Homeless Children and Parents: Short-Term Mental Health Outcome
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ABSTRACT

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

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

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

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

INTRODUCTION

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

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

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

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

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

**METHOD**

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

One hostel utilized a family support worker model to coordinate services before and after rehousing, whilst the other hostel utilized a key worker approach. Both systems provided assistance and support with families’ housing and social care needs during their stay at the hostel. No follow-up or support arrangements were available after the families had been rehoused in the community. The majority of families who participated in the follow-up assessment were in new homes (22, or 69%). Ten families were still at their original hostel, one had moved to another hostel, and two had been rehoused but had subsequently returned to the hostel. Both of these families had experienced domestic violence, a risk factor for repeated and chronic homelessness (Bassuk et al., 2001). Of those families still in hostels, five had accepted new accommodation and were waiting to move.

MEASURES

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

- The Hospital Anxiety and Depression Scale (HADS – Zigmond & Snaith, 1983) is a standardized and widely used measure of anxiety and depression in adults. Each of the 14 items (7 for anxiety and 7 for depression) is rated between 0–3, depending on the severity of the symptom (range 0–21 for each subscale). A cut-off total score of 11 or more indicates likely psychiatric morbidity, while a score of 7 or more on either subscale indicates the likelihood of anxiety or depressive disorder.
- The Parenting Daily Hassles Scale (PDHS – Crnic & Greenberg, 1990) assesses the impact and frequency of 20 experiences that can be perceived as problematic by parents. The carer rates each item for frequency and intensity. The total frequency (range 0–80) and intensity scores (range 0–100) are obtained, with scores for challenging behaviour (range 0–35) and parenting tasks (range 0–40) being further derived from the intensity scale.
- The Eyberg Child Behaviour Inventory (ECBI – Eyberg & Ross, 1978) is a standardized measure of child behavioural (oppositional) problems. Items refer to 36 common childhood problem behaviours. Each item is rated as (a) present or absent, the sum of
which consists of the problem number score (range 0–36); and (b) on its frequency (1–7 Likert scale), the sum of which constitutes the problem intensity score (range 36–252). Cut-off scores of 11 on the problem number score and 127 on the problem intensity score have been found to indicate behaviours which might require assessment and treatment (Eyberg & Robinson, 1983).

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

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

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

**DATA ANALYSIS**

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

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

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

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

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

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

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

The impact of baseline maternal mental health and parenting on changes in child behavioural problems was tested by a multiple linear regression model, with changes on the ECBI as the dependent variable, and initial HADS and PDHS scores as the covariates. Changes in ECBI scores were predicted by two parenting problems subscale scores, but not by any of the HADS scores:
PDHS challenging behaviour: $B = -6.98$, 95% CI = $-11.11$ to $-2.85$, $p = 0.002$.
PDHS parenting tasks score: $B = -5.09$, 95% CI = $-9.36$ to $-0.82$, $p = 0.021$.

**COMPARISON OF REHOUSED FAMILIES WITH THOSE STILL LIVING AT THE HOSTEL**

Although the number of families still living at the hostel was small ($N = 13$), the impact of this variable on outcome was taken into consideration. There was no statistically significant difference in the baseline or follow-up HADS or PDHS scores between families who had been rehoused and families still living at the hostel (see Table 1). Children who had been rehoused showed no significant changes on the EBCI scores or on the HoNOSCA subscale scores (see Table 2), except for improvement on the HoNOSCA subscale for understanding the nature of their child's difficulties ($Z = -2.27$, $p = 0.023$). When children still living in the hostels were compared on behavioural and other mental health problems between the first and second assessment, there was no significant difference on the ECBI scores (number of problems score $Z = -0.20$, $p = 0.84$; intensity score $Z = 0.05$, $p = 0.96$), but they were found to improve on the HoNOSCA subscales for emotional symptoms ($Z = -1.99$, $p = 0.046$), self-care ($Z = -2.00$, $p = 0.046$) and problems in family life ($Z = -2.11$, $p = 0.035$).

**PARENTS’ SERVICE SATISFACTION**

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

**Housing and related needs**

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

### Table 1

<table>
<thead>
<tr>
<th>Test compared pre/post</th>
<th>All mothers ($N = 35$)</th>
<th>Rehoused mothers ($N = 22$)</th>
<th>Mothers still in hostel ($N = 13$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADS anxiety score</td>
<td>$Z = -0.49$ $p = 0.62$</td>
<td>$Z = -1.84$ $p = 0.67$</td>
<td>$Z = -0.27$ $p = 0.79$</td>
</tr>
<tr>
<td>HADS depression score</td>
<td>$Z = -0.45$ $p = 0.66$</td>
<td>$Z = -0.63$ $p = 0.53$</td>
<td>$Z = -0.18$ $p = 0.86$</td>
</tr>
<tr>
<td>HADS total score</td>
<td>$Z = -0.56$ $p = 0.58$</td>
<td>$Z = -0.52$ $p = 0.60$</td>
<td>$Z = -0.31$ $p = 0.76$</td>
</tr>
<tr>
<td>HADS score within clinical range</td>
<td>$Z = -0.38$ $p = 0.71$</td>
<td>$Z = -0.45$ $p = 0.66$</td>
<td>$Z = -0.00$ $p = 1.00$</td>
</tr>
<tr>
<td>PDHS frequency score</td>
<td>$Z = -0.14$ $p = 0.89$</td>
<td>$Z = 0.05$ $p = 0.96$</td>
<td>$Z = -0.56$ $p = 0.57$</td>
</tr>
<tr>
<td>PDHS intensity score</td>
<td>$Z = -0.20$ $p = 0.85$</td>
<td>$Z = -0.54$ $p = 0.59$</td>
<td>$Z = -0.44$ $p = 0.66$</td>
</tr>
<tr>
<td>PDHS challenging behaviour score</td>
<td>$Z = -1.61$ $p = 0.11$</td>
<td>$Z = -1.18$ $p = 0.24$</td>
<td>$Z = -0.97$ $p = 0.33$</td>
</tr>
<tr>
<td>PDHS parenting tasks score</td>
<td>$Z = -0.34$ $p = 0.74$</td>
<td>$Z = -0.18$ $p = 0.86$</td>
<td>$Z = -0.26$ $p = 0.80$</td>
</tr>
</tbody>
</table>
Table 2

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

<table>
<thead>
<tr>
<th>Test compared pre/post</th>
<th>All children</th>
<th>Rehoused children</th>
<th>Children still in hostels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyberg behaviour score</td>
<td>Z = -1.28 p = 0.20</td>
<td>Z = -1.55 p = 0.12</td>
<td>Z = -0.20 p = 0.84</td>
</tr>
<tr>
<td>Eyberg intensity score</td>
<td>Z = -0.11 p = 0.91</td>
<td>Z = -0.15 p = 0.88</td>
<td>Z = -0.51 p = 0.96</td>
</tr>
<tr>
<td>HoNOSCA disruptive behaviour</td>
<td>Z = -1.93 p = 0.05</td>
<td>Z = -1.63 p = 0.10</td>
<td>Z = -1.08 p = 0.28</td>
</tr>
<tr>
<td>HoNOSCA attention deficit</td>
<td>Z = -1.53 p = 0.13</td>
<td>Z = -1.15 p = 0.25</td>
<td>Z = -1.00 p = 0.32</td>
</tr>
<tr>
<td>HoNOSCA non-accidental self-injury</td>
<td>Z = -1.19 p = 0.23</td>
<td>Z = -1.13 p = 0.26</td>
<td>Z = -0.45 p = 0.66</td>
</tr>
<tr>
<td>HoNOSCA substance misuse</td>
<td>Z = -0.333 p = 0.74</td>
<td>Z = -0.45 p = 0.66</td>
<td>Z = 0.00 p = 1.00</td>
</tr>
<tr>
<td>HoNOSCA scholastic and language problems</td>
<td>Z = -0.03 p = 0.98</td>
<td>Z = -0.49 p = 0.63</td>
<td>Z = -0.41 p = 0.68</td>
</tr>
<tr>
<td>HoNOSCA physical illness/disability</td>
<td>Z = -0.07 p = 0.94</td>
<td>Z = -0.69 p = 0.49</td>
<td>Z = 0.82 p = 0.41</td>
</tr>
<tr>
<td>HoNOSCA hallucinations/delusions</td>
<td>Z = -1.73 p = 0.08</td>
<td>Z = -1.41 p = 0.16</td>
<td>Z = -1.00 p = 0.32</td>
</tr>
<tr>
<td>HoNOSCA somatic/non-organic symptoms</td>
<td>Z = -0.64 p = 0.52</td>
<td>Z = -0.55 p = 0.58</td>
<td>Z = -0.27 p = 0.79</td>
</tr>
<tr>
<td>HoNOSCA emotional and related symptoms</td>
<td>Z = -1.08 p = 0.28</td>
<td>Z = -0.12 p = 0.90</td>
<td>Z = -1.99 p = 0.05</td>
</tr>
<tr>
<td>HoNOSCA peer relationships</td>
<td>Z = -0.66 p = 0.51</td>
<td>Z = -1.05 p = 0.29</td>
<td>Z = -0.11 p = 0.9</td>
</tr>
<tr>
<td>HoNOSCA problems with self-care/independence</td>
<td>Z = -1.08 p = 0.28</td>
<td>Z = -0.37 p = 0.71</td>
<td>Z = -2.00 p = 0.05</td>
</tr>
<tr>
<td>HoNOSCA problems in family life/relationships</td>
<td>Z = -0.99 p = 0.32</td>
<td>Z = -0.04 p = 0.97</td>
<td>Z = -2.11 p = 0.04</td>
</tr>
<tr>
<td>HoNOSCA poor school attendance</td>
<td>Z = -1.11 p = 0.27</td>
<td>Z = -0.53 p = 0.60</td>
<td>Z = -0.96 p = 0.34</td>
</tr>
<tr>
<td>HoNOSCA nature of difficulties</td>
<td>Z = -1.81 p = 0.07</td>
<td>Z = -2.27 p = 0.02</td>
<td>Z = -0.00 p = 1.00</td>
</tr>
<tr>
<td>HoNOSCA lack of services</td>
<td>Z = -0.47 p = 0.64</td>
<td>Z = -1.10 p = 0.27</td>
<td>Z = -0.71 p = 0.48</td>
</tr>
</tbody>
</table>

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

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

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

The majority of the hostel residents (8, 62%) found the staff helpful and supportive, although there were some complaints about privacy: [staff] very supportive, very nice’; ‘gives moral support, very understanding how you feel’; ‘difficult to get privacy’.
The negative comments generally related to the lack of facilities, cleanliness and noise, and sharing with other residents: ‘only three washing machines . . . no fridge freezer’; ‘finding it boring’; ‘noisy, kids playing on the stair’.

**Schooling**

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

**Mental health**

In the majority of rehoused families (13, 59%), the parents commented positively on their own mental health, with perceived improvement in mood symptoms, stress levels and substance abuse: ‘feel much happier, it was depressing and unpleasant’; ‘I’ve changed for the better . . . being sober’; ‘now off antidepressants, stopped one month after the hostel’. A few parents (4, 18%) described either a continuation of mental health problems after rehousing, or problems relating to their current residence that were creating additional stress: ‘I’ve had enough, want to give up, hate new home’; ‘don’t feel good, need counselling for violence from ex’; ‘get anxious easily . . . on medication’.

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

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

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

The majority of parents (9, 69%) commented that the mental health of their children was worse in the hostel environment, particularly with deterioration in their behaviour: ‘[child] keeps knives for protection, poor sleeper’; ‘kids unsettled, swearing, aggressive, in trouble with the police’; ‘[child] now very aggressive, older children encourage it’.
The findings of this study indicate further the increased and continuing levels of mental health needs among homeless families, even after their rehousing in the community. In the absence of substantial longitudinal evidence with vulnerable child and parent populations, these findings predominantly have implications for policy and service development. The underlying psychosocial factors which contributed to becoming homeless often persist after rehousing, thus remaining detrimental to the mental health of children and their parents. The characteristics of these families were similar to those in previous studies, with the main causes of homelessness reported as domestic violence, neighbour harassment and relationship breakdown (Vostanis et al., 1997). The majority of the families had been rehoused at four months; however, a substantial proportion still resided in the hostels, while two families had been re-admitted because of domestic violence.

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

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

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

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

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

There were limitations to this study. The results may have been affected by the small sample size; however, the combination of quantitative and qualitative data addressed some of these limitations by providing the families’ subjective evaluation of the situation and relations with services. Although not every family answered all of the questions on the semi-structured interview, themes were established for the whole sample. A larger sample size would help to address these concerns. It would have been useful to follow up the families for a longer period of time but, as discussed previously, the mobility of this group often results in their loss of contact with statutory agencies, consequently making it difficult to trace them for research purposes. The complex needs of these families, as established in this study, have implications for providers of health and social care on a local and national level. The range of needs implicated in the maintenance of mental health in both children and their parents has to be met by a co-ordinated strategy. It is positive to note the development
of a central government directorate in the UK to oversee the provision of homeless services, and that each Local Authority is required to develop an inter-agency strategy (O'Connell, 2003).

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