental health services had little impact on depression levels among homeless mothers, isolation from social networks did increase depression among homeless mothers. Our findings suggest that policy should put more emphasis on rapid reintegration into the community through providing housing, and it should put less emphasis on providing services.

During the 1990s, the decade-long policy of placing homeless families in welfare hotels gradually gave way to new initiatives organized around shelters offering intensive services. These shelters often were well-kept facilities with individual rooms or apartments replete with counseling services, educational programs, and remedial "life management" training (New York Mayoral Office 1992; Rossi 1994).

Implicit in the goals and character of these "service-intensive" shelters was the assumption that the personal problems of homeless parents had caused their homelessness. As Snow, Anderson, and Koegel (1994) have argued, scholars and policy makers often discuss homeless people using a "language of disability" (p. 467)—a rhetoric that formulates homelessness as a social phenomenon caused by the deficiencies of individuals. The premises behind this new vocabulary derived in large part from the first round of research into the wave of homelessness that began in the 1970s, and became embedded in the policy apparatus that developed and matured in the late 1980s and early 1990s. (For a partial list of such research, see note 4).

The most visible sign of this new perspec-

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tive was the integration of services aimed at ameliorating the psychological problems of homeless parents into the shelter program strategy (Bogard et al. 1995). By the early 1990s, Rossi (1994:368) reported that 85 percent of family shelters in the nation required that residents receive some form of counseling; most made participation a prerequisite for assistance with permanent housing (Bogard and McConnell 1994; Gerstel et al. 1996).

A less visible but equally pervasive expression of the language of disability was the denigration of the social networks of the homeless. One research tradition, building on much earlier work on "hobos" in the 1930s, portrayed homeless people as socially isolated or disaffiliated.[1] Another, deriving from the culture of deprivation tradition, viewed social relationships of homeless mothers as a negative influence on their willingness and ability to establish a stable household.[2] Taken together, these two premises led to shelter policies that either moved homeless families far from their community of origin or deliberately restricted or prohibited contact with friends and family.

Almost as soon as the parameters of the new shelter system were discernible, a critical literature began to develop questioning both the assumptions underlying the new perspective and its effectiveness in reestablishing homeless people in permanent housing.[3] In this paper we extend that critical literature by investigating two central foci of service-intensive shelters: (1) the utilization of mental health treatment as a primary component of the shelter service package and (2) the policy of isolating sheltered families from their communities of origin.

We begin with a brief history of the development of public policy concerning homelessness in the past twenty years. We next review and critique research connecting homelessness with mental health problems that served as a basis for much homelessness policy. We then turn to findings from our own longitudinal study of family shelters.

LINKING POOR MENTAL HEALTH TO HOMELESSNESS: RESOURCES, RESEARCH, AND POLICY DEVELOPMENT

The idea that mental health problems were integrally linked to homelessness gradually became embedded in the literature, in part because, during the re-emergence of homelessness in the late 1970s, deinstitutionalization from state mental hospitals was pointed to as a primary factor underlying it (Bassuk 1984; Bassuk, Rubin, and Lauriat 1984; Baxter and Hopper 1981; Herman 1980; Sulzberger 1981; for a critique, see Blau 1992; Ropers 1988 and Bogard [unpublished]). During the 1980s, the National Institutes for Mental Health (NIMH) provided much of the funding for research on homelessness. It sponsored ten major research studies that became the primary scholarly work in this area and, in a subsequent review of NIMH-funded research on homelessness, suggested that further research focus on still other mental health aspects of homelessness (Tessler and Dennis 1989). A measure of the dominance of this focus in scholarly work on the homeless can be found in Toro and Warren's (1991) search of the psychological indexes: Of 341 articles on homelessness, 75 percent were devoted to an examination of mental health as a key causal factor.[4]

This vast body of research made psychotherapy an obvious candidate for inclusion as a key element of the service package in the new shelters that began to develop in the late 1980s. Additional impetus for this focus was found in the availability of resources and new legislation on homelessness. Mental health services were Medicaid billable and therefore provided an important source of funding for shelters (Gerstel et al. 1996).

The drift toward service-intensive shelters was officially validated and given further financial and policy impetus by federal legislation in the Stewart B. McKinney Act of 1987 (U. S. Congress 1987). In the midst of draconian cutbacks in social services during the Reagan administration, the original McKinney legislation earmarked $589 million over a two-year period for temporary, service-intensive shelters, including $180 million for "demonstration projects." In contrast, direct subsidies for permanent housing amounted to only $70 million, with that money reserved for homeless individuals labeled as having permanent mental or physical disabilities.

The McKinney Act introduced the concept of "supportive housing" into the lexicon of social service statutes (U. S. Congress 1987:500). To qualify for supportive housing

status, shelters had to provide a core of essential services, most notably substance-abuse treatment, mental health counseling, job training, and education for homeless children. These services were deemed necessary, as the act stated, for "achieving independent living" (p. 498); without them, the reasoning went, most homeless families would not be able to sustain a household after leaving the shelter. With these services, however, a five-to-six month stay in a service-intensive shelter would make families "housing ready"—that is, capable of finding and keeping a permanent dwelling. Though subsequent federal guidelines allocated some resources for housing assistance, the 1987 policy established an institutional framework for sheltered homeless families that insured that the treatment of their personal problems would be the dominant policy emphasis for the next decade.

The early wave of homelessness research and the policy of supportive housing that followed this research has itself been subjected to several important lines of criticism (for a detailed summary, see Snow et al. 1994; Rossi 1994). First, almost all of the early studies that found mental illness in a large proportion of the homeless were based on cross-sectional samples. Whether used to sample street or sheltered homeless populations, this prevalence method greatly oversamples the small minority of those who stay on the streets or in shelters for extended periods of time, while capturing only a small proportion of that much larger group that has brief sojourns of homelessness. Since serious or chronic mental health problems often make finding and keeping a residence more difficult, cross-sectional sampling inevitably results in an overestimate of this segment of the population. The magnitude of the distortion is quite large. Sampling strategies based on the incidence of homelessness in the previous five years in a national random sample of U.S. citizens demonstrated that, from 1989 to 1994, the "chronic" part of the homeless population—the long term homeless—made up just 7 percent of the total number of people who became homeless each year (Link et al. 1994). This stands in sharp contrast to prior cross-sectional studies which, because they were cross sectional, typically found that, on any particular day, long-term homeless people accounted for about 50 percent of that day's homeless population (Jencks 1994; Schwartz [unpublished]).

Second, much of the early mental-health-related research focused on single street dwellers. Generalizing from this population presumed similar high levels of mental-health problems would be found among heads of homeless families targeted by service-intensive shelter policies (Baxter and Hopper 1981; Segal, Baumohl, and Johnson 1977). This assumption remained empirically unchallenged until research focused on family homelessness began to appear in the late 1980s (Burt and Cohen 1989).

Third, early research often used poorly chosen comparison groups. Rossi, for example, found higher rates of depression among the homeless than in the general population (1989). Since the homeless are not drawn from the general population—they overwhelmingly are drawn from already impoverished populations—a comparison with the general population has little utility (Knickman and Weitzman 1989). Moreover, these early studies of depression were based on samples of single homeless men. Since both gender and status as a custodial parent are important influences on rates of mental illness, these measurements were particularly suspect when applied to the mainly female heads of homeless households.[5]

Working together, these factors produced dramatic overestimates of the centrality of mental health concerns to homelessness that were particularly inaccurate when applied to homeless mothers living with their children. Yet this was the empirical data that was used to validate, or at least justify, the concept of "supportive housing" for these mothers.[6]

RESEARCH QUESTIONS

We now turn to our longitudinal study of homeless families residing at family shelters. We address two research questions. First, we compare levels of depression between the homeless mothers we studied and an equivalent sample of economically dislocated and socially disadvantaged, but housed, custodial mothers. A 1990 review (Susser et al.) of the literature on mental health problems among homeless people found that only Bassuk and Rosenberg (1988) had attempted such a careful comparison among comparable groups of homeless and nonhomeless mothers. While this study found slightly higher rates of psychopathology among the homeless mothers,

Bassuk and Rosenberg concluded that prevalence rates of psychopathology were too low to be a major factor in the loss of housing.

Beyond providing needed replication of Bassuk and Rosenberg,[7] our measurement corrects two problems in the earlier study. First, the earlier study suffered from the problems in cross sectional sampling mentioned above. Second, the method used to diagnose mental disorder in the 1988 study may have been contaminated by experimenter bias. As Susser and his colleagues commented in their review of this research, "There might even have been an overestimation of the proportion with severe psychopathology, since the investigator who made the psychiatric diagnoses was not blind to whether the mother was homeless or housed" (Susser et al. 1990:7).

Our second research question relates to the connection between mental health services and the psychological status of a homeless population. As Susser et al. (1990) wrote, only a longitudinal study can effectively address this issue:

> When possible, a sample of newly homeless persons should be followed over time, to describe a "natural history" for homelessness. The factors that influence the pattern and duration of homelessness, and the role of homelessness as a cause of mental disorder, may then be clarified (p. 12).

That is what we will do in the second section of our paper. This section examines the impact on depressive symptoms of the mental health services offered in shelters, controlling for the full range of other influences, including various demographic characteristics, key life events before and during their sojourn, and the social isolation shelters impose on the families. Unlike cross-sectional research, our longitudinal data allow us to examine which factors actually affect depressive symptomatology by comparing the psychological state of homeless mothers at the onset of a homeless episode with their psychological state after living in a shelter designed in part to treat that state.

DATA AND METHODS

Sample

The data for this study are derived from a three-year, three-wave, longitudinal study of homeless families in Westchester County, New York. We collected systematic information on 340 families who sought emergency housing from the Westchester County Department of Social Services between January 1 and December 31 of 1992 and who were then assigned to one of ten shelters for homeless families.[8] We followed these families (virtually all of those who became officially homeless in the county in 1992; the refusal rate was less than 5 percent) through their stay in one or more of the county's ten family shelters and into other housing situations. Because this research is drawn over a year-long period and approximates the entire population of those requesting shelter in 1992, it does not oversample the long-term homeless.

We conducted interviews at three points in time: wave 1, shortly after entry into the system; wave 2, after at least six months had passed during which homeless families experienced the service protocol of the shelter to which they had been assigned; and wave 3, after at least a year had passed, when most had moved on to some other type of housing. (The average length of stay was 14.3 months for families entering at the onset of the study—in early 1992—and nine months for those entering later in the year.) In addition, we had access to the official records of the Westchester County Department of Social Services, which allowed us to track movements among shelters and departures from the shelter system. In this paper, we focus primarily on waves 1 and 2.

We limit this analysis to women because such a small portion of our sample is male and because the experiences of homeless women and men differ so markedly. When we compare the mental health and backgrounds of mothers to other populations we use the entire wave 1 sample of women ($n = 298$). In order to address changes in depression during homelessness we only use those mothers reinterviewed at wave 2 ($n = 225$). Our analysis indicates that those who we were not able to reinterview do not differ markedly from the retained part of the sample on various critical demographic variables (including age, race, number of children, marital and nonmarital partner status, and level of education), or on network size or depressive symptoms at wave 1. In addition, we employ observational data from our three years of regular site observa-

tions and our attendance at various policy and staff meetings and material from 63 taped qualitative interviews, most of them conducted while our respondents were living in a shelter. We use these data to contextualize our quantitative findings.

The Interview

The quantitative research consisted of face-to-face interviews containing standardized, detailed measures of life events, mental health, social networks, shelter conditions, and sociodemographic characteristics.

Adapting the life history calendar technique developed by the Michigan Panel Study on Income Dynamics for collecting retrospective data (Freedman et al. 1988), our interviews covered numerous relevant life events. In this paper we rely on that portion of the life history that covered spells of psychiatric institutionalization, work history, and marital and nonmarital relationship history.

Because so much literature stresses the disaffiliation of homeless people and policy emphasizes isolating them from previous social ties (for reviews, see Rossi 1989; Shinn 1992), we obtained detailed data on the social networks of our respondents. Adapting Claude Fischer's (1982) method for collecting information on helping networks, interviewers asked respondents to name all those individuals who had provided financial, practical, emotional, or social support. We also asked respondents whether there were other important people in their life during the previous six months. This method enabled us to obtain a full network list and a measure of network size. Because we used this technique in all waves of the study, we have measures of changes in respondents' networks. As part of a self-administered assessment of the shelter facility in wave 2, we also asked respondents whether they felt they had lost touch with their families.

As a measure of psychological well-being, each respondent answered the full Center for Epidemiologic Studies Depression Scale (CES-D) in every wave of the study.[9] The CES-D scale has been used extensively in study populations of all sorts and has demonstrated both reliability and validity (Radloff 1977; Weissman et al. 1977). In our analysis, the scale has a reliability coefficient (Chronbach's alpha) of .87 for wave 1 and .86 for wave 2.

The CES-D scale was not intended for use as a clinical diagnosis tool, nor is it able to distinguish between clinical subcategories such as primary and secondary depression. Some scholars have suggested that the scale is best thought of as a measure of demoralization—or depressive symptoms—directly resulting from unfortunate life events or ongoing despair which is related to (but not synonymous with) clinical depression (Link and Dohrenwend 1980). For our mental health measures we used mean CES-D scores at waves 1 and 2. In discussing these scores we refer to them as indicators of depressive symptoms.

In the wave 2 interview we measured service utilization among homeless parents during their shelter stays. Respondents were read a twenty-two-item list of services, including all those offered in the county shelters. The list included questions about whether respondents had received mental health counseling or case management. Positive responses were added to create a continuous variable reflecting the number of these mental health services received by each respondent.

We also included a number of measures of life events during shelter stay. In particular, we asked whether they had separated from a partner and whether or not they were living with a partner at the time of the interview.

To compare homeless mothers to an otherwise comparable sample of housed mothers, we used data from the Live Birth Survey (LBS) conducted in 1991. The LBS, conducted under the auspices of the Department of Health and Human Services, was a followup to the National Maternal and Infant Health Survey conducted in 1988. The LBS obtained data on health issues, with a particular focus on children's health, by surveying women who had completed the baseline questionnaire in 1988 and whose children were alive at the time of the 1991 interview. African American women and women who had given birth to low birth weight infants were over sampled in the original study, which otherwise was a national random sample of women of childbearing age. The 1991 followup study had 8,285 cases. In addition to standard demographic variables and a range of questions about financial status (e.g., household income, Aid to Families with Dependent Children and Medicaid status), the

questionnaire contained the full twenty-item CES-D scale.

This sample therefore offered a good comparison with our study of homeless mothers on several counts: (1) identical measures of depressive symptoms were used; (2) African American women were over sampled (they are disproportionately represented among homeless mothers); and (3) all respondents were women of childbearing age, as were our respondents.

Research Sites

The homeless families we studied entered ten different shelters, ranging from a dilapidated welfare hotel to a beautiful condominium-like structure set in a forest. All but the welfare hotel were located in suburban neighborhoods. At the onset of our study, some shelters offered a wide array of services; others offered little beyond barely-adequate housing accommodations. Two of the shelters in our study were Housing Enterprises for the Less Privileged (HELP) shelters; HELP was one of three national service-intensive demonstration programs funded through McKinney legislation. The HELP program was designed by Andrew Cuomo—who became the nation's "housing czar" in 1993. As an undersecretary at the Department of Housing and Urban Development (HUD) he oversaw a national expansion of service-intensive shelters. Cuomo became the Secretary of HUD in 1996. Thus, in its general outline, HELP became the model upon which many shelter service programs of the 1990s were based.

The HELP shelters in our study assessed and treated personal pathologies, including mental health concerns. During the longitudinal study the basic structure of HELP inspired the Westchester County Department of Social Services to encourage complex service protocols in the other shelters. This, however, left ample variation in the number of services available to, and utilized by, individual families.

Shelter policy promoting social isolation from former social ties formed an important aspect of a policy that pathologized the behaviors of homeless mothers. Shelters with intensive service programs typically discouraged their residents from contact with kin or friends outside the shelter, based on the assumption that the types of individuals homeless women had in their networks were likely to exacerbate the reasons for the spell of homelessness. This assumption had little face validity; the number of women with overt reasons to seek isolation was very small. Only ten respondents (3.3 percent) in our sample listed domestic violence as the sole reason why they had lost their housing; another ten respondents listed this as one of several reasons.[10] For over 90 percent of our respondents, then, desire for isolation from past network members was not a reason given for becoming homeless.

Yet rules segregating residents from others were quite encompassing at some shelters: they included prohibitions against unauthorized visits by outsiders, curfews for adults as well as children, and limitations on the amount of time that residents could spend away from the shelters. Visiting rules and the perpetual presence of security guards limited interaction with friends and relatives; barbed wire fences, security cameras, and security guards limited interaction with the surrounding community. Guards who broke up congregating residents and the resulting feeling of supervision in common areas limited interactions among residents. Overall, then, service-intensive shelters sought to rehabilitate their residents through both treatment and isolation from the purportedly dangerous communities from which they came.[11]

Sample Characteristics

Table 1 demonstrates that key personal characteristics of our sample at the time individuals entered the shelter system are similar to those found in other studies of homeless families.

Most of our families were small (2.5 children is the sample mean, while 2.1 is the national average); African American (69 percent in our study; 54 percent nationally) and were headed by single mothers (85 percent in our study; 81 percent nationally). About half of the parents had been married (45 percent in our study; 53 percent nationally).

Although only a small minority of Westchester County homeless adults (17 percent) and those of other studies (20 percent) were working when they entered the shelter system, virtually all (93 percent) of our respondents had worked at some point in their

TABLE 1. Profile of Homeless Families in Westchester County, 1992, Compared to Other Studies

	Westchester County, NY	Other Studies of Homeless Families[a]		
		Median Value	Range	
			Lowest	Highest
Age (Median)	29	28	27	30
Women	86%	89%	73%	100%
Race				
African American	69%	54%	10%	91%
Latin American	16%	7%	2%	33%
European American	12%	30%	4%	85%
Other	2%	—	—	—
Marital History				
Never Married	55%	47%	14%	56%
Currently Single Parent	85%	81%	52%	100%
Total Number of Children (Mean)	2.5	2.1	1.5	2.7
Currently Live With (Mean)[b]	1.8	—	—	—
Ever Separated from Minor Child	32%			
Employment				
Current/Last Month	17%	20%	13%	26%
Ever	93%	74%	59%	89%
Education (Median Years)	12.0	—	—	—
Some College or Technical School	32%			
Personal Problems				
Hospitalized for Psychiatric Reasons	10%	8%	4%	14%
Ever in Substance Abuse Treatment	13%	17%	5%	32%
Neither of the Above	85%			

[a] Comparative figures taken from Rossi (1993). All comparative figures are based on nine studies except: Current Single Parent (N = 8); Current Employment (N = 1); Last Month Employment (N = 3); Ever Employed (N = 2); Percent Latino (N = 8).

[b] Total number of children included adult children not living with respondent and any children then living with other relatives, in foster care, or in other arrangements.

adult lives. The national figures, which show a median of 74 percent, are somewhat lower, but this probably reflects the thoroughness of our life history methodology rather than a real difference in work experience. The majority of our respondents had graduated from high school (other studies did not collect comparable data on education). Our group is also similar to others on rates of prior institutionalization for mental illness. Ten percent of our sample reported ever being hospitalized for any mental illness; the average for other studies was 8 percent. These figures already begin to question the assumption of a pervasive association between mental illness and homeless mothers—a point we explore further below.

In short, the similarities between our sample and other studies suggest that the patterns we find among our respondents should apply to other families in similar settings elsewhere.

FINDINGS

Mental Distress and Homelessness: Comparing Homeless Mothers with Housed Mothers in Similar Circumstances

As many studies have documented, families who become homeless are overwhelmingly drawn from the ranks of the very poor (Burt 1992; Jencks 1994; Rossi 1989, 1993). To address the issue of whether mental health concerns, particularly depressive symptoms, are integrally linked to homelessness, homeless mothers are most reasonably compared with similarly poor but housed women. We compared our women respondents' wave 1 CES-D scores with scores of housed but otherwise similar mothers from the Live Birth Survey (LBS).

To accomplish this comparison we adjusted the scores from both the LBS study and our

own data. Since the LBS data were collected from a national random sample of women, we developed estimates of CES-D scores for destitute women in the LBS survey whose circumstances were comparable to those of our sample at the time they became homeless. To do this we regressed CES-D on key indicators of poverty and life conditions.[12] In performing this regression we tested for all interactions; only one was significant: Medicaid by age. The results are reported in Table 2. We then inserted the means for our Westchester sample of homeless mothers into the regression equation reported in Table 2 to obtain the best estimate for housed women comparable to our sample of homeless women.[13] The average CES-D score was 13.8 for these destitute but housed mothers. To compute the average score for our sample at the time of admission, an adjustment for time of first interview was needed. Our first interview usually took place within a month of admission to the shelter, but some interviews were conducted as long as 15 weeks after admission (mean = 2.63 weeks). Since CES-D levels rose during the period just after admission and then declined later, we needed to control for this effect in order to calculate CES-D at the time of admission. We again utilized ordinary least squares (OLS) regression, with time-since-admission and time-since-admission-squared as regressors. When we set the time variable equal to zero to estimate the average CES-D at entry, the average score as indicated by the intercept was 15.2, and both variables were significant.[14] These results are reported in Table 3. We also modeled this effect using a variety of control variables which also significantly affected CES-D level, but none of these interacted with time, and, therefore, the full model gave the same results as the model with only time as an independent variable. Key control variables tested were: whether respondents left their last housing voluntarily, number of prior marriages, highest pay ever received, and percent of lifetime spent in institutions.

The two scores were therefore 15.2 for homeless women when entering the shelter and 13.8 for similarly destitute but housed women. While this difference of 1.6 is statistically significant, it is only about one seventh of a standard deviation, which is substantively small.[15] Moreover, it confirms and broadens the earlier finding of Bassuk and Rosenberg (1988) that depressive symptoms are not a strong distinguishing characteristic of poor mothers who became homeless.

From this result it is apparent that mental health concerns (at least insofar as they are measured by depressive symptoms) are not a key determinant of homelessness for mother-headed families. Levels of depressive symptomatology among homeless mothers are similar to those of comparable mothers who are housed. Indeed, as Link et al. (1994) point out, a spell of homelessness is becoming increas-

TABLE 2. Regression of CES-D Scores on Key Indicators of Homelessness—Live Birth Study

	B Coefficient	SE
Control Variables		
Age (in years)	−.15***	.02
High School Degree (1 = yes; 2 = no)	−1.69***	.27
AFDC Status (1 = yes, 0 = no)	1.32***	.32
Medicaid Status (1 = yes, 0 = no)	−.87	1.08
Household Income (x $1000)	−.11***	.02
Respondent Living with a Partner	−.47*	.27
Race		
African American	1.04***	.24
Latina	.38	.38
Other Nonwhite	1.04	.62
Interaction		
Age × Medicaid	.08*	.04
Intercept	16.56	
R^2	.09	
Adjusted R^2	.09	
N = 8,285		

* $p < .05$; ** $p < .01$; *** $p < .001$ (adjusted for one or two-tailed test)

TABLE 3. Regression of CES-D on Time Since Entry into Shelter

	B Coefficient	SE
Months Since Entered Shelter		
Months	2.85*	1.74
Months Squared	−.45*	.25
Intercept	15.20	
R^2	.12	
Adjusted R^2	.10	
N = 225		

* $p < .05$ (one-tailed test)

ingly typical of a wide segment of impoverished families. Our results therefore give support to the growing body of literature indicating that homeless mothers are an unexceptional subset of impoverished mothers and that there are no systematic psychological differences that predispose them to homelessness.

On the other hand, it is important to note that both the homeless women in our sample and the economically destitute women in the LBS sample have extremely high scores on the CES-D when compared to the general population, which ordinarily averages about 8.5 (Rossi 1989:149). It is therefore logical to conclude that high levels of depressive symptomatology among homeless mothers (relative to the general population) may well be a result of their ongoing poverty—a measure of demoralization due to ongoing adverse living conditions (Link and Dohrenwend 1980).

This conclusion is further supported by our findings that women entering the shelter system typically experience a significant increase in depressive symptoms. For the average woman in our sample, CES-D scores increased steadily for the first four months of residence—reaching a maximum of 19.7 at 3.1 months after entering the shelter—and then declining just as quickly—returning to 15.2 at 6.3 months. This strongly supports the conclusion that both poverty and homelessness are key factors in *causing* depressive symptoms. Yet many shelter programs, including the ones we studied in Westchester County, presume the reverse causal order—that depression is the cause of homelessness, or at least that it prevents successful rehousing. This presumption results in policy that mandates an array of services that are presumed to be needed by homeless mothers. Successful completion of these services are often required before sheltered families are eligible for rehousing; the presumption here is that a continuation of the depression will contribute to a second homeless episode.

We now turn to a more direct examination of the impact of these services.

The Effects of Shelter Life on Depression

Our second set of questions concerns the effects of the shelter program on the depressive symptomology of homeless mothers. We begin by comparing the CES-D scale at waves 1 and 2 in order to begin assessing the effects of shelter life on depression. At admission (wave 1) our respondents had a mean score of 15.2 on the CES-D scale. At wave 2, after undergoing the service protocol, their mean score was 15.8 on the scale. A t-test demonstrates that there is no significant difference between these scores.[16]

Nevertheless, there were large and sometimes dramatic changes (in both directions) in CES-D scores for many of our respondents. We therefore used OLS regression to determine the extent to which these changes in depression scores were related to shelter programs or services and segregation from prior social networks. We also examined whether changed scores might be a consequence of other factors associated with shelter life or background characteristics of sheltered homeless mothers.

The regression contains three sets of independent variables: (1) shelter programs and conditions; (2) changes in social networks; and (3) individual characteristics, including life events and living arrangements of the respondents while living in the shelter. The key independent variables include two indicators of services received in the shelter (the number of mental health services received and the amount of caseworker contact) and two indicators of changes in social networks, one objective (change in the size of network) and one subjective (whether shelter life made them feel they had lost touch with family). We included marital status (single, living with partner, separated from partner during stay at shelter) because marital separation is a common consequence of homelessness and is a life event that often causes depression in nonhomeless populations (Gerstel 1994; Gerstel, Riessman, and Rosenfield 1986; Taylor, Bass,

and Hoeffler 1993). We also included three additional control variables: wave 1 CES-D, age, length of shelter stay, and whether respondents moved out of the shelter by wave 2.[17]

Our dependent variable was the CES-D score at wave 2. By controlling for CES-D scores at wave 1, we were able to ensure that we were only measuring the effects of events that occurred between waves 1 and 2.

First, as Table 4 indicates, the number of services received at the shelter conferred no mental health advantage on our sample, insofar as depressive symptoms measure mental health.[18] That is, given two groups of shelter residents with the same distribution of CES-D scores upon entry, if one were to receive the full battery of services and the other none at all, the two would emerge at the second test with no real differences in their average levels of depressive symptoms. If anything, there was a tendency (not statistically significant) for the well-serviced group to score slightly higher on the second CES-D protocol.

On the other hand, the frequency of contacts with a caseworker did tend to reduce respondents' level of depression. On average, in two groups of comparable individuals, the group with an average of eight extra visits would score one point lower on the CES-D at wave 2. However, since the null result for services indicates that it is not the mental health services performed by caseworkers that reduced depressive symptoms, we must look at other aspects of the casework relationship to explain this result. In the shelters, the main "nontherapeutic" tasks of caseworkers was assistance with filling out forms, referral calls to housing and social service agencies made on behalf of the respondent, and other resource-enhancing activities. That is, the caseworker became a highly skilled and resourceful member of the shelter resident's social network.

This interpretation of caseworker visits fits neatly into the results for the social network variables: Both a reduction in network size and the feeling of losing touch with key network members were significant predictors of increases in CES-D scores. That is, network isolation increased depressive symptoms, and enhanced network relations reduced them.

Third, family composition results contribute further to this pattern. Respondents who separated from a partner during this time had higher CES-D scores at wave 2. Women who did not have a partner living with them were also more likely to have increased feelings of depression at wave 2, as compared to comparable women who maintained a partnership

TABLE 4. Factors Associated With Changes in Depressive Symptoms[a] Among Sheltered Homeless Mothers

	B Coefficient	SE
Shelter Programs and Conditions		
Number of mental health services received	.28	.75
Number of visits with caseworker in the last month	–.12*	.07
Social Networks		
Felt they had lost touch with family while in shelter	.97*	.57
Change in size of social network[b]	–2.04*	1.25
Life Events and Living Arrangements		
Separated from spouse or partner since first interview	7.57**	2.48
Living with spouse or partner at second interview	–2.21*	1.30
Control Variables		
Wave 1 CES-D score	.54***	.06
Age	–.22**	.09
Length of stay at current shelter (months)	5.35E-03	.004
Moved out of shelter by wave 2	1.67	1.44
Intercept	11.98***	3.58
R^2	.35	
Adjusted R^2	.32	
N = 225		

* $p < .05$; ** $p < .01$; *** $p < .001$ (adjusted for one or two-tailed test)

[a]CES-D score at wave 2 (6 months after entry into shelter). High score indicates high depressive symptoms.

[b]Network size at wave 2 minus network size at wave 1.

relationship between the two interviews. Thus, these results reinforce those reported earlier: Insofar as the women sustained intimate relationships, they exhibited fewer depressive symptoms than those without them, and those who lost such relationships were the most likely to show a great increase in such symptoms.

Taken together, these results strongly indicate that network ties of all sorts are crucial to changes in depressive symptoms among the homeless. Ties to caseworkers, to friends and relatives, and to intimate partners are all implicated in changes in depressive symptoms, as measured by the CES-D scale. These results therefore cast an impressive shadow of doubt over the policy of indiscriminate isolation of homeless families.[19]

DISCUSSION AND CONCLUSION

These findings add weight to the argument that we must explain homelessness by means other than mental distress, and they also highlight the problems inherent in forging family homeless policy using a disability model. Indeed, our findings suggest that being categorized as "homeless" has become a loaded designation—a stigma—that brings with it presumptions of a whole range of personal failings for which a regimen of treatment is said to be needed if the stigmatized person is to rejoin society (Jones et al. 1984).

While the homeless are, on average, much more depressed than the general population, they are not much more depressed than others experiencing similar social and economic dislocation. Once the shock of the homeless process is absorbed, an episode in a family shelter has little affect on average levels of depression (though many individual women experience either increases or decreases in feelings of depression).[20] At first, this finding is both surprising and counterintuitive, since so much of the shelter's resources are devoted to therapeutic intervention. The structural conditions that produce homelessness, however, suggest an alternative explanation.

In Westchester County, like many other areas in New York and across the nation, housing is expensive and public assistance benefits were simply not sufficient for many families to afford decent housing. Most families in the county who enter the shelter system leave overcrowded and dilapidated dwellings and have few prospects of finding adequate permanent housing on their own. For many of these families the official declaration that they are homeless is the only viable method of accessing the subsidies and services needed to obtain new housing (Gerstel et al. 1996). In Westchester County, the typical family—once it completed mandated therapeutic programs—is assisted in obtaining both housing and the subsidies necessary to finance it. Without such assistance, however, the chances of accessing subsidized housing are slim. There is little public housing, and the few available subsidy programs, notably the Federal Section 8 certificate program, had waiting lists as long as five years during the study period. Families designated as homeless, however, with the increased intervention ability of their caseworkers because of this designation, often had increased access to Section 8 certificates or other forms of subsidized housing. Thus, the promise of housing or dashed hopes concerning it may prove to be more significant in creating change in depressive symptoms than either underlying mental health problems or mental health therapy they may receive while in the shelter.

Our findings also suggest that social networks have a complex influence on depressive symptoms among homeless mothers. Views expressed by respondents completing qualitative interviews suggested some reasons for this. We found that for some women, especially those few in our sample who listed domestic violence as a reason why they had become homeless (6.7 percent), being isolated from their partner was beneficial. Other women, however, had elevated levels of depression because their partners were not able to stay at the shelter because of ineligibility[21] and because shelter rules often made visiting difficult.

Many homeless mothers were sheltered at some distance from their previous neighborhoods and felt they were not able to stay in contact with relatives, neighbors, and friends because of the cost or time involved in traveling or because of the trouble involved in traveling with young children on public transportation. In addition, several shelters had few telephones available for resident use, and some members of our respondents' social networks did not have telephone service of their own. Some mothers expressed anxiety that they were not able to fulfill their usual obligations

to prior network members while they were in the shelter and that they would thus feel hesitant to call on these people when they were in need in the future (for other features of respondents' social networks, see Bogard 1998). While a few reported a desire to move to a new neighborhood after the shelter period or to leave problematic network members behind, most of our respondents desired to return to a better situation in or near their old neighborhoods so that they could remain close to their friends and family.

The past few decades have produced an enormous literature focusing on the numerous ways in which social networks in the general population can be supportive (Edin and Lein 1997; Gerstel 1988; Gottlieb 1981; Granovetter 1974; Walker, Wasserman, and Wellman 1994; Wellman 1992). Indeed, that literature has been subject to criticism for its focus on the virtues associated with, rather than the burdens imposed by, social networks. Ironically and sadly, the view of social networks among homeless populations has mostly focused on the opposite—that the social networks of homeless people are primarily burdensome, exploitative, or morally compromising.[22] This paper suggests that both views need to be better attuned to the complexity of human relationships, especially under conditions of poverty. As many researchers have noted, social networks among the very poor are essential to their survival in ways those of the middle-class are not (Edin and Lein 1997; Stack 1974).

We have suggested here that the focus on mental health in both research and social policy on family homelessness has resulted from the availability of funding, from constraints on how those funds are used, and from a research-based tendency to medicalize homelessness, and thus see it as an individual disability. Our results suggest that this focus on the personal problems of the homeless, notably mental health problems, has for the most part deflected attention away from more relevant issues of economic decline, underemployment, and affordable housing (Snow et al. 1994).

Given that the current system of rehabilitation-based shelter programs is likely to continue for some time, there are still two ways in which shelter policy could be reformulated so as to better serve the needs of sheltered women.

First, our analysis suggests that any social policy that seeks to change social networks of impoverished women must be far more specific. Homeless women themselves often differentiate among the dangerous neighborhoods in which they live and the personal networks upon which they rely. While shelter policy that enforces isolation from supportive personal networks is costly for these women, shelters that help them escape from dangerous neighborhoods or abusive partners may be central to their psychological well-being. What policy must provide is shelter that can both preserve needed networks and offer protection from unsuitable housing and domestic violence. A more liberal policy allowing nonabusive partners of homeless mothers to live on site, while problematic from a funding source point of view, would be a constructive part of such a policy.

Second, in the shelters we studied the mental health services were not even targeted to those who needed them most. That is, mental health services were delivered indiscriminately to sheltered mothers. This allocation system may result in a failure to deliver sufficient services to those who most need them. Since our results indicate that a recent change in a personal relationship is highly correlated with increased depressive symptoms, shelter programs that focus mental health services on those who have recently experienced traumatic changes in personal relationships with a boyfriend or partner might serve homeless respondents better than presuming homeless mothers, by definition, are experiencing mental health problems requiring treatment.

Social policy that has directed resources toward "supportive housing"—the therapeutic treatment of poor, homeless families—like that represented in the McKinney Act and HUD's initiative supporting service-intensive shelters has been strategically clever; it ultimately garnered the funds to provide what homeless families needed most—some form of housing. Justified as it may be from this standpoint, as a therapeutic intervention, service-intensive shelters have not been effective as a cure for homelessness. More importantly, they have effectively prevented public discussion of the severe housing crisis facing many of America's poor families.

NOTES

1. See Bahr (1968, 1970, 1973); Bruns (1980); Spradley (1970). For an exploration of the role of disaffiliation among homeless families, see Passaro, Zax and Zozus (1989); Shinn, Knickman, and Weitzman (1991).
2. See, for example, Farr (1986); Roth, Lust, and Saveana (1985); and Vernez et al. (1988). For a review of early studies documenting the need for services among homeless families, see Rossi (1989).
3. See Blasi (1994); Hombs (1992); Hopper and Baumohl (1994); McChesney (1990); Shinn (1992); and Snow et al. (1994).
4. A partial list of this type of writing includes Arce and Vergare (1987); Arnoff (1975); Bachrach (1984); Bassuk (1984); Bassuk and Gerson (1978); Borus (1981); Fischer and Breakey (1986); Jones (1983); Lamb (1984); Lipton, Sabatini, and Katz (1983); Morse (1985); Rosnow (1985); Roth and Bean (1986); Scull (1985). For a review of this literature see Shinn and Weitzman (1990).
5. Rossi (1989) used the 1974 Health and Nutrition Examination Survey (HANES) of the general population (for which the CES-D was originally developed) and compared its results with those from two cross-sectional samples of homeless men drawn in 1986 from the Chicago area (1989:59–61). He found that Chicago homeless men have an average (adjusted) CES-D score of 19.2 while the HANES sample had an average of 8.5. (Our homeless respondents also had high CES-D scores compared with HANES participants—an average of 15.2 at wave 1.) When Rossi compared his Chicago homeless respondents with a study of impoverished Kansas City residents (also conducted in the early 1970s) he found CES-D scores were heavily correlated with race and income (Comstock and Helsing 1976). In the Kansas City study, income was found to be the strongest predictor of CES-D scores. Rossi extrapolated the Kansas City findings to the extremely low levels of income found among homeless people and predicted that if the nonhomeless poor had incomes similar to those homeless, they would likely score similarly on the CES-D scale. This points to a need for better comparable data than was available to Rossi when he conducted his study (Rossi 1989:146–7). Other findings in the more general mental health epidemiology literature also substantiate the need to distinguish homeless mothers from homeless single adults. Such research has demonstrated both that women report higher levels of depression than men and that social class disadvantage—whether measured by education or income—is highly correlated with depression (Anshensel 1992; Cockerham 1992; Link and Dohrenwend 1980; Mirowsky and Ross 1995; Neugebauer, Dohrenwend, and Dohrenwend 1980; Radloff 1977; Taylor et al. 1993). A convincing case that links mental distress and family homelessness can only be made by employing these more accurate comparison populations (Rossi 1989; Snow et al. 1986; Snow, Baker, and Anderson 1988).
6. For literature critical of this tendency, see Shinn (1992); Snow et al. (1994); and Sosin, Piliavin, and Westerfelt (1990). As we argue elsewhere (Gerstel et al. 1996), constructing homelessness as a complex of fixable personal problems had fiscal advantages for the designers of homeless shelter programs. Providers of these therapeutic services bring additional funding and political capital into the shelter program which helped to stabilize it as a new type of institution for the poor.
7. We know of no further systematic assessment of this crucial issue.
8. Our sample includes residents of service-intensive shelters funded in part by the McKinney Act as well as small family shelters, large congregate shelters with some services, and a large no-service welfare hotel. Thus, there is variation in our sample in both the types and amounts of services family members received.
9. The CES-D scale is a twenty-item self-administered scale (with possible scores ranging from a low of 0 to a high or most depressed of 60). For those who could not read, interviewers read the statements and response categories to the respondents. The scale was also translated into Spanish. We used all cases with 15 or more valid answers, prorating cases with missing responses so that they were comparable to the full twenty-item scale.

10. These low figures reflect the fact that the two shelters in Westchester County that were specifically designated for victims of domestic violence were excluded from the study because of problems of confidentiality.
11. This policy of social isolation has clear roots in a conservative interpretation of "culture of poverty" arguments that presume impoverished families come from neighborhoods with cultural attributes that are in conflict with mainstream values and behaviors (Katz 1989).
12. Key indicators of poverty include Aid to Families with Dependent Children, Medicaid status and household income; life conditions include age, race, and living with a partner.
13. The values used were: age (29.3 years); high school degree (44.6%); receiving AFDC (79.4%); household income ($7,800); living with partner (23.4%); African American (69%); Latina (16%); other nonWhite (2%); White (14%).
14. That is, the intercept of the equation measures the mean CES-D score at time of admission.
15. Measurement of significance in this case is extremely complex, since each of the means are OLS estimates with large associated standard errors. If these are included in the estimate of significance the difference is not statistically significant. We have opted for a more conservative test that gives the best chance for significance (since our argument is for no difference). We assumed that the standard error of the mean for women at the time of admission to the shelter was equal to that of the wave 1 CES-D test (10.5/square root(298) = .61), and the standard error for destitute women in the LBS sample was equal to that of the whole sample (12.2/square root(8,285) = .13). This yields $t = 1.5/.62 = 2.24$ with degrees of freedom greater than 1000; $p < .01$.
16. The test of difference is: Mean(D) = 0.8; SE = .711; $t = 1.125$ with 202 degrees of freedom; $p = .15$, not significant.
17. If respondents had left the shelter by wave 2, they were asked about their shelter experience before they left. Thus, we had service intensity measures for all respondents, regardless of their placement at the time of the wave 2 interview.
18. We also tested the various services separately; none had a positive impact.
19. Although often used as a measure in past homelessness research, network size by itself may not be an adequate indicator of social isolation. Instead, it is possible that changes in the composition, emotional closeness, or contributions of network members may be significant in explaining changes in depression scores. Further analysis of these variables is required to determine whether these network characteristics significantly affect depression scores.
20. Because our initial interview on average occurred one to two weeks after entering the shelter, the initial adjustment period had already occurred prior to our measure of CES-D in wave 1.
21. Previous live-in partners who were not married to our respondents were often not eligible to accompany them to the shelter, especially if these partners were not the father of any of the children. Boyfriends who had not lived with the family previously were also not eligible for the family shelter.
22. Gwendolyn Dordick in her 1997 ethnography *Something Left to Lose*, which documents the strong relationships that are crucial to many homeless people's survival, is a notable exception to this trend. Letiecq, Anderson, and Koblinsky (1998) also document the strains that homeless mothers' social networks undergo during the shelter period by comparing mothers during and after homeless shelter stays.

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