2014

Programs for homeless children and youth: A critical review of evidence

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Herbers, J. E., & Cutuli, J. J. (2014). Programs for homeless children and youth: A critical review of evidence. In M. E. Haskett, S. Perlman, and B. A. Cowan (Eds.) *Supporting Families Experiencing Homelessness: Current Practices and Future Directions* (pp. 187 – 207). New York: Springer. DOI 10.1007/978-1-4614-8718-0_10

Abstract

To date, there are few studies that use rigorous research designs to evaluate interventions designed to address the needs of homeless children. Strengths and noteworthy findings as well as the challenges and limitations of this literature are summarized. The studies reviewed in this chapter represent laudable efforts on the part of researchers, practitioners, and community partners to engage in intervention studies with the challenging and understudied population of children in families experiencing homelessness. However, within the guidelines of the What Works Clearinghouse (WWC) standards for evidence based practices, none of the interventions represented in these studies have sufficient evidence to be rated as having Positive Effects. Most often, this is due to lack of quality evidence that evaluates the program outcomes. Policymakers, funding agencies, researchers, clinicians, and community practitioners can expand the evidence base for interventions with homeless children through understanding what constitutes quality evaluations and supporting high-quality research. This chapter concludes with recommendations for building a robust and rigorous evidence base of what works to allow stakeholders to improve the well-being of at-risk children, bettering their lives through increasingly effective and efficient programs.

The needs of children experiencing homelessness and recommendations for intervening with these children and families have been well documented (Bassuk, 2010; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; D. J. Rog & Buckner, 2007; Samuels, Shinn, & Buckner, 2010). However, there are surprisingly few studies or reports that document rigorous evaluations of such intervention programs. Among the studies that do exist, there is great variety in the needs targeted by interventions, the services and methods by which interventions are delivered, the sub-populations of homeless families included, and the methodological and psychometric rigor of the studies. As a result, the research evidence to support intervention effectiveness is difficult to interpret. In this chapter, we review the literature on interventions designed to address the well-being of children experiencing family homelessness, highlighting strengths and weaknesses of the existing evidence for what works. Before reviewing specific studies, we discuss the importance of evidence-based practices in general, noting several standards that exist for establishing well-supported and promising programs and interventions based on evidence. We then use these standards as a context for evaluating the work that has been done, and still needs to be done, to establish a more robust evidence base for various interventions with homeless children.

Children who experience family homelessness have varied needs and experience a number of different risks to healthy development spanning all domains of functioning. Opportunities to intervene are similarly complex and varied. The National Center of Family Homelessness has identified five broad categories of needs that should be addressed in interventions for children from homeless families: housing, maternal well-being, child well-being, family functioning, and family preservation (DeCandia, 2012). These categories emphasize the child's context, acknowledging that as children develop, they are sensitive to their

environments at the levels of family, neighborhood, and broader culture and society. Efforts to support the healthy development of children who experience homelessness should attend to the ecology of their experiences and the diverse causes, correlates, and consequences of homelessness (Kilmer, Cook, Crusto, Strater, & Haber, 2012). Because the primary drivers of homelessness are extreme poverty and lack of affordable housing, attending to immediate housing and financial needs would likely prevent children from experiencing additional risks and potentially traumatic events related to living with residential instability (Bassuk, 2010; Burt, Pearson, & Montgomery, 2005; Haber & Toro, 2004). Since most homeless families are headed by young, single mothers who have experienced significant trauma in their own lives, addressing maternal well-being and family functioning can improve child well-being indirectly by fostering more nurturing parent-child relationships and reducing the likelihood of additional trauma within the family (Bassuk, 2010; Kilmer et al., 2012; Paquette & Bassuk, 2009). Finally, child well-being can be addressed directly starting with assessment for early identification of developmental or other health problems, and access to programs or services that can address these needs (DeCandia, 2012).

Evidence-Based Practices

Research evidence is necessary for demonstrating whether different intervention efforts are effective. Across diverse fields including medicine, psychology, education, and public policy, there are increasing demands for prevention and intervention programs that are supported by sound empirical evidence (Levant & Hasan, 2008). The National Institute of Medicine has defined Evidence-Based Practice (EBP) in health care as "the integration of best research evidence with clinical expertise and patient values." Similarly, the American Psychological Association (APA) adopted as policy the definition of Evidence Based Practices in Psychology

(EBPP) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, 2005).Meanwhile the federal Office of Management and Budget (OMB) has called for expanded capacity and use of rigorous evaluation and evidence in governmental grant-making and other decision-making (Zients, 2012).

Different groups and agencies continue to develop and refine various tiered frameworks to determine the quality of program evaluation studies. For example, at the federal level the Department of Education (Institute of Education Sciences, 2013; What Works Clearinghouse, 2011) and the Substance Abuse and Mental Health Services Administration (SAMHSA) (Substance Abuse and Mental Health Services Administration, 2013) each have explicit review criteria to determine the quality of evidence, while the Top Tier Evidence Initiative of the Coalition for Evidence-Based Policy has established a checklist for reviewing randomized controlled trials (RCT) for social service program evaluation (Coalition for Evidence-Based Policy, 2010) and the American Psychological Association utilizes a set of criteria to characterize the research support for individual psychological treatments or interventions (American Psychological Association, 2005; Chambless et al., 1998), to name just a few. It is beyond the scope of this chapter to provide a detailed analysis of all such efforts individually. Nevertheless, most frameworks share a number of common elements. Most of these criteria share some recognition that evidence should be considered within the context of the needs and situations of the target populations, and, therefore, should help guide (and not replace) good judgment by clinicians, providers, executive leaders, and other decision-makers. In addition, most emphasize the importance of robust methodology (e.g., by explicitly requiring or favoring certain study designs like RCT), representative samples or population-based approaches with

sufficient numbers of participants to detect effects of the expected sized, appropriate and rigorous analytical methods, replication (sometimes by independent groups), meaningful effect sizes that are significant with respect to real-world differences (and not just statistically significant), and comprehensive review (e.g., in a peer refereed journal and/or by a specific, independent review process with explicit evaluation criteria).

Applying any of these criteria to the research on prevention and intervention programs for homeless children requires careful consideration of the quality and quantity of existing empirical evidence. For the purposes of this chapter, we use standards from the What Works Clearinghouse (WWC) of the Department of Education's Institute of Educational Sciences (Institute of Education Sciences, 2013; What Works Clearinghouse, 2011). These criteria are sufficiently defined to provide a framework that can be used to evaluate intervention programs across a range of social science disciplines, and they provide guidelines for rating individual studies as well as for rating interventions. According to WWC evidence standards, a study "meets evidence standards" only when it employs an RCT with low attrition rates, the study includes valid and reliable outcomes measures, and measures of effect can be attributed solely to the intervention. A study could "meet evidence standards with reservations" in two different situations; either the study is an RCT with high attrition or a quasi-experimental design (QED), but in either case the groups must be equivalent in relevant characteristics and the study includes valid and reliable outcomes measures with effects attributed solely to the intervention. When any of these criteria are not met, or when a study uses a design other than RCT or QED, the study "does not meet evidence standards" according to the WWC guidelines.

To determine the rating of an intervention, the WWC also provides guidelines for combining findings from multiple studies meeting evidence standards (with or without

reservations), which may have conflicting results. The intervention rating scheme is used to categorize interventions as having Positive Effects, Potentially Positive Effects, Mixed Effects, No Discernible Effects, Potentially Negative Effects, or Negative Effects. To be rated as having Positive Effects, an intervention must be supported by two or more studies, one of which must be an RCT, showing statistically significant effects in favor of the intervention and no studies showing statistically significant or substantial negative effects. To be rated as having Potentially Positive Effects, an intervention must be supported by at least one study showing a statistically significant or substantial effect in favor of the intervention, no studies showing significant negative effects, and fewer or the same number of studies showing indeterminate effects as those showing positive effects. An intervention could be rated as having Mixed Effects when either the number of studies with positive and negative effects is equal, or when there are more studies showing indeterminate effects than studies showing significant effects, either positive or negative. An intervention will be rated as having No Discernible Effects when none of the studies show statistically significant positive or negative effects. Finally, and intervention is rated as having Negative Effects or Potentially Negative Effects when a study or studies show statistically significant effects opposed to the intervention, depending upon the strength of evidence.

Like other EBP rating systems for evaluating evidence, the WWC guidelines aim to uphold scientific rigor and reduce potential sources of bias. First and foremost, the WWC standards rely primarily on evidence from RCTs or quasi-experimental designs. In an RCT, participants (or groups like schools or shelters) are randomly assigned to the intervention condition or one or more alternative conditions. All participants complete the same assessment procedures prior to, during, and following the conditions, and results of the assessments are

compared to determine whether the target intervention has effects on relevant outcomes. The alternative conditions can involve assessment with no intervention, a placebo condition, a different intervention, or a wait-list for later participation in the focus intervention. Random assignment dramatically reduces the likelihood that participants in different conditions will differ from each other in ways that could impact the results of the study. For example, if participants are allowed to choose either the target intervention or assessment without intervention, those who choose the intervention might be more open to change and more likely to benefit from any services provided. This characteristic of the participants in the intervention group would then inflate the observed effect of intervention, and the program might be presumed more beneficial than it truly is for the broader population. Alternatively, if participants were placed in different conditions based on their location (e.g. different homeless shelter sites), and there were characteristics of the non-intervention site only that otherwise improved client outcomes, results of the research might underestimate the true impact of a beneficial intervention. In many cases, RCTs are not feasible due to considerations of costs, resources, ethics, or political concerns (Baggerly, 2004; Seibel, Bassuk, & Medeiros, 2012). Costs can prevent the number of participants that can be included, reducing sample sizes and limiting options for comparison groups. More importantly, ethical and political considerations challenge the appropriateness of randomly assigning individuals at risk to conditions of no-treatment, or to conditions which local stakeholders view as suboptimal (whether or not such a view is supported by an evidence base). When randomization is not possible, quasi-experimental designs (QEDs) can provide valuable evidence under certain conditions. QEDs involve comparison among groups that have not been randomly assigned, such as by participant choice or by shelter site. According to the WWC, QEDs can "meet evidence standards with reservations" when equivalence between groups is

established with any necessary statistical adjustments applied (What Works Clearinghouse, 2011), like statistically controlling for established or suspected differences in individual variables or through more complex methodologies like propensity score matching (Heckman, Ichimura, Smith, & Todd, 1998; Heckman, Ichimura, & Todd, 1997; Smith & Todd, 2005).

Clearly WWC standards strongly emphasize RCTs and QEDs to determine whether individual studies meet evidence standards. In addition, the highest rating of "Positive Effects" requires replication of findings. Replication ensures that initial findings are robust and not due to unmeasured factors of a particular sample. Furthermore, when results are replicated by an independent team of researchers, the likelihood that investigator bias impacts the results is reduced (Chambless & Hollon, 1998). Intervention manuals are important not only for enabling replication of intervention research, but also for ensuring fidelity in the implementation of interventions that have been supported by research. Practitioners committed to the use of evidence-based practice must have the ability to enact those practices consistent with the specific methods and procedures that the research evidence supports. Finally, inherent in the WWC criteria, the 2005 APA policy statement, and other calls for EBPs described above also are data analysis methodology reflecting best practices for measurement and evaluation (American Psychological Association, 2005; Chambless et al., 1998; Levant & Hasan, 2008; Zients, 2012). These best practices are continually evolving and will vary from field to field as different sorts of data require a host of different considerations. As such, continuing education and ongoing collaborations with experts in data analysis are important in maintaining an up-to-date skill set in this area.

Various organizations including the Department of Education and APA demonstrate a commitment to evidence-based practices by maintaining evolving online lists of EBPs

(American Psychological Association, 2005; Coalition for Evidence-Based Policy, 2010; Substance Abuse and Mental Health Services Administration, 2013; What Works Clearinghouse, 2011). While a great deal of evidence exists for a variety of programs that effectively address children's mental health and academic achievement in general (Kazak et al., 2010), very few have been adapted or designed and targeted for use with children experiencing homelessness (Seibel et al., 2012). Next we review the literature on interventions with homeless children in light of the WWC criteria, beginning with the body of descriptive studies then considering studies that use RCTs or quasi-experimental designs.

Descriptive Projects: Not Meeting Evidence Standards

To date, there are few studies that evaluate interventions for homeless families and even fewer that evaluate child outcomes with rigorous research designs (Bassuk, 2010; Hwang et al., 2005; Samuels et al., 2010). The majority of research on programs is descriptive in nature, without RCTs or QEDs that utilize comparison groups. The interventions represented in the descriptive literature also vary widely in their approaches to improving outcomes for homeless children. Some programs have focused primarily on housing needs of homeless families while others have targeted maternal well-being, child well-being, family functioning, or a combination of these through case management services or specific therapies and treatments. The existing intervention studies also vary in methods used to assess and describe change that may be associated with their efforts. In this section, we first describe studies on interventions for homeless children without use of RCTs or QEDs. According to the WWC, none of these studies meet evidence standards. We summarize the strengths and noteworthy findings as well as the challenges and limitations of this literature.

Several reports in the literature consider housing programs for families and their effects on residential stability. Interventions specifically designed to address housing needs include subsidized housing, permanent supportive housing, and transitional housing (Samuels et al., 2010). A study in New York City examined differences among 138 families who requested shelter and received housing subsidies compared to 106 who requested shelter and did not receive housing subsidies. Families who requested shelter and received subsidies were over 20 times more likely to achieve stable housing (Shinn et al., 1998) than families who did not receive subsidies. Whether or not families received subsidies was not determined randomly but depended upon the type of shelter, the amount of time the family stayed in shelter, and whether the family circumstances involved domestic violence (Shinn et al., 1998). Because these differences were not accounted for (statistically or otherwise) in the evaluation of housing stability, it is not clear whether stability resulted from the receipt of housing subsidies or because of other factors that distinguish the groups. Another study used administrative data and hazard functions to predict shelter reentry within two years among 24,640 families in New York City. Families that left shelter to enter subsidized housing were much less likely to return to shelter (Wong, Culhane, & Kuhn, 1997). Similarly, families were not assigned to different housing conditions, and there were differences among groups in important characteristics that were not accounted for in the models.

While affordable, stable housing is clearly important, families appear to benefit more when they are able to connect with additional services (Samuels et al., 2010). In the Homeless Families Program, 1,298 families across nine sites received Section 8 vouchers, some level of case management, and access to services (D.J. Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, & Holupka, 1995). Analyses of housing stability at follow-up revealed that families who

received more intensive services packages in addition to Section 8 subsidized housing certificates fared better in terms of housing stability than families who received fewer services. However, the families included in the study were not representative of homeless families in general, and there were considerable differences in recruitment strategies, selection criteria, and referral sources across the nine sites such that groups being compared were not equivalent and results cannot be attributed to differences in services (Rog et al., 1995). The Sound Families Project involved funding housing units with services available in three counties in Washington State, with intensive case management including referrals for substance use problems, mental health issues, and education or job training for homeless mothers (Bodonyi, 2008). Data from 10 case study sites suggested that most families moved to permanent housing within about a year, that many parents increased their employment and incomes, and that children improved their school attendance and stability (Bodonyi, 2008).

Several other studies have documented intervention efforts towards improvements in housing stability and other outcomes in contexts of supportive or transitional housing programs, with intensive case management and a range of services and opportunities available (Fischer, 2000; Medeiros & Vaulton, 2010; Murrell et al., 2000; Swann-Jackson, Tapper, & Fields, 2010). For example, Keeping Families Together (KFT) was a pilot program that provided permanent supportive housing with intensive services to 29 families in New York City that had been homeless for at least one year and had at least one case of child abuse or neglect open with the city's Administration for Children's Services (Swann-Jackson et al., 2010). In addition to supportive housing, families received flexible spending grants for one-time expenses to promote positive family functioning and individual case management services from on-site social workers, including referrals and access to additional services both on-site and through

community providers. Twelve adults in the program participated in substance abuse treatment programs and seven received psychiatric treatment for mental illness. Results of the program were evaluated using data on housing stability, welfare involvement, and children's school attendance and academic achievement. Compared to 15 families who were eligible for the program but chose not to participate, the KFT families maintained superior housing stability. Over the course of the 3-year program, over half of the open child welfare cases were closed for the KFT families, and all children who were in foster care with the goal of reunification were reunified with their families. Children involved in KFT significantly improved their school attendance. Parents in KFT also reported that the program helped them to rebuild social supports and enhanced their desire to become better parents (Swann-Jackson et al., 2010).

Other intervention efforts involve more targeted programs to improve maternal well-being. The AfterCare project was designed to provide support, education, and connections to health care services for mothers currently homeless or at risk based on previous homelessness (Murrell et al., 2000). The 79 mothers who participated were either pregnant or had an infant 6 months or younger. They received case management services and home visits from nurses, and they participated in a women's support group. Survey data indicated high rates of prenatal care and successful births among the mothers (Murrell et al., 2000), but effects were not compared to any comparison group. Another program targeted young, unmarried mothers of first child infants to provide transitional housing with available day care, transportation, counseling, parent-training, educational opportunities, and job-related skills (Fischer, 2000). Qualitative evaluations indicated some improvements in housing, employment, and self-sufficiency, though most of the mothers were still dependent on welfare following participation in the program (Fischer, 2000).

Without a comparison group or any rigorous analysis, it is unclear what impact this program may have had.

Efforts to improve maternal well-being, family functioning, and child behavior also take the form of interventions targeting parenting skills. Because parenting interventions are discussed in detail in Chapter 10 of this volume (Gewirtz et al.), we review them here only briefly. Many of these programs are evaluated using a pre-post design that tests for within-individual change before and after the intervention. While pre-post designs provide meaningful evidence, they fall short of the level of rigor that comes with random assignment or QED approaches. One study evaluated the Adolescent Transition and Parent Management Curriculum for mothers of adolescents at risk for behavior problems living in long-term shelter (Puterbaugh, 2009). Results indicated changes from pre-test to post-test on two parent-report measures of child behavior (Puterbaugh, 2009). Another study described the implementation of the evidence-based intervention, Parenting Through Change, for 10 mothers living with their children in domestic violence shelters, with initial findings indicating good attendance at sessions and mothers reporting that they enjoyed sessions and felt that their parenting skills were improving (Gewirtz & Taylor, 2009). Kelly, Buehlman, and Caldwell (2000) trained parent-child advocates to deliver early intervention services to homeless mothers, with the goal of improving parent-child interactions. Observational ratings of parent-child interactions indicated that parent teaching behaviors increased significantly following intervention.. Another study (Davey, 2004) involved the use of a retreat to target role clarification and communication among family members, with results of a brief survey suggesting that families enjoyed the retreat and parents felt it helped families feel more positive about themselves and deal with stress. Using a therapeutic nursery program with services for parents in shelter, Norris-Shortle and colleagues

implemented an intervention called Wee Cuddle and Grow, which utilizes video-taped interactions to provide feedback to caregivers (Melley et al., 2010; Norris-Shortle et al., 2006). The program involved individual parent-child therapy, structured activities, and parent support groups in which parents were coached to respond to their children's cues, teach skills, develop family routines, and engage in child-centered play. Results of pre-post analyses suggested that children improved in all domains assessed by the Assessment with Nursing Child Assessment Satellite Training tool, and amount of participation in interventions was related to improvements (Melley et al., 2010; Norris-Shortle et al., 2006). The project had a large sample of 99 mothers but no comparison group. Finally, a program targeting homeless fathers with children under the age of 5 required fathers to participate in the evidence-based program Parents as Teachers in order to obtain supporting housing (Ferguson & Morley, 2011). Fathers participated in a curriculum about early childhood development and weekly individual sessions and support groups. Unfortunately, evaluation of this program consisted only of qualitative reports from a focus group of 4 fathers, and there was no information regarding fidelity of implementing the Parents as Teachers program.

Programs also have been designed to target child behavior and well-being directly. An early study described providing day care for 87 preschool children who were staying with their mothers at a "welfare hotel" (Grant, 1991). Based on observations by the childcare providers, it was reported that most children in the intervention were functioning at age level by the end (Grant, 1991). However, it is unclear whether outcomes were based on any sort of psychometrically supported assessment. A more recent intervention engaged children ages 5-11 in child-centered group play therapy with the goal of improving self-esteem and symptoms of anxiety and depression (Baggerly, 2004). Pre-post design results from the 25 children who

completed therapy and standardized assessments indicated some improvement in self-concept but mixed results for anxiety and depression (Baggerly, 2004).

Finally, several intervention programs have targeted parent well-being, child well-being, and family functioning with separate components delivered simultaneously. A camp-based program involved 42 mothers and their children in outdoor activities for families. In addition, caregivers participated in discussion groups related to parenting while children engaged in groups for behavior management. Qualitative interviews indicated that parents enjoyed some aspects of the programming, but no psychometrically established assessment was reported (Kissman, 1999). In a different school-based summer program, 20 homeless children and 33 low-income children participated in mental health services and parents received training in behavior management (Nabors, Proescher, & DeSilva, 2001; Nabors et al., 2004). Parents in both homeless and non-homeless, low-income groups reported decreases in total behavior problems, with larger changes among the homeless group. Teacher reports indicated improvement in social skills for both groups as well (Nabors et al., 2001; Nabors et al., 2004). In a large, 5-year study called Strengthening At Risk and Homeless Youth, Mothers, and Children, a range of services were provided to mothers aged 18-25 and their children in four different sites across the country to address homelessness, residential instability, and developmental issues of the children (Medeiros & Vaulton, 2010). While some services differed by site, all programs included intensive case management, housing assistance and supports, counseling for parents and children as well as therapy to improve the parent-child relationship, and regular developmental screenings. Overall, results from the four sites indicated that with housing assistance, about 80% of the mothers were stably housed in their communities, and that the cost of the intervention was

less than the cost of emergency housing for the same number of families in the those communities (Medeiros & Vaulton, 2010).

In the process of conducting each of these descriptive studies, the researchers and practitioners gained insight into the challenges associated with intervening with children and families experiencing homelessness. Several reports noted the impact of high attrition rates and time limitations associated with highly mobile families staying in emergency shelter for short periods of time (Davey, 2004; Fischer, 2000). Others noted cost concerns arising from training of staff and best use of resources in a context of high need (Baggerly, 2004; Gewirtz & Taylor, 2009). Emphasis was placed on the importance of collaborations among researchers, practitioners, schools, and community providers in the development and implementation of intervention programs (Gewirtz & Taylor, 2009; Nabors et al., 2004; Swann-Jackson et al., 2010). Several reports also noted that children and families were generally receptive to intervention programs and reported enjoying a variety of intervention activities (Davey, 2004; Fischer, 2000; Gewirtz & Taylor, 2009; Kissman, 1999), which speaks to feasibility of implementation. Several studies made use of measures with good psychometric properties (Baggerly, 2004; Medeiros & Vaulton, 2010; Nabors et al., 2004; Swann-Jackson et al., 2010), and some included manuals or based their interventions on existing EBPs (Ferguson & Morley, 2011; Gewirtz & Taylor, 2009; Nabors et al., 2004). Most of the studies were embedded and delivered in the contexts of the children's daily lives, such as shelters and schools.

While each of the studies described above provides useful information about the feasibility of interventions with homeless families, none have sufficiently rigorous designs to test efficacy or effectiveness. Few of the studies evaluated their programs using psychometrically established, quantitative assessments. Even among the studies that measure outcomes and report

positive pre-intervention to post-intervention changes, the effect of these services are unclear because studies did not include comparison groups assigned to different programs. With the exception of the housing outcomes in the Keeping Families Together intervention, there were no comparison groups that did not receive the intervention being evaluated. Single-group designs that consider only individuals receiving an intervention can provide preliminary insight into the feasibility and likely value of further pursuing the more rigorous evidence that comes with an RCT or QED approach for any particular program, recognizing that these comparison-group designs often carry additional logistic, cost, ethical and political investment and challenges. Nevertheless, rigorous evidence requires RCT or QED methodologies to adequately control for various forms of bias that usually cannot be detected nor accounted for in single-group designs.

RCTs and QEDs: Potentially Meeting Evidence Standards

RCTs or quasi-experimental designs more rigorously evaluate the potential benefits of their programs. Based on WWC guidelines, these studies have the potential to meet evidence standards with or without reservations depending upon other aspects of the methods and findings. As with the variety of approaches represented in the descriptive studies, the following intervention studies range from specifically-targeted to broad-based and address different categories of needs. We review each study in detail, discuss strengths and weaknesses, then summarize the findings overall with respect to WWC guidelines.

Tischler and colleagues (2002) evaluated an intervention with UK families residing in emergency hostels providing mental health outreach services to families with children ages 3-16 with an identified need. Services included counseling for children and support provided to parents to engage other agencies, such as finding child care and participating in child protection conferences. The intervention group involved 23 families with 27 children who were compared

to a group of 31 families with 49 children staying at other hostels that did not provide mental health outreach services. Parents in the intervention group reported a greater reduction in children's symptoms from baseline to a 6 month follow-up on the Strengths and Difficulties Questionnaire for the intervention group, with no significant differences in parents' self-reported symptoms on the General Health Questionnaire (Tischler et al., 2002). However, the authors noted that there was higher attrition and lack of follow-up in the control group than the intervention group. Strengths of the study include a quasi-experimental design with use of sound quantitative measures. Based on recruitment of the experimental and control groups, however, it seems likely that site differences could influence the results. It is also not clear how intervention participants were initially screened, as authors indicate that about 29% of otherwise eligible families were not recruited because they did not need a mental health intervention (Tischler et al., 2002). Furthermore, the services provided had no manual, and the level of services families received varied considerably in the intervention group, ranging from 1-24 appointments with an average of 6 sessions. While the results of the study suggest that mental health outreach services could provide benefit, methodology issues limit the strength of the findings and the study would be difficult to replicate. As such, the study would be considered not meeting evidence standards by WWC.

Beharie and colleagues (2011) conducted a family-focused intervention with homeless youth and their parents to prevent HIV/AIDS and substance abuse, to strengthen family communication, and to improve mental health. The HOPE Family Project involved an 8 session curriculum that was based on material from 3 different EBPs: the Strengthening Families Program, which involves parent skills, child skills, and family life skills; the SISTA Project, a prevention program developed by the CDC to increase safe sex behaviors; and the CHAMP

Program, an HIV prevention program for youths and families. With close community partnerships, the intervention was delivered to 102 caregivers and 122 youth ages 11-14 in six urban shelters. For comparison, a group of families participated in a three-session group discussion of HIV and drug use, with caregivers and youth in separate groups with no combined activities. Assessments occurred at pre-test, post-test, 6 month follow-up, and 12 month follow-up, and included a number of psychometrically established measures (the Parenting Skills Questionnaire for parental monitoring and supervision, the Children's Depression Inventory for youth mental health, the Brief Symptom Inventory for parent mental health) as well as questions designed to assess family support, parent-child communication, youth substance use, and youth sexual behavior. Results indicated increased knowledge of HIV at post-test and 6 and 12 months follow-up for both the intervention and comparison group. Also, there were statistically significant increases in parent-child communication for the HOPE Family group compared to the HOPE Health group at post-test, 6-month, and 12-month follow-up, and there were significant decreases in suicidal ideation for teens in the HOPE Family group (Beharie et al., 2011). Unfortunately, no information was provided regarding the number of families who participated in the comparison condition, how families were placed in groups, or whether there were differences between the intervention and comparison groups at baseline. Thus, despite some apparent strengths in methodology (e.g., use of psychometrically strong measures and use of a comparison group) the information provided is not sufficient for determining whether this study meets evidence standards.

Another program focused on teaching parents to emphasize preschool child language development (O'Neil-Pirozzi, 2009). Sixteen single parents residing with their children in Boston family homeless shelters were randomly assigned to either the intervention group (12 parents) or

the control group (4 parents). These families represented 84% of eligible families in shelter at the time. Parents in the intervention group attended four weekly, 90-minute small-group program sessions focused on understanding, discussing, and learning about language development in preschool children and methods for encouraging it. They also were given two children's books to read with their children between sessions. The control group parents participated in a social group and also received books for their children. Both groups were asked to keep track of reading activities with their children. Measures included parent receptive vocabulary skills with the Peabody Picture Vocabulary Test, attendance, parent-recorded reading practices, and observations of how parents facilitated their children's use of language during shared book reading both before and after intervention participation. Parents in the intervention group facilitated child language use more at post-test than parents in the control group (O'Neil-Pirozzi, 2009), although these differences were not statistically significant. Strengths of this study include its RCT design and measurement of relevant outcomes. By comparing the intervention group to a group who participated in assessments and received books but did not receive the instruction sessions, the researchers could be more confident that observed differences were due to the intervention itself. This intervention also was designed specifically to improve parent facilitation of preschool children's language development, and the study design and measures matched this specificity. However, the study was limited by a small sample size, particularly with regard to the control group of only 4 parents. It is possible that with a larger sample size, the differences would emerge as statistically significant. Only short-term outcomes were examined, and there were no measures of child outcomes to verify that enhancing parents' skills in facilitative language would benefit child language development. Also, it was not clear whether a manual was developed to enable replication or dissemination of the program. Based on all these

considerations, this study likely would not meet evidence standards despite the strengths of its RCT design.

Project Support is a program designed specifically for mothers and their children ages 4-9 in domestic violence shelters who had experienced violence by male partners during the previous 12 months. It was evaluated as an RCT. This program focused on mothers, but with an emphasis on behavior management skills for reducing child conduct problems as well as instrumental and emotional support during transition out of shelter (Jouriles et al., 2009). In order to be eligible to participate, mothers had to have at least one child meeting criteria for oppositional defiant disorder (ODD) or conduct disorder (CD), could not be receiving other services for child behavior problems, and could not have significant mental health issues or substance use problems. The manual for Project Support was based on research and treatment studies showing that reducing inconsistent and harsh parenting can reduce child conduct problems and that targeting parent adjustment and psychiatric symptoms can improve treatment impacts, particularly with mothers who have experienced interpersonal violence. The child management portion of the intervention was modeled after other behavioral training programs (Jouriles et al., 2009). Following an initial, promising randomized clinical trial with a small sample of 36 families (Jouriles et al., 2001; McDonald, Jouriles, & Skopp, 2006), researchers conducted a second randomized clinical trial with 66 families. Families were screened first in shelter then again after leaving shelter before being randomly assigned to program (N = 32 families) and comparison (N = 34) conditions. Trained therapists worked with mothers in the intervention condition, and mothers in the comparison condition received only instrumental and emotional support by phone. Mothers in the comparison condition were encouraged to seek other community resources if needed. Baseline and outcome assessments involved psychometrically

established measures, including the CBCL and the Eyberg Child Behavior Inventory (ECBI) for child conduct problems, the Parenting Dimensions Inventory (PDI) and the Revised Conflict Tactics Scale-Parent-child as measures of their inconsistency and acts of aggression, and the SCL-90-R as a measure of psychiatric symptoms. Finally, mothers' negative affect and harsh parenting behavior were observed and coded by trained raters with good reliability. Results indicated significant reductions in conduct problems on the CBCL and ECBI and in inconsistent and harsh parenting, with greater effects in the Project Support group than the comparison group.

Overall, the Project Support study design was methodologically strong with random assignment to groups, measures with sound psychometric properties and multiple methods, and long-term follow-up in addition to immediate post-treatment assessment. The researchers considered both statistical and clinical significance of findings. Furthermore, the detailed treatment manual enables attempts at replication and dissemination of the intervention. Limitations of the study and its findings include a reliance on mother's report for most outcomes, particularly child externalizing behavior. Because the intervention targeted mother behavior and symptoms, it is possible that participation in the Project Support intervention would impact how mothers reported on their parenting and their children's behavior without altering these behaviors in actuality, introducing bias. The findings would be strengthened if intervention impacts were apparent in reports of child behavior from other sources, such as teachers or other caregivers. Similarly, differences in mother-reported parenting behaviors were significant whereas differences in observed parenting behavior were not. Finally, the inclusion criteria for the study based on level of child behavior problems and lack of mother's mental health or substance use problems were quite strict such that less than half of families screened for the intervention were eligible, and an even smaller percentage were followed out of shelter, producing high attrition

rates. This suggests that the families in the study are not representative of the general population of families staying in domestic violence shelters and limits the extent to which the findings can be generalized more broadly. Thus, the study could meet standard with reservations, based on an RCT with high attrition but equivalence, allowing the intervention to be considered to have Potentially Positive Effects.

In contrast, another program focused on mothers with substance abuse issues who were either homeless or at-risk for homelessness. Using a quasi-experimental design, Sacks and colleagues (2004) examined the impact of a residential therapeutic community (TC) with additional components designed for needs of homeless mothers. A therapeutic community refers to a comprehensive psychosocial intervention with documented effectiveness for treating substance abuse problems and improving both psychological functioning and social behavior (De Leon, 2000; Sacks et al., 2004). In addition, the homeless parents' therapeutic community intervention (HP-TC) emphasized parenting, world of work, housing stabilization, and building a supportive community. Parenting aspects included a parents' group and family counseling, as well as child-focused activities such as daily child care, assessment with referral for early intervention, a children's group for age-appropriate substance abuse prevention activities, and prevention activities for visiting children not currently residing with the family in the therapeutic community. Work intervention activities included education preparation, work readiness seminars, assistance with job searches, and goal-setting and self-monitoring. Housing stabilization efforts involved case assistance and groups focused on applications, leases, and re-entry into the community. Families were recruited for participation at two HP-TC sites (intervention group, 77 families) and two traditional TC sites (comparison group, 71 families). Because intervention participation was not random but was based on geographical location,

researchers used propensity scores and statistical control techniques to account for preexisting differences between groups. Outcomes were measured primarily by parent-report across domains of parenting (including the Parenting Stress Index), housing stabilization, substance use/abuse, criminality, HIV risk behavior, employment, trauma, psychological distress (including the Beck Depression Inventory-II and the Symptom Check List 90-Revised), community, and health/treatment. Results indicated significant improvements in psychological distress and health for the HP-TC intervention group relative to the TC comparison group. There were no significant differences in other domains including parenting, substance use, and housing stabilization.

When an RCT is not possible, the sort of quasi-experimental design used in the TC study provides the next best evidence for evaluating an intervention's effectiveness, provided that sources of bias are controlled and groups can be considered equivalent on relevant domains. Another strength of the HP-TC study is that the novel intervention was compared to an established intervention, the traditional TC. The lack of difference between the intervention and comparison groups on mothers' substance use outcomes may indicate that both the HP-TC and traditional TC interventions were equally effective in improving substance use issues. It is noteworthy, however, that parenting and housing stability were not better among mothers who received the HP-TC intervention, despite being outcomes specifically targeted by the HP-TC protocol. Without a no-intervention comparison group, it is not clear whether both intervention conditions improved these outcomes, or whether these outcomes were unaffected. The HP-TC study also relied on parent report for most outcomes. The HP-TC study failed to measure child outcomes, so there is no evidence for impacts of the program on child behavior, mental health, or general well-being. With regards to child outcomes, the study does not meet evidence standards. For parent outcomes of health and psychological distress, the study may meet evidence standards

with potentially positive effects. In contrast to targeted interventions, the HP-TC intervention involved multiple components to address a range of goals, with case management, parent-directed programming, and child-directed programming. When several components are tested simultaneously in the same individuals, it is not clear whether all components are necessary, or if certain components are responsible for the effects. The two RCTs described next were similarly broad in their approaches.

Buckner and colleagues conducted a large, eight-site study to examine the effectiveness of a mother-focused intervention for improving behavior of children experiencing homelessness (Buckner, Weinreb, Rog, Holupka, & Samuels; D. J. Rog & Buckner, 2007). The intervention, the CMHS/CSAT Homeless Families Program, introduced an array of services to mothers such as mental health and substance abuse treatment, trauma recovery services, assistance in securing housing, and parent training. The study design was based on the assumption that improvements in maternal functioning would indirectly benefit children, improving their behavior and well-being. Furthermore, the study was designed for longitudinal follow-up to examine longer-term impacts of intervention and changes in behavior problems over time. Over 1,500 families were involved in the study, and 1,103 children ranging in age from 2-16 years had assessment data for behavior problems, with initial assessments and three follow-up assessments at 3, 9, and 15 months. At each site in the intervention study, about half of the families were assigned to the target intervention group or comparison group with either randomized or quasi-experimental designs. The comparison group received services within the shelters and community that were considered "services as usual" rather than the specialized package of services designed as the target intervention at each site. Because sites differed somewhat in the services that were included and emphasized in their target intervention packages, treatment status and

programmatic emphases were both considered in analyses. Results across sites indicated that although behavior problems improved for children over time, there were no significant differences based on intervention status or programmatic emphases (Rog & Buckner, 2007).

The Family Critical Time Intervention (FCTI) was implemented in Westchester County, New York to target the well-being of homeless mothers with mental illness or substance abuse problems for rapid re-housing and intensive case management services (Samuels et al., 2010; Samuels, Shinn, & Fischer, 2006). The intervention was based on the Critical Time Intervention, a distinct evidence-based and manualized treatment that originated with single homeless men in New York City (Herman et al., 2000). For FCTI, Families were stratified by size then randomized into an intervention group (97 families receiving FCTI) and a comparison group (113 families) who received services as usual. Families in the intervention group received intensive case management to connect the mother with appropriate services in the community then encourage increasing independence within a network of community supports (Samuels et al., 2010; Samuels et al., 2006). Child outcomes were measured at baseline and at 3, 9, 15, and 24 months in three broad domains of mental health, school functioning, and stressful life events. For mental health outcomes, parents completed the Child Behavior Checklist (CBCL), youth ages 11-16 completed the Youth Self-Report (YSR), and youth ages 6-16 completed the Children's Depression Inventory (CDI). School outcomes were measured based on parent and child report of attendance and parent report of the child's attitude towards school or childcare, experience of school or childcare, and troubles with school or childcare. Children also reported on their troubles with school and their level effort in school. Finally, youth completed a measure to report whether they have experienced items from a list of 24 negative life events. Results of the study indicated that children in the FCTI intervention group had "modestly" better scores on

mental health and school outcomes, but that these improvements were less stable than the general improvement observed in both groups over time, as families stabilized (Samuels et al., 2010; Samuels et al., 2006).

Both the CMHS/CSAT Homeless Families Program overall and the Family Critical Time Intervention study included strong research designs with large samples across different geographical sites or shelters, well-validated measures assessing child behavior problems, and longitudinal follow-up to assess possible impacts over time. The intervention groups were compared to families receiving a different set of services rather than a no-treatment control. This created a stringent test of intervention effects above possible benefits afforded by receiving any services. Interestingly, both studies found no significant effects of the interventions on child outcomes. Because both groups were receiving services, it is possible that both packages of services, the intervention and "services-as-usual," provided benefit to families and that the intervention had no added effect beyond services-as-usual. This could only be explored with the use of an assessment-only comparison group, which is impossible for both ethical and practical reasons (Seibel et al., 2012). However, if both sets of services are producing equal benefit, other considerations such as the resources needed and costs of both programs could be considered to determine which condition provides benefit most efficiently. Overall, the studies of the CMHS/CSAT Homeless Families Program and the Family Critical Time Intervention meet evidence standards based on RCT or QED design; however the interventions themselves would be considered to have No Discernible Effects at this time, based on the lack of findings in either a positive or negative direction. In other words, these studies have produced quality evidence that the interventions produced no meaning effects on the considered outcomes. Furthermore,

additional studies could consider individual components of the programs in isolation to determine whether and which services within the broad packages account for positive change.

Summary and Conclusion

The studies reviewed in this chapter represent laudable efforts on the part of researchers, practitioners, and community partners to engage in intervention studies with the challenging and understudied population of children in families experiencing homelessness. Challenges associated with intervening with this population are well-documented in these studies, including issues of great heterogeneity in the needs and characteristics of families experiencing homelessness, cultural sensitivity, trauma-informed care, high mobility, and ongoing stressors in the lives of these families. In response to the varied challenges, these studies also have provided insight about what works to engage stakeholders, communities, practitioners, and families. Wisdom and experience acquired through these initial efforts is valuable as it provides clinical expertise in the context of client characteristics, values, and preferences. According to the Institute of Medicine and APA, such expertise in context is essential for developing Evidence Based Practices. Also essential, however, is the integration of best available research evidence (American Psychological Association, 2005; Kazak et al., 2010; Seibel et al., 2012). Based on our review of existing studies within the guidelines of the What Works Clearinghouse (WWC) standards for Evidence Based Practices (What Works Clearinghouse, 2011), none of the interventions represented in these studies have sufficient evidence to be rated as having Positive Effects. In most cases, this is because quality evidence that evaluates the program effects does not exist.

First and foremost, more studies with rigorous methodology including RCTs or QEDs are critical for advancing the evidence base for interventions with homeless children. Studies that do

not include equivalent comparison groups simply cannot demonstrate that positive changes result from the intervention itself rather than other factors. In particular, families who experience homelessness tend to improve in functioning over time (Buckner et al.; D. J. Rog & Buckner, 2007; Samuels et al., 2010), making it is particularly important to demonstrate that intervention efforts produce benefits beyond those experienced by families receiving no intervention or care as usual. Descriptive studies alone are not sufficient for providing this information. In the context of well-designed RCTs and QEDs, it also is essential that studies include valid and reliable outcome measures, low attrition rates or equivalent groups despite attrition, statistical adjustments for pre-intervention differences in a QED, and specificity such that intervention are not combined and tested simultaneously (What Works Clearinghouse, 2011). To build an evidence base such that an intervention can be considered to have Positive Effects, results in favor of the intervention must be replicated in multiple studies, conducted with fidelity to the intervention, which requires that interventions have manuals (Chambless & Hollon, 1998; What Works Clearinghouse, 2011).

Next steps in developing evidence-based interventions with homeless families must seek to combine the wisdom and expertise gained by efforts represented in this review with empirical studies that meet evidence standards. Interventions that are represented in descriptive studies but have not been tested with RCTs or QEDs may indeed produce positive effects, and thus the intervention developers are encouraged to rigorously evaluate their programs with strong designs and valid, reliable assessments. Other efforts may involve adapting existing EBPs for use with children experiencing homelessness, rather than starting from scratch (Bassuk, 2010; Gewirtz & Taylor, 2009; Samuels et al., 2010). Examples of such efforts currently underway include using Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, Berliner, & Deblinger,

2000), Parenting Through Change (Forgatch & DeGarmo, 1999; Gewirtz, Forgatch, & Wieling, 2008), Early Risers (August, Realmuto, Hektner, & Bloomquist, 2001) through the Healthy Families Network (Gewirtz, 2007), and the Building on Strengths and Advocating for Family Empowerment (BSAFE), an adaptation of the Critical Time Intervention developed by the National Center on Family Homelessness (Bassuk, 2010). Of course, adaptations of EBPs or even EBPs implemented without adaptation should be rigorously evaluated within the population of homeless families, as contextual differences may impact the effectiveness of any intervention. Finally, attention should be paid to the specificity of interventions. Given the heterogeneity among families experiencing homelessness and the diverse needs of this extremely high-risk population, programs combining multiple interventions or components may be most likely to be effective. However, such programs also are likely to be more expensive. Individual components must be tested separately and even compared to determine which produce positive effects most efficiently. Such efforts would be best served by programs of research and multiple studies that could examine intervention components individually and in combination.

Conducting empirical investigations that meet evidence standards may be costly in terms of funding, training, resources, and time. States and municipalities have begun developing and investing in ways to routinely evaluate their programs and services in rigorous-but-cost effective ways, such as through integrated administrative data systems (Culhane, Fantuzzo, Rouse, Tam, & Lukens, 2010). Without an investment in quality evidence, however, little can be learned beyond what we already know regarding the best practices for intervening with children experiencing homelessness, and what we already know is largely not based on rigorous evidence when it comes to programs for children in families experiencing homelessness. Policymakers, funding agencies, researchers, clinicians, and community practitioners can expand the evidence

base for interventions with homeless children through understanding what constitutes quality evaluations and supporting these sorts of efforts. Building a robust and rigorous evidence base of what works will allow stakeholders to improve the well-being of at-risk children, bettering their lives through increasingly effective and increasingly efficient programs.

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