Homeless Mothers with Severe Mental Illnesses and Their Children: Predictors of Family Reunification

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Although many homeless women lose physical custody of children, prior studies have not examined predictors of reunification. To explore factors associated with separation and potential resources for reunification, baseline data from 1,542 homeless women with mental illness were used to identify unique characteristics of separated mothers. Separated mothers demonstrated greater vulnerabilities than accompanied mothers did, but more resources than women who are not mothers did. Of 698 separated mothers, 118 (17%) were reunited with children at 12 months. Changes in housing, psychosis, substance use and therapeutic relationships predicted reunification. Results suggest that programs for homeless mothers with severe mental illness can affect changes that promote family reunification.

In the past two decades, there has been a dramatic increase in homelessness among women and families with children. Women comprise over one-fifth of the adult homeless population (Buckner, Bassuk, & Zima, 1993; Burt, Aron, Douglas, Valente & Lee, 1999). Families, headed primarily by single mothers of preschool-aged children, comprise at least one-third of the total homeless population (Buckner et al., 1993; Burt et al., 1999), and in the recent past, mothers with children represented one of the fastest growing segments of the homeless population (Bassuk & Weinreb, 1994). Family preservation is understandably a major concern for homeless mothers, especially since up to 70% are separated from at least one of their minor children (Burt et al., 1999; Robertson & Winkelby, 1996; Zima, Wells, Benjamin & Duan, 1996; Zlotnick, Robertson & Wright, 1999). Although several factors associated with break-up of homeless families have been identified (Bassuk & Weinreb, 1994; Robertson, 1991; Solarz, 1992), published data have not yet established the percentage of homeless families that reunify, nor have any empirical studies identified specific factors that are associated with family reunification.

For many homeless families, the precipitant of family separation is housing-related. Some mothers voluntarily place their children in the care of relatives and friends while they search for housing (Bassuk & Weinreb, 1994; Robertson, 1991). In other instances, families may be forced to separate in
order to obtain emergency housing because available shelters do not accommodate large families or adolescent boys. Homeless mothers may also lose their children to involuntary foster care placement if their inability to provide a home is perceived as neglect (Bassuk & Weinreb, 1994; Roberston, 1991; Solarz, 1992). Once without children, homeless mothers may lose welfare benefits and food stamps, further decreasing their chances of securing housing and reuniting their families. Due to this vicious cycle, homeless mothers may be unable to regain custody of their children, even in cases without prior evidence of parental abuse or neglect (Bassuk & Weinreb, 1994; Roberston, 1991; Solarz, 1992).

Mental illness and substance abuse have been recognized as contributing risk factors for homelessness, as well as for fragmentation of homeless families. When compared to domiciled low-income mothers, homeless mothers exhibit higher rates of serious mental illness and substance abuse (Buckner et al., 1993; Robertson, 1991; Robertson & Winkelby, 1996; Zima et al., 1996; Zlotnick et al., 1999), and they are more likely to be separated from at least one child (Buckner et al., 1993; Zima et al., 1996; Zlotnick et al., 1999).

Studies of homeless women converge to suggest that solitary homeless women demonstrate greater vulnerabilities than homeless women with children in their care. Homeless mothers separated from their children and women who are not mothers tend to be older, receive less income and exhibit higher rates of substance abuse than homeless mothers accompanied by children (Robertson & Winkelby, 1996; Smith & North, 1994; Zlotnick et al., 1999). Although findings are mixed regarding the rates and severity of psychiatric illness among homeless women (Robertson & Winkelby, 1996), studies generally report a higher prevalence of serious psychiatric disorders among solitary homeless women (Burt & Cohen, 1989; Robertson & Winkelby, 1996; Smith & North, 1994). This pattern of findings has led previous authors to conclude that homeless mothers with children in their care may benefit from increased attention to social services, whereas solitary homeless women may benefit from increased screening for psychiatric problems and substance abuse (Robertson & Winkelby, 1996; Smith & North, 1994). No studies, however, have examined whether service use and concomitant changes in clinical status and community adjustment are associated with reunification of homeless mothers and their children.

The focus of this study is on one-year outcomes for homeless women enrolled in the Center for Mental Health Services’ Access to Community Care and Effective Services and Support Program (ACCESS). ACCESS is an 8-site, five-year demonstration program designed to examine the influence of service systems integration on use of services and related improvement in quality of life among homeless people with mental illness (Randolph, Blasinsky, Leginski, Parker & Goldman, 1997). The current outcome study addressed two questions for homeless women. First, how do mothers separated from their children differ from mothers accompanied by children and women who are not mothers in their personal characteristics and service use? Second, what changes in health status, community adjustment and service use are associated with reunification of homeless mothers and their children at one-year follow-up?

METHODS

The ACCESS Program

In 1994, the ACCESS program was implemented in 18 communities across the United States. All sites participating in the ACCESS demonstration established specialized outreach teams to make contact with untreated homeless people with severe mental illness, and assertive case management teams to provide comprehensive services for 100 new clients each year. The first cohort was recruited between May 1994 and July 1995 and the fourth cohort between May 1997 and July 1998.

Client Eligibility Criteria and Sources of Data

Clients were eligible for case management if they were homeless, diagnosed with a severe mental illness, and were not involved in ongoing mental health treatment. Operational entry criteria for homelessness and mental illness have been described elsewhere, along with validating data (Rosenheck & Lam, 1997).

Those who met program eligibility criteria were invited by their outreach worker to participate in the case management phase of the ACCESS program. Those who gave written informed consent were evaluated with a comprehensive baseline interview and were re-interviewed three and twelve months post-baseline.

Measures

Sociodemographics and housing status.

Documented personal characteristics included: age, gender, race, marital status and years of education. Housing characteristics that were examined included the total duration of the current homeless episode and where the client had been staying during the 60 days prior to each interview (i.e., shelter, institution, street, and housed).

Background and community adjustment.

Additional data were obtained on community adjustment and background, including income, employment, quality of life (Lehman, 1988), social support networks (i.e., number of people to whom the client felt close and
types of people that the client could depend upon for loan, transportation or emotional support), victimization within 60 days prior to interviews, and lifetime history of incarceration.

Psychiatric and substance use status. Psychiatric status was assessed with standardized scales measuring self-reported symptoms of depression (Robins, Helzer, Croughan, & Ratcliff, 1981) and psychosis (Dohrenwend, 1982), as well as interviewer ratings of psychotic behavior. Psychiatric problems and alcohol and drug use were assessed using the composite problem scores from the Addiction Severity Index (ASI) (McLellan, Luborsky, Woody, & O'Brien, 1980). Diagnoses were based on working clinical diagnoses of the admitting clinicians on case management teams.

Service use. Service use was assessed with a series of 23 items concerning the use of various health and social services. These were collapsed into aggregate scales measuring the number of days in the previous 60 that clients reported receiving outpatient psychiatric, substance abuse and medical treatment. Another series of questions addressed reported receipt of public support payments and housing assistance.

Therapeutic relationship. The strength of clients' therapeutic relationships was assessed with a series of 10 questions. Clients were first asked if they had a primary clinician. Those who responded affirmatively were then administered a 9-item scale assessing therapeutic alliance (Chinman, Rosenheck & Lam, 1999). The scale included questions about clients' satisfaction with therapy, levels of trust toward their therapists, and perceptions of their therapists' abilities to help them. These responses were then converted into a three-level ordinal variable: 0 = no relationship with a primary clinician, 1 = low therapeutic relationship (clients with scores at or below the median on the scale assessing therapeutic alliance) and 2 = high therapeutic relationship (scores above the median on the scale).

Change characteristics. Changes in client status were developed by subtracting baseline scores from 12-month follow-up scores on measures of housing status, psychiatric symptoms, substance use, social support, quality of life and service use.

Dependent measures. The first dependent variable was a three-level categorical variable representing three subgroups of homeless women: mothers living apart from children under the age of 18 (separated mothers), women who were not mothers (non-mothers), and mothers accompanied by minor children (accompanied mothers). In order to avoid misclassification of women with adult children as non-mothers, we performed a cross tabulation of client age by number of minor children and found that it was very rare for women over the age of 50 to have minor children in their care. Consequently, to avoid confounding due to the inclusion of older women whose children live independently, we limited the sample to women between the ages of 18 and 50.

The second outcome measure in this study was a dichotomous variable representing mothers who were reunited at the 12-month follow-up and those who were not. Reunited mothers were those living apart from all of their children at baseline, and who were living with at least one minor child at the 12-month follow-up.

Data Analysis
Analyses were conducted in several stages. Bivariate analyses were performed to identify differences among subgroups of homeless women (separated mothers, non-mothers and accompanied mothers) on baseline sociodemographic characteristics, and measures of clinical status, community adjustment and service use. In order to identify which characteristics independently predicted differences between the subgroups of women, backward step-wise multinomial logistic regression was performed with a three-level categorical dependent variable representing the three subgroups of homeless women.

In a second series of analyses, bivariate analyses were performed to identify differences between separated mothers who were reunited with their children and those who were not. Backward-stepwise logistic regression analyses were then performed to identify which changes in client status and service use independently predicted family reunification, controlling for baseline scores, site and race.

Results
Sample Characteristics
During the first four years of the program, a total of 7,225 homeless clients provided informed consent to participate in the program evaluation. Among the 2,027 women between the ages of 18 and 50 included in the total sample, 1,543 (76%) completed baseline and 12-month interviews. These 1,543 homeless women comprised the sample for this study.

Most of the women (61%) were mothers, but only one-quarter of the mothers had children in their care (26%). The mothers in the sample had an average of 2.4 children. The composition of the sample included 698 separated mothers (45%), 604 non-mothers (39%) and 241 accompanied mothers (16%).

The mean ±SD age of women was 35.31 (S.D. = 7.8 years). A total of 53 percent were African American, 38 percent were Caucasian, 4 percent were Latino and 5 percent were of other ethnic back-
Within the sample of women separated from their children, logistic regression was used to identify differences between women who completed only baseline interviews and those who completed both baseline and 12-month interviews. Women who were successfully followed-up were younger (p<.04) and less likely to receive housing assistance (p<.04).

### Characteristics that Distinguish Separated Mothers from Accompanied Mothers and Non-Mothers

The results of two multinomial logistic regressions are presented in Table 1. The first regression was performed to identify the characteristics that differentiated the three subgroups of homeless women (separated mothers, non-mothers and accompanied mothers), using separated mothers as the reference group. The second regression explored differences in service use among the three subgroups of homeless women, controlling for personal characteristics.

Mothers with children in their care differed from separated mothers in personal characteristics and in patterns of service use. Compared to separated mothers, accompanied mothers were significantly younger, more likely to be African American, and less likely to exhibit psychiatric problems, substance abuse problems and lifetime prevalence of incarceration and psychiatric hospitalization. Service use characteristics between the two groups also differed. Mothers with children in their care were more likely than separated mothers to report receipt of public support payments and housing assistance, and less likely to report use of outpatient substance abuse treatment, which is expected since accompanied mothers were significantly less likely than separated mothers to report substance-related problems. Notably, although accompanied mothers reported fewer personal

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### Table 1 - Multinomial Logistic Regression of Characteristics That Differentiate Separated Mothers from Accompanied Mothers and Non-Mothers

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>ACCOMPANIED MOTHERS (N=241)</th>
<th>NON-MOTHERS (N=604)</th>
<th>SEPARATED MOTHERS (N=698)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Nagelkerke coefficient of determination</td>
<td>0.30***</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td>-0.44***</td>
<td>-0.49***</td>
<td>1</td>
</tr>
<tr>
<td>African-American</td>
<td>0.46*</td>
<td>-0.46***</td>
<td>1</td>
</tr>
<tr>
<td>Incarcerated during lifetime</td>
<td>-0.09***</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>N lifetime psychiatric hospitalizations</td>
<td>-0.03*</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>Psychotic behavior score</td>
<td>-1.40*</td>
<td>0.75</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol problems score (ASI)</td>
<td>-2.50***</td>
<td>-1.54</td>
<td>1</td>
</tr>
<tr>
<td>Drug problems score (ASI)</td>
<td>-1.13*</td>
<td>-0.02</td>
<td>1</td>
</tr>
<tr>
<td>Quality of life score</td>
<td>-0.01</td>
<td>-4.14***</td>
<td>1</td>
</tr>
<tr>
<td>N people feel close to</td>
<td>-0.04</td>
<td>-0.09***</td>
<td>1</td>
</tr>
<tr>
<td>Instrumental social support score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service use characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Nagelkerke coefficient of determination</td>
<td>0.35***</td>
<td>0.00</td>
<td>1</td>
</tr>
<tr>
<td>Public support payments</td>
<td>0.00***</td>
<td>0.00</td>
<td>1</td>
</tr>
<tr>
<td>Housing assistance</td>
<td>0.08***</td>
<td>-0.04</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient substance treatment</td>
<td>-0.04</td>
<td>-0.04***</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient psychiatric treatment</td>
<td>-0.00</td>
<td>0.01</td>
<td>1</td>
</tr>
<tr>
<td>Therapeutic relationship score</td>
<td>-0.13</td>
<td>-2.4*</td>
<td>1</td>
</tr>
</tbody>
</table>

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*Regression coefficient represents differences relative to mothers separated from children.

**Regression adjusted for ethnicity and site.

***Regression adjusted for client characteristics, ethnicity, and site.

* p<.05

** p<.01

*** p<.001
vulnerabilities and greater use of social services than separated mothers, their overall quality of life scores were significantly lower.

Women who were not mothers also exhibited characteristics that distinguished them from non-mothers. Compared to separated mothers, non-mothers were more likely to be white and less likely to have a lifetime prevalence of incarceration. Although the two groups showed similarly severe levels of psychiatric and substance abuse problems, non-mothers reported using less outpatient substance abuse services than separated mothers. Non-mothers also described poorer social support networks than separated mothers, including poorer therapeutic relationships with their primary clinicians, feeling close to fewer people and receiving less instrumental support.

In sum, although separated mothers in this study demonstrated more vulnerabilities than accompanied mothers, they also reported greater social support and service resources than non-mothers, providing a potential foundation for family reunification.

**Characteristics that Predict Family Reunification**

Of 698 homeless mothers who were initially separated from their children, almost one-fifth (n = 118, 17%) were reunited with at least one of their children at the one-year follow-up. The results of the logistic regression exploring factors associated with family reunification are presented in Table 2. Baseline characteristics associated with reduced likelihood of reunification included psychotic behaviors, victimization within the two months prior to the interview and perhaps paradoxically, the total number of non-professionals to whom the client felt close. Baseline characteristics that did not make significant independent contributions to family reunification included the mothers’ ages, total income, depressive symptoms and the numbers of days housed, incarcerated and/or institutionalized.

The results of the final logistic regression model are presented in Table 2. The findings show that after controlling for baseline characteristics, family reunification at one year was predicted by the following changes in mothers’ health status and community adjustment: increases in days housed, reductions in psychotic symptoms, reductions in drug use and improved therapeutic relationships. Changes in days that the mothers spent in institutions and jail did not predict family reunification.

**Table 2 — Logistic Regression of Baseline and 12-Month Follow-Up Characteristics Associated with Family Reunion**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>BASELINE</th>
<th>12-MONTH FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline client characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Nagelkerke coefficient of determination</td>
<td>.25***</td>
<td>.09*</td>
</tr>
<tr>
<td>N days housed in past 60</td>
<td>n.s.</td>
<td>.09</td>
</tr>
<tr>
<td>N people feel close to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic behavior score</td>
<td>-.08*</td>
<td>-.10**</td>
</tr>
<tr>
<td>N of 5 types of victimization in past 60 days</td>
<td>-.07*</td>
<td>(n.s.)</td>
</tr>
<tr>
<td>Change characteristics plus baseline characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Nagelkerke coefficient of determination</td>
<td>.35***</td>
<td>.15***</td>
</tr>
<tr>
<td>N days housed in past 60</td>
<td>—</td>
<td>.15***</td>
</tr>
<tr>
<td>Psychotic symptoms score</td>
<td>—</td>
<td>.09**</td>
</tr>
<tr>
<td>Drug problem score (ASI)</td>
<td>—</td>
<td>.08**</td>
</tr>
<tr>
<td>Therapeutic relationship score</td>
<td>—</td>
<td>.06*</td>
</tr>
</tbody>
</table>

*Two analyses were conducted: one for individual baseline characteristics and one for change characteristics, controlling for baseline characteristics, ethnicity and site.

*p<.05

**p<.01

***p<.001

**Discussion**

In order to identify factors associated with separation of homeless mothers with severe mental illnesses and their children, as well as resources that could provide a potential foundation for family reunification, we first examined how mothers with mental illnesses separated from their children differed from other homeless women with severe mental illness. Our findings, consistent with research on non-clinical samples of homeless women, suggested that mothers separated from their children were significantly more likely than mothers with children in their care to demonstrate serious substance abuse problems (Robertson & Winkelby, 1996; Smith & North, 1994), psychiatric problems (Smith & North, 1994), as well as previous involvement in the criminal justice system. Our data further suggest that although separated mothers and women who were not mothers exhibited similarly severe levels of substance abuse and psychiatric problems, separated mothers described significantly greater utilization of outpatient substance abuse treat-
ment, stronger relationships with their primary clinicians and stronger social support networks. Consequently, separated mothers possessed some unique resources that might increase their chances for family reunification.

Most of the women in this study were mothers, but only one-quarter maintained physical custody of all of their children. The high prevalence of family fragmentation in this study is not surprising, as family preservation has been identified as a serious problem for homeless mothers, particularly among those with substance abuse and mental illness (Zlotnick et al., 1999).

Of the 698 homeless women with severe mental illness who were separated from their children at baseline, 118 (17%) were reunited at the one-year follow-up. Family reunification was predicted by changes in mothers’ health status and community adjustment, including increases in days housed, decreases in psychotic symptoms, decreases in drug use and improved relationships with their primary clinicians. It is not surprising that decreases in psychosis and substance abuse were associated with reunification, as both of these factors have been strongly implicated in homelessness and in loss of child custody (Buckner et al., 1993; Zlotnick et al., 1999). Parental substance abuse, in particular, has been described as the largest contributing factor to child placement in foster care (Zlotnick et al., 1999).

Although previous studies have shown benefits of intensive case management services for homeless individuals with severe mental illness (Morse & Calsyn, 1992), the results of this study suggest that a potential added benefit of these programs is that they can facilitate family reunification. Consequently, services directed toward homeless mothers might also benefit some homeless children who have been separated from their mothers. For example, when children are placed in temporary foster care when the only reason is lack of housing, they can suffer negative emotional sequelae due to additional traumatic dislocations, as well as potential developmental and long-term emotional problems (Bassuk & Weinreb, 1994). Bassuk and Weinreb (1994) argue that foster care placements should be limited to circumstances in which children’s safety is threatened, parents are unable to provide a basic level of care, or parents opt to participate in drug treatment programs that don’t allow several limitations to this study must be addressed. First, detailed information about the reasons for family separation was not available, including whether separation was voluntary or not, or whether family reunification would be beneficial for mothers and their children. Second, this study focused only on how characteristics of the mothers were associated with family reunification, as detailed information about the children was not available, including their ages, health status and behavioral characteristics. The first two limitations are because these data were originally intended as part of a program focused on evaluating the impact of systems integration on homeless services, and not primarily collected to evaluate factors associated with family reunification. Third, the assessment of substance abuse was limited by the use of the ASI, an instrument not designed for use with people with serious mental illness, and the absence of chemical tests of substance use. Fourth, because the findings in the present study are based on self-reported interview data, they are subject to recall bias and under-reporting of sensitive issues, such as substance use and victimization. Lastly, because this study did not use an experimental design, it is possible that some of these families would have reunited in the absence of treatment, and we can not therefore establish a causal relationship between case management and family reunification. In spite of these limitations, however, our findings suggest that programs for homeless mothers with se-
vere mental illness can affect changes in mothers’ health status and community adjustment that promote family reunification.

References


