

Integrating Behavioral Health Services for Homeless Mothers and Children in Primary Care

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This article describes an innovative trauma-informed care management model in which mental health, substance abuse, and support services are integrated for homeless families in primary care. The rationale for service integration in a health care setting is discussed and the conceptual underpinnings of the model are elaborated, drawing from the literature and clinical experience. Service encounter data collected by each staff member over a 1-year period ($N = 7,214$ encounters) allow for description of program functions and provider roles and activities, an essential step in developing the fidelity indicators necessary for future program replication and rigorous testing in additional settings. The feasibility of implementing an integrated set of services for homeless families in primary care is demonstrated. Practice, training, and research implications are discussed.

Keywords: homelessness, behavioral health, primary care

An estimated 13.5 million Americans have spent time in shelters, abandoned buildings, or on the streets; an additional 12.5 million have “doubled-up” with family or friends during a period they considered themselves homeless (Letiecq, Anderson, & Koblinsky, 1998; Link et al., 1994). The prevalence of families among the homeless, typically a single mother about 30 years of age with two children, has grown significantly over the past two decades (Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, & Holupka, 1995; Rosenheck, Bassuk, & Salomon, 1999).

These families face an array of complex challenges in addition to being homeless. Three out of four homeless mothers meet criteria for at least one lifetime psychiatric diagnosis; lifetime rates of substance abuse disorders in homeless mothers (41%) are also more than twice those reported in national surveys of women (Bassuk, Buckner, Perloff, & Bassuk, 1998). Homeless mothers experience high rates of chronic illness and limitations in physical functioning compared to the general population (Weinreb, Goldberg, & Perloff, 1998). Most homeless mothers have experienced severe physical or sexual victimization at some point in their lives (Weinreb, Goldberg, & Perloff, 1998) and may be coping with the emotional and physical sequelae of trauma. High levels of

physical illness and emotional and behavioral health difficulties are also common among homeless children, who also are more likely to have been victims of or to have witnessed violence (Weinreb, Goldberg, Bassuk, & Perloff, 1998; Bassuk, Weinreb, Dawson, Perloff, & Buckner, 1997; Buckner, Bassuk, Weinreb, & Brooks, 1999).

In the late 1990s, the U.S. surgeon general drew attention to the pivotal role that primary care settings play in the identification and treatment of mental disorders (USDHHS, 1999). Collaborative approaches between medical and mental health providers improve adherence to treatment, increase patient satisfaction, and improve mental health outcomes (Rubenstein et al., 1999; Katon et al., 1997). Primary health care visits provide an opportunity for basic health screening and preventive services for the homeless, as well as a context for screening, assessment, treatment, and referral to mental health and substance abuse services (Gelberg, Andersen, & Leake, 2000; Stein, Andersen, Koegel, & Gelberg, 2000; Weinreb & Bassuk, 1990a). Although Health Care for the Homeless Programs across the country provide an array of mental health, substance abuse, and primary care services to homeless adults and families, there is considerable diversity in local delivery systems and approaches used to coordinate care (USDHHS, 2006). The literature specifically lacks detailed descriptions of models of integrated mental health and substance abuse services for homeless families in primary health care (Morse, 1999). Well-specified, detailed descriptions of program practices and clearly articulated standards provide the underpinnings for intervention fidelity assessment strategies, an essential step in intervention replication and testing, and in the ultimate development of an evidence base (Mowbray, Holter, Teague, & Bybee, 2003).

In the Homeless Families Program (HFP) of Worcester, Massachusetts, based at a federally funded community health center, the Family Health Center, Inc. (FHC), the mental health and substance use issues and trauma-related sequelae of homeless mothers and their children are identified and addressed in the

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primary care setting. Begun in 1988 in response to the growing numbers of homeless families in the community, the HFP initially focused on the provision of primary health care. The HFP evolved over the years to include a multifaceted set of services including primary health care, family advocacy/case management, parent education and support, and mental health and substance abuse treatment. Family members receive services while they are homeless, that is, either sheltered or “doubled-up” with relatives or friends, and then during the initial phase of their stabilization in permanent housing.

The HFP was 1 of 14 study sites selected in 1999 by the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in Phase I of a 5-year, two-phase multisite study of the effectiveness of interventions for homeless mothers with psychiatric and/or substance use disorders who were caring for their dependent children. The Worcester HFP was the only intervention in the SAMHSA multisite study in which services are provided in a health setting. Phase I of the multisite study, the planning period, spanned 2 years (1999–2001). Descriptive data were obtained on the target population of homeless families, as well as on available resources, to inform the refinement of interventions in each site. Methods were developed for describing and assessing the fidelity of interventions, suitable comparison groups were identified, and the ultimate outcomes study design was delineated. To be considered homeless for the study, a family had to either lack a fixed, regular address and adequate nighttime residence or be living doubled-up in a temporary situation in which the mother’s name was not on the lease and she and her family were subject to the hospitality of the host (Rog, Rickards, Barton-Villagrana, Hastings, & Holupka, in press). The intervention in each site was time limited and comprehensive, aimed at meeting the mental health, substance abuse, and/or trauma service needs of homeless women with children. Although interventions shared a common set of core elements, for example, case management, parent support, mental health services, and so forth, the type and intensity of services offered varied across interventions. Services were provided in a range of settings including, for example, shelters and transitional housing programs.

For Phase II (2001–2004), 8 study sites from the original 14 were chosen to participate in the outcomes evaluation. Each site administered a cross-site interview protocol, developed by collaborating sites and the federally funded coordinating center, to study participants at the time of enrollment into the study and at 3-, 9-, and 15-month follow-up intervals. The interview protocol included items in 13 domains, including background and demographics, mental health, trauma history and symptoms, and so forth, utilizing a combination of standardized and original instruments (Rog et al., in press). Each site had the option to administer unique measures as well.

Homeless families receiving the HFP intervention were compared with homeless families in Worcester receiving “services as usual.” Families for the comparison condition were recruited from the same shelters as families in the treatment group but were receiving health care from providers other than those at the intervention site. Findings from the outcomes study will be presented in future manuscripts. In Phase II, data were also obtained on the process of implementing the HFP intervention, as well as on the fidelity of the implementation with the proposed model.

The goal of this article is to lay the groundwork for fidelity assessment, replication, and rigorous testing of the HFP model by thoroughly describing program components and practices. Two strategies are employed to begin to define indicators for intervention fidelity: (a) the use of expert opinion as derived from the published literature and (b) the use of a research model based on participatory action research to gather descriptive data (Mowbray et al., 2003). The article begins by offering the rationale for the integration of trauma-informed mental health and substance abuse services for homeless mothers and children in the primary care setting. The target population and the conceptual underpinnings (or “key ingredients”) of the HFP model are elaborated, drawing from the published literature and extensive clinical experience. The day-to-day process of integrating services for homeless mothers and children in the intervention is described. Service record data, that is, information provided by HFP staff members regarding encounters with or on behalf of a client family member in a 1-year period of time, allow for the detailed description of providers’ roles and activities with homeless families participating in the intervention. These data begin to establish parameters for fidelity and provide the detailed understanding of the HFP model essential to future replication and further testing in other settings. The article concludes with a discussion of practice, training, and research implications.

Why the Primary Health Care Setting?

The literature regarding homeless mothers and their children, and women with mental health disorders in general, lends support to placing an intervention that addresses comprehensive needs in the primary health care setting. In the context of the high rates of childhood and adulthood victimization commonly experienced by homeless mothers, it is not surprising that many homeless mothers suffer from mental health disorders (Bassuk et al., 1998; Weinreb, Buckner, Williams, & Nicholson, 2006). However, despite high levels of mental health disorders, many homeless mothers are unlikely to receive mental health services (Bassuk et al., 1998; Zima, Wells, Benjamin, & Duan, 1996). Women with mental health disorders are more likely to seek treatment from a nonpsychiatric physician than from a mental health professional (Norquist & Regier, 1996; Sherbourne, Dwight-Johnson, & Klap, 2001). Homeless adults with mental health disorders also more commonly access mental health services via primary care rather than via specialty mental health care (Zima et al., 1996). Finally, women struggling with victimization histories or psychiatric disorders often suffer from comorbid physical health conditions that result in high levels of medical care utilization, thereby increasing the likelihood that their needs can be identified in primary care settings (Bassuk, Dawson, Perloff, & Weinreb, 2001; Greenberg et al., 1999; Stein et al., 2000; Switzer et al., 1999; Weinreb, Goldberg, & Perloff, 1998).

Having services located in the primary care setting may help homeless mothers overcome the obstacles to access and participation that the stigma of mental illness, substance abuse, or child abuse places in the way in other treatment or child welfare-affiliated settings. To be eligible for services in traditional treatment or child welfare-funded settings, a psychiatric diagnosis or a substantiated report of child abuse or neglect is most likely required. Therefore, a mother typically seeks services in these set-

tings because something is “wrong”; that is, she or her child is experiencing symptoms of mental illness or, in the worse case scenario, she has “failed” as a parent, that is, has been abusive or neglectful. Even in primary care settings, homeless mothers, particularly those of color, may be hesitant to come themselves or bring their children in for treatment because of the risk of being judged or losing custody of their children if abuse or neglect is suspected. Mothers with serious mental illness, for example, report that providers often have negative attitudes about them as parents simply because they meet diagnostic criteria for mental illness (Nicholson, Sweeney, & Geller, 1998b). However, when mothers come, or bring their children for health care services, they are oftentimes doing something “right,” that is, seeking routine preventive care or treatment for physical illnesses. Provider–patient relationships may be more likely to be built on patients’ strengths in the primary care setting, enhancing family members’ engagement, participation, and progress in services (Banyard & Graham-Bermann, 1995).

The family medicine approach, which is committed to patient–provider relationships that emphasize trust and caring, lends itself particularly well to engaging families that struggle with a range of complex issues in addition to their need for medical care (Green et al., 2004). In situations in which child abuse or neglect are truly concerns, mothers who have been treated by providers as having strengths as well as deficits may be more open to recommendations for intervention.

The Community Health Center Context

The FHC offers a family practice–based model of primary care with three primary care teams that include physicians, nurse practitioners, nurses, and bilingual medical assistants. Similar to most federally qualified community health centers across the country, the FHC offers a comprehensive array of services including mental health and substance abuse services; urgent care; and dental, pharmacy, radiology, and laboratory services, though these services are not necessarily coordinated or integrated within the community health center setting. Programs targeted to special populations include an HIV program and obstetrical and newborn services, as well as the HFP. The patient mix is ethnically and racially diverse: 28% white, 13% black, 48% Latino, 7% Asian, and 7% other. Currently, 51% of patients have publicly funded insurance, 36% are uninsured, and 11% have private insurance. Uninsured patients are eligible to receive free care. Although the ethnic/racial breakdown of families served by the HFP is the same as the overall health center, approximately 90% of homeless families served at FHC are Medicaid subscribers.

Homeless Families in Worcester

Worcester, Massachusetts, is a medium-sized city in central New England (population 172,648) located 40 miles west of Boston. Although 2000 census data indicate a population that is 15% Hispanic, 7% black, and 77% non-Hispanic white, Worcester’s Transitional Aide to Needy Families (TANF) population consists of approximately 45% Hispanics, 10% African Americans, and 45% non-Hispanic whites. Data from the Phase II SAMHSA-funded evaluation interviews with participants indicate the target population of homeless mothers in Worcester is, on average, 29

years of age and from a diverse mix of racial and ethnic backgrounds (21% non-Hispanic white, 50% Hispanic, and 16% African American, and 13% other) (Weinreb et al., 2006). Most of the mothers are heads of household and report an average of two children. Many have experienced homelessness at some time prior to the current episode. About one quarter (28%) are high school graduates; 6% of mothers are currently employed. About 70% report experiencing violence at some point in their lives. More than 80% experienced a mental health disorder in the past year as evidenced by a diagnostic assessment, most commonly depression, posttraumatic stress disorder, or substance abuse (Weinreb et al., 2006).

The population characteristics of homeless families in Worcester are similar to those in many cities and community health centers, which contributes to the generalizability of the HFP model to other sites across the country. Worcester’s homeless mothers are similar in age, education, and poverty level to homeless mothers in other studies, though they are more likely to identify with a racial and ethnic minority group (Burt, 2001; Rog et al., 1995; Shinn et al., 1998). Similar to studies in other cities, rates of childhood victimization and recent or current exposure to adult violence are high (Rog et al., 1995; Shinn et al., 1998). Data from the SAMHSA-funded multisite study allow for current comparison of homeless families in Worcester with those in five other participating cities across the country in New York, Arizona, Missouri, Connecticut, and North Carolina. With the exception of ethnicity, that is, higher rates of Latino families and fewer black families in Worcester, homeless female heads of household in Worcester are comparable to women in other SAMHSA sites in demographic characteristics, victimization history, health, mental health, and substance abuse history (Rog et al., in press).

HFP Key Ingredients

Extensive clinical experience, review of the literature, and focus groups with HFP consumers and providers suggested that an effective intervention for homeless mothers and their children must be comprehensive, flexible, family centered, strengths based, and trauma informed. These are the key ingredients of the HFP and the dimensions along which program fidelity is routinely assessed.

Comprehensive. The challenges facing homeless mothers and children are many and varied, crossing the traditional boundaries of primary care, mental health, and substance abuse services, and reflect unmet basic needs. Rates of current depression (52%) and posttraumatic stress disorder (42%) obtained by questioning homeless mothers in Worcester between 2001 and 2003 are more than three times higher than those observed in the Worcester Family Research Project a decade earlier (Weinreb et al., 2006). Mental illness and substance abuse cause a myriad of problems for homeless women that affect their ability to access services and to parent, as well as to maintain stable housing and employment (Weinreb & Bassuk, 1990b). Compared to the general population, homeless mothers report more functional limitations due to physical health problems and high levels of chronic illness (Weinreb, Goldberg, & Perloff, 1998). Homeless children have more acute and chronic health problems, developmental delays, and emotional, behavioral, and learning difficulties than housed poor children (Bassuk & Rosenberg, 1990; Buckner & Bassuk, 1997; Weinreb, Goldberg, Bassuk, & Perloff, 1998).

Economic or social difficulties can easily disrupt a poor family's precarious housing stability and force them into homelessness (Belle & Doucet, 2003; Bogard, McConnell, Gerstel, & Schwartz, 1999; Buckner, Bassuk, & Zima, 1993; Link et al., 1994). Despite access to public welfare, the incomes of homeless families average less than half the federal poverty level (Burt, 2001). Poverty is one of the most consistent correlates of depression in women, especially those with young children (Belle & Doucet, 2003; Brown & Moran, 1997; Bassuk et al., 1998; Miranda & Bruce, 2002).

Almost three fourths of the homeless mothers in this study indicated needing help meeting basic family needs, including housing and transportation. More than 40% reported needing help accessing entitlements. The vast majority requested support in obtaining child care services. Homeless mothers wanted help identifying and accessing educational and job training opportunities. Goals are set with all HFP family members in relevant role domains, for example, parenting and vocational/educational training for adults and school, family, and peer relationships for children. An array of services is provided in-house or referrals are made to community agencies and organizations.

Flexible. Homeless mothers and children must overcome many barriers to service access and use. Poor women may lack access to the medical or mental health services they need, in part because of Medicaid ineligibility, given welfare reform changes (Coiro, 2001; Miranda & Green, 1999; Zima et al., 1996). Service access may be compromised for women by low-income service jobs with inflexible schedules that make it difficult to take time off work to attend appointments (Miranda & Green, 1999). Racial and ethnic minorities are overrepresented among the homeless (USDHHS, 2001). Race, ethnicity, and culture affect the expression of mental health problems, as well as help-seeking behavior (USDHHS, 2001). Minority group members, particularly those whose primary language is not English, have limited access to mental health services, and those they do receive are likely to be of poor quality (New Freedom Commission on Mental Health (NFC), 2003; USDHHS, 2001).

HFP services are designed to be flexible, to allow mothers and children to overcome existing barriers, and to avoid creating new obstacles to service participation. The level of intensity of HFP services varies with the needs of the family, with goals set in partnership with homeless mothers and their children. Services are provided when and where the family needs them, at the health center, in the shelter or the home, at schools, and in court, and in the language of choice. Appointments are scheduled in advance, or homeless mothers and children can drop in and meet with a member of the HFP team. Transportation is provided if necessary to facilitate program participation.

Family centered. Homeless mothers are distinguished from other homeless adults by their status as mothers who are caring for dependent children. Many are juggling competing role demands, including motherhood. Current work obligations under welfare guidelines require many homeless mothers to enter or continue in the workforce. Without adequate childcare, the burdens of motherhood and employment can be enormous (Nicholson, Sweeney, & Geller, 1998a). Children's medical emergencies and school problems compete for mothers' limited energy and resources (Rosenheck et al., 1999). Low-income women report that feeling inadequate in these competing roles is a precipitant to depression (Wolf, 1987; Edin & Lein, 1997). Parenting efficacy can mediate the effects of

maternal depression (Cutrona & Troutman, 1986; Teti & Gelfand, 1991). Mothers with mental illness report conflict between meeting the needs of their children and managing their illnesses and suggest significant barriers related to parenting that must be overcome to access treatment (Nicholson et al., 1998a).

Parent-child relationships are reciprocal. The mental health status of parents has considerable impact on the emotional health of their young children (NFC, 2003). Although homelessness appears to have direct effects on the mental health of school-age children who can more fully comprehend their circumstances (Buckner et al., 1999), it is likely that homelessness has more indirect effects on younger children as mediated through the emotional distress and parenting practices of mothers (Bassuk et al., 1997). Among both preschoolers and school-age children, a strong relationship is observed between mothers' level of emotional distress and adverse child behavior outcomes (Bassuk et al., 1997; Buckner et al., 1999), suggesting that interventions that help to improve mothers' mental health and parenting practices may result in improvements in their children's outcomes.

Originally drawn from the family medicine model, HFP clients are families. Family medicine is the medical specialty that is concerned with the total health care of the individual and family and includes the provision of continuing and comprehensive care to each family member, regardless of sex, age, or type of problem (AAFP, n.d.). Aspects of the family constellation, community and home environments, economic resources, and social supports are considered to bear directly upon the health and well-being of all family members and are reflected in any management plan (Weinreb & Bassuk, 1990a). Normalizing and recognizing the typical nature of situations, rather than emphasizing deficits, is a basic tenet of the family-centered approach (McManus, 1998). The family is seen as central in the lives of individuals; parenting is a key role for homeless women. The HFP respects families' definitions of membership and provides services to all members. At the HFP, family members' records are filed by family names, rather than by the names of individual patients. HFP staff members support women in the parenting role and recognize them as partners in goal setting and service planning.

Strengths based. As found in prior research and our own experiences, homeless mothers provide evidence of many strengths in spite of the adversities they have experienced (e.g., Banyard & Graham-Bermann, 1995; Thrasher & Mowbray, 1995). These positive qualities include resourcefulness, determination, and a deep concern for their children's well-being. It is advantageous for clinicians to recognize and build on these strengths in assisting homeless mothers to gain more autonomy and to develop feelings of self-efficacy and empowerment (Banyard & Graham-Bermann, 1995; Weinreb & Buckner, 1993); strengths are the building blocks for change (Banyard & Graham-Bermann, 1995).

HFP staff members create opportunities to identify, explore, and support families' positive capabilities. The strengths of all family members are identified and documented in family records. Goals are set and service plans made that focus on the strengths and resources that family members bring to the setting, rather than on their deficits. When difficulties do emerge, for example, situations in which child abuse or neglect is suspected or identified, HFP staff members work with participating mothers to file necessary

reports and provide ongoing advocacy and support to promote the safety of all family members.

Trauma informed. Homeless mothers have experienced very high rates of childhood and adulthood victimization (Bassuk et al., 1998; Weinreb et al., 2006). The long-term effects of childhood and adulthood trauma may be especially devastating, even for the most resilient of women, and may impact women's health, mental health, substance abuse, capacity to maintain work over time, and willingness and ability to form positive relationships, including those with children and treatment providers (Bassuk et al., 1998; Browne, 1992, 1993; Browne, Salomon, & Bassuk, 1999; Miller, Downs, & Testa, 1993; Wilsnack, Vogeltanz, Klassen, & Harris, 1997). Relationship issues are especially salient in the treatment of patients with past trauma experiences. Children who experience abuse may have no opportunity to develop positive trusting relationships or appropriate interpersonal boundaries (Everett & Gallop, 2001). Therefore, trauma survivors may be fearful, guarded, and hypervigilant in relationships as adults or, possibly, intrusive and controlling in an effort to protect themselves from the pain and disappointment they learned to expect as children. They may be sensitive to the power dynamic in relationships and not respond well to "being told what to do." These issues commonly play out in health care settings, given the power hierarchy and role expectations implicit in traditional medicine.

If the impact of trauma experiences is not considered, either in understanding the etiology of physical and mental health or substance abuse disorders, or in building patient-team relationships, the likelihood of improved patient outcomes is jeopardized. Implications for interventions therefore include defining roles and goals; validating women's perceptions; modifying procedures, including medical procedures, to reduce the likelihood of retraumatization; and supporting the development of treatment relationships in ways in which women feel most comfortable (Geller, Nicholson, & Traverso, 1997; Harris & Fallot, 2001; Spielvogel & Floyd, 1997). HFP staff members acknowledge the virtually universal prevalence of violence in the lives of homeless women and families, recognize the impact of trauma on the functioning of women and children in all their roles, and pace the processes of treatment engagement and relationship development accordingly.

Integrating Services in the HFP Intervention

HFP services are provided when and where a family needs them, by a multidisciplinary, multicultural team. Services are provided to family members of all ages and vary depending upon individual and family needs. Most families learn about the HFP through referral by shelter staff or local agencies, most of which are very familiar with the program. Families initially receive a core set of services that includes primary care, family advocacy/case management, and, typically, two to three initial sessions with a clinic-based mental health clinician (psychologist or social worker). Additional services, including longer-term FHC-based mental health and substance abuse treatment; shelter- and home-based outreach provided by a family advocate or psychologist; school-based advocacy; and psychiatric consultation are available to all families. The average tenure of intensive services for newly homeless families ranges from 6 to 12 months as needed. Primary health care is available to families on a continuing, long-term basis.

The integrated team approach, which differs from a traditional case management model in that responsibilities are shared, enables the HFP team to serve 125 new families and 300 children yearly. The HFP team meets weekly to review the needs, goals, and progress of families and to ensure that efforts within the HFP staff team as well as with other involved providers are coordinated. An important focus of team meetings is provider "retraining" to adhere to basic tenants or key ingredients of the HFP model. Most providers are traditionally trained in the medical model, that is, medically necessary treatment is provided to an individual based on determination of a diagnosis. Not only does an intervention derived from a family medicine model require team members to be tuned in to and comfortable meeting the needs of all family members, but the HFP intervention requires providers to be vigilant to basic family needs as well as trauma sequelae and to address these issues via the identification of family members' strengths as well as deficits or diagnosable disorders. This requires ongoing training and consultation as well as team reflection on procedures and practices to ensure fidelity to the HFP model.

Families are assigned a primary care provider and family advocate upon entry into the program, though the entire HFP team shares responsibilities for the services provided to each family. Assessment of mental health, substance abuse, and trauma experiences occur in the context of the routine health visit. Family advocates meet with mothers to assess basic family needs, set goals, and develop a plan for achieving them. Family advocates follow up regularly with families. An HFP mental health clinician meets with all mothers and children either during the first visit or shortly thereafter to conduct parenting and child assessments, assists in setting goals, provides consultation on parent-child issues, and recommends appropriate referrals for additional supports, for example, early intervention for young children. The mental health clinician works to enhance parent-child interactions and to provide guidance and support regarding developmental and adjustment issues, particularly related to the family's adjustment to life in a shelter or in someone else's home. All families also receive two to three outreach-based visits from a mental health clinician as they stabilize in permanent housing. Nurse monitoring support is available for women and children who face serious chronic health problems or who are using psychiatric medications; psychiatry consultation is available when needed. See Figure 1.

Mental health and substance abuse treatment is provided by the HFP mental health clinicians as dictated by the needs of family members. Referrals are made to appropriate services within the FHC or to other community agencies if specialized treatment is required. The mental health clinicians provide school advocacy, by informing school professionals about family issues and needs and participating in educational planning and review sessions with mothers and school professionals. Parenting and trauma recovery issues are addressed by all HFP providers in their respective service contexts. A brief family example allows for a more substantive understanding of the roles and activities of the HFP team:

L, a 29-year-old homeless mother, was the victim of childhood and adulthood abuse and came to the HFP health care provider with chronic headaches and PTSD symptoms. Unhappy with past counseling experiences, L refused a referral for "traditional" mental health treatment. The HFP health clinician prescribed an appropriate medication and met with L every 2 weeks for 2 months, then every month, to build a relationship, monitor her progress, and provide an oppor-

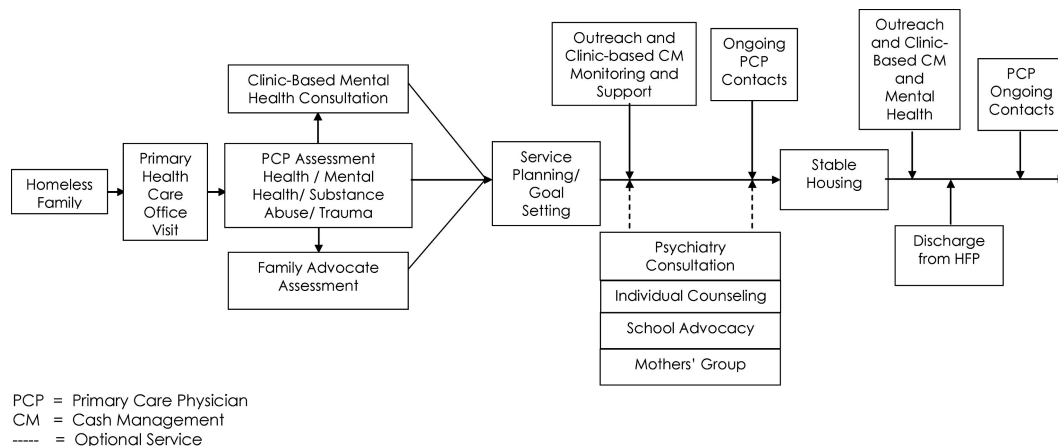


Figure 1. The flow of patients through the HFP.

tunity for patient education. The family advocate, a woman of the same cultural background and speaking the same language as L, developed a supportive relationship with her through consistent, dependable, and nonthreatening contacts at locations determined by L, often in the office or at the shelter. The family advocate helped L identify steps toward obtaining essential resources for her family, as well as find a part-time job as a nurse's aide. The mental health provider was able to address some of L's immediate concerns about her children's development and their aggressive sibling interactions and attended a meeting with L to work together with school professionals in developing appropriate education plans for the children. After 6 months, some improvement in her symptoms, and periodic gentle prodding by the HFP Team, L was open to seeing an FHC psychotherapist and joining the next parent education and support group.

Measures: The Service Record Form

Data to describe mothers' and children's contacts with HFP staff and staff activities are obtained in service record forms (SRF) completed by HFP staff after each encounter with or on behalf of an HFP client. The SRF was developed in partnership with HFP clients and staff, using qualitative methods and participatory research strategies (Mowbray et al., 2003). HFP clients and staff met in independent focus groups to elaborate the range and characteristics of HFP practices. Focus group findings were distilled into a draft form, and service categories and elements were defined. The form was piloted following an initial training for all staff, and revisions were made reflecting staff input. New staff members were trained in using the form by the program supervisor as they joined the HFP staff. Staff members routinely discussed the form and its use in weekly team meetings to ensure agreement and consistency in the coding of encounters.

A SRF is completed by each staff person following any activity or contact with or on behalf of an HFP client. The HFP staff during the time period reflected in this article included one full-time program supervisor, three full-time family advocates, one full-time therapist, two part-time psychologists (12 hours/week), two part-time psychiatrists ("child" and "adult," 4 hours/month each), and health care providers: one full-time outreach nurse, one part-time family practice physician (8 hours/week), one part-time nurse practitioner (4 hours/week), and part-time residents.

The HFP staff member dates the form, adds the program identification number assigned to the client, provides the staff member's name, and completes the form by checking the appropriate boxes in a variety of categories including the following: (1) client (check one), for example, mother, child, family seen together, or other; (2) location where services are provided (check one), for example, at the health center, shelter or home, on the telephone, or other location; (3) staff/provider (check one), for example, family advocate, primary care provider (outreach nurse, clinic-based physician, nurse practitioner, resident, or medical student), or behavioral health specialist (psychiatrist, psychologist, or therapist/social worker); (4) length of session (check one), that is, 15 min, 30 min, 60 min, or other; (5) service type (check one), for example, advocacy, primary care, or behavioral health; (6) focus of encounter (check all that apply), including (a) assessment/goal setting, (b) basic family needs (e.g., benefits/entitlements, employment/training/education, food/clothing needs, household/money management, housing, school/early intervention/child care, and transportation), (c) primary health care, (d) behavioral health care (e.g., mental health, substance use, trauma issues and treatment, crisis intervention, child development and behavior, and parenting), and (e) emotional support (e.g., generic "good listening" and supportive feedback).

Data reported in this article were obtained in SRFs completed for encounters in a 12-month period from July 1, 2002, to June 30, 2003 (total $n = 7214$). (This n is the total number of staff-family member encounters in the specified time period.) This time period reflects program activity in the middle of the evaluation phase of federal funding, when staffing was complete, and recruitment and enrollment were in keeping with the program's objectives. A year's worth of data were analyzed to capture the impact of seasonal fluctuations in patient flow or staffing patterns.

SRFs are compiled each week by the HFP program supervisor, who removes any identifying information, other than project identification number, for the purposes of data entry. Forms are reviewed each week by the supervisor and staff member and checked against clinic schedules to confirm the accuracy and thoroughness of information reported. SRF data were entered into an MS Access® database developed for the program by research assistants at the University of Massachusetts Center for Mental Health Services Research. Data were double entered to ensure accuracy. The

frequencies of responses for each element of each category of the form were calculated. Percents of the total number of encounters were calculated for each broad category or element, with the total number of encounters adjusted for missing data. Percentages calculated within the category of focus of encounter exceed 100%, as more than one element could be checked.

It is important to note that the percentages in some categories reflect either the percentage of effort possible by provider type, for example, there were three full-time family advocates and the equivalent of 1.4 full-time health care providers, or the specialized knowledge required by provider type, for example, health care providers and the outreach nurse provide the majority of medically related services. The data provide a description of program activities that is, to some extent, bounded by staffing pattern and staff expertise.

Results

Families' Experiences

Homeless mothers are seen individually in almost three quarters of all HFP encounters. Their children are seen alone by HFP providers in approximately 6% of encounters. Mothers and children together account for about 20% of encounters. HFP staff may have contact with other individuals without family members present regarding a family's circumstances or situation, for example, housing workers, child welfare workers, shelter staff, payers, or other family members, though these types of encounters account for less than 1% of all encounters. Contacts with mothers and family members tend to be by telephone (about 45% of encounters) or in person at the health center (about 42% of the encounters). Contacts at shelters while families are homeless account for about 4% of encounters; contact in the home increases to about 7% of encounters once families are housed. Client family members have the majority of their encounters with family advocates (approximately 59%). Primary care providers are the next most frequently seen by HFP clients, with the outreach nurse accounting for 20% of the encounters, and clinic-based health care providers providing about 5% of the encounters. Client family members see the psychologists (4% of the encounters) and therapist/social workers (just more than 5% of the encounters) to about the same extent they see their clinic-based health care providers. The consulting psychiatrist is seen by HFP clients in only slightly more than 1% of encounters over the course of a year.

Session length data suggest flexibility in HFP client-staff encounters, with the majority (61%) being relatively short, that is, 15 min or less. Almost one fifth of client family encounters with HFP staff are between 15 and 30 min (17%) or between 30 and 60 min (18%). Only approximately 4% of client encounters with HFP staff are more than 60 min in length. Almost two thirds of client encounters with HFP staff involve family advocacy (64%), 11% are behavioral health services encounters, and one quarter are primary care encounters. The focus of the encounters of HFP client families spans the possible categories, regardless of specific service type checked off on the SRFs (advocacy, behavioral health, or primary care). Basic family needs are addressed in almost three quarters of the client-staff encounters (74%). Behavioral health needs are the focus of more than half the HFP client-staff encounters (55%). Health needs are the focus of about 29% of client encounters with HFP staff. Clients are involved in assessment/goal setting activities in just less than one fifth of encounters (19%).

Providers' Activities

Family advocates spend their time with mothers in the vast majority of their encounters (more than 87%). Encounters with families all together (about 10%) and children alone (about 2%) were much less frequent. Family advocates provide assessment and goal-setting services in more than 22% of their encounters with family members. Family advocates deal with basic family needs in 94% of their encounters. See Table 1.

The encounters of primary health care providers are more evenly spread across family members. The outreach nurse is more likely to see families together (more than 50% of encounters) rather than individual mothers (about 40% of encounters) or individual children (about 8%). The clinic-based health care providers are more likely to see individual family members, with mothers alone representing almost 62% of encounters and individual children accounting for about 37% of health care provider encounters. Although the health care providers largely provide services related to needs traditionally defined as medical, they often deal with mental health treatment, parenting, and child development and behavior.

Behavioral health service providers' activities are split across family members, with consulting psychiatrists focusing the majority of encounters on mothers (almost 60%) or children (just more than 39%) alone. The psychologists are most likely to have encounters with entire families (almost three quarters of their encounters) and less likely to see individual children (19%) or mothers alone (about 6%). The therapist/social workers spend most of their time with mothers (more than 96% of their encounters) but provide some services to children (about 2%) and families (about 2%). By and large, the behavioral health service providers deal with mental health issues and treatment as the focus of encounters. Parenting and child development and behavior are often the focus of encounters as well.

Providing "generic" emotional support is often a focus of encounters across all providers. Family advocates and primary care providers report focusing on emotional support. For behavioral health providers, providing emotional support is reported secondarily to providing mental health treatment.

Discussion

The present study extends beyond prior descriptions of interventions for homeless families by providing detailed information about a comprehensive health center-based intervention. Findings demonstrate that it is feasible to integrate services that address the physical and behavioral health and support needs of homeless families in a primary health care setting. Detailed descriptive data presented about staff roles and activities begin to establish parameters for fidelity assessment, an essential first step to ensure adequate replication and rigorous testing of the HFP model in other settings.

HFP staff members provide a comprehensive array of assessment, advocacy, consultation, and treatment services. Services are family centered in that all family members are seen by one or more members of the HFP team, and parenting, child development and child behavior are common foci of encounters. In fact, health care providers, while providing traditional medical services, describe focusing on issues related to parenting and/or child development

Table 1
HFP Providers' Activities for the Period From July 1, 2002, through June, 30, 2003^a

Activities	Family advocates (<i>n</i> = 3,922) (%)	Health care providers (<i>n</i> = 1,794) (%)	Behavioral health providers (<i>n</i> = 757) (%)
Assessment/goal setting	22	20	4
Basic family needs			
Benefits/entitlements	17	12	0.3
Employment/training/education	5	6	0.1
Household/money management	4	8	0.6
Housing	20	10	0.7
School/early intervention/childcare	7	13	2
Transportation	39	3	0.03
Behavioral health care			
Mental health	6	35	74
Substance abuse	0.6	4	0.5
Trauma issues and treatment	0.7	4	1
Crisis intervention	8	6	2
Child development/behavior	5	16	11
Parenting	8	35	33
Emotional support	56	37	18
Primary health care			
Evaluation	3	33	8
Intervention	0.7	43	1
Education	5	42	1
Medication	2	45	5

Note. HFP = Homeless Families Program.

^a (*n* = total number of encounters); values add to more than 100% because focus of encounter is a multiple response item.

and behavior in more than one third of their encounters with HFP family members. A considerable number of families' encounters with the HFP are with family advocates. To the extent that the foci of encounters suggest acute needs as prioritized by families, meeting basic family needs may well be the first step on the path toward more active participation in specialized treatment for specific mental health or substance use issues.

Behavioral health issues and treatment are often the foci of encounters by all providers—family advocates and health care providers, as well as behavioral health service providers. Mental health, substance use, and trauma issues are commonly dealt with in these encounters. Family advocates and health care providers provide a great deal of emotional support to HFP clients, as do behavioral health providers in the context of their assessment and treatment encounters with clients. It is not surprising that the provision of emotional support figures prominently in the services delivered by all staff types. The literature describes that homeless mothers have limited supports and difficulty mobilizing supports (Letiecq, Anderson, & Koblinsky, 1998). The provider team–patient relationship merits considered attention given the role that social support can offer in buffering stressful life events (Gore, 1981, 1985; Kessler & McCleod, 1985). Network ties of all kinds are suggested as critical to improved mental health outcomes among homeless women (Bogard et al., 1999). Reframing traditional medical and mental health treatment adherence in the context of building safe and sustaining social support, including that in the formal provider–patient relationship, may be a critical component for programs serving homeless mothers.

Implications for Practice

Although the primary health care setting offers an important opportunity to identify, engage, and treat mental health, substance abuse, and trauma-related conditions in homeless mothers and children, as well as address their basic family and medical needs, the successful provision and integration of these services requires a range of strategies. It is essential to shift the paradigm of the agency, program, and providers from a traditional, medical-model focus on problems and deficits to a family-centered, strengths-based, trauma-informed approach to working with homeless families. There are many barriers to this shift. People come to service providers with problems; they expect providers to ask about problems and are usually prepared with a laundry list of their ailments, issues, concerns, or perceived failures. Agency forms and routines, driven by the requirements of service eligibility and third-party reimbursement, require the identification of problems and the development of treatment plans to ameliorate those problems. The development of the HFP model and interdisciplinary team, therefore, required a thorough review of agency procedures, practices, charts, and forms to enhance opportunities to identify and support client's strengths, to provide trauma-informed services, and to avoid opportunities for retraumatization of clients. Assessment forms were modified to include not only lists of problems but additionally mothers' strengths, their perspective of their children's strengths, and a list of goals related to mothers' role as heads of household and parents and mothers' self-care. Past and current trauma history questions for both mothers and children

were integrated into routine assessment materials for health provider, mental health, and family advocate staff.

Reimbursement exigencies make the provision of family-oriented and flexible services and support of sufficient training and team collaboration time an ongoing challenge. Few third-party payment resources are allocated to the provision of family advocacy services or the more flexible provision of mental health services. It is often difficult to overcome the access and eligibility barriers created by rigid funding streams. For example, the HFP psychologist may be asked to respond to a mother's acute need for emotional support, even though she only has 15 min to talk and therefore the session cannot qualify for reimbursement. Organizational contingencies and the reimbursement framework do not often allow for the communication and collaboration required by a comprehensive team approach. A strategy that blends third-party payment and modest grant support with continued refinement and modification of service provision to maximally capture billable revenue has been essential to the HFP's sustained success. Ongoing dialogue and partnership with mental health payers has enabled pilot programs that allow more flexible billing practices, but more robust and sustainable billing that meets the needs of families is required. Continuous attention focused on fundraising has been required to support portions of the HFP.

The development of data-collection tools was the result of extensive focus group work with program participants and staff in which relevant outcomes were identified, coupled with a clear understanding of the key information needed to meet program monitoring needs. Program staff resistance, and multiple priorities and time demands, had to be overcome to support data collection. To be successful, it was essential to fully integrate data collection methods into routine service delivery, to identify measures and data that provided meaningful day-to-day clinical information to caregivers, and to modify some of the types of data collected as the program evolved and requirements changed.

Detailed information about HFP processes and practices will be useful to providers in other settings as they plan and implement the HFP intervention. For example, information about the roles and responsibilities of family advocates can be considered as criteria for hiring and hiring decisions are made. Adequate resources for essential training and support of the staff team can be included in budget planning.

Implications for Training

Training programs for medical and behavioral health professionals traditionally provide trainees with the background knowledge and skills to formulate a rationale for how problems have developed, to classify problems, and to derive treatment plans based on this rationale and classification system. Adaptation of traditional health care services to support the key ingredients of the HFP model required the modification of traditional roles, attitudes, and disciplinary boundaries to shift the health setting's and providers' orientation from illness, deficits, and problems to health, strengths, and empowerment for this vulnerable population.

Extensive training was needed to support trauma-informed practice. For health providers, this included improving awareness of client readiness for medical procedures, avoiding unnecessary medical procedures, and facilitating client choice whenever possible. Training for mental health and advocate staff focused on the

importance of maintaining boundaries, following through with agreements, and reframing their thinking about clients to be context sensitive and strengths based. For example, training focused on helping staff to understand that the "manipulative" client had developed strong survival skills and that "symptoms" that are now challenging to deal with probably assisted the client in coping with a difficult circumstance in the past.

Integrating data-collection strategies to monitor delivery of service components, intervention fidelity, and participant outcomes into the busy practice of caregivers required significant effort by program administrative staff, as well as an ongoing process of staff training and supervision. It is often challenging to help staff understand the potential value of information that is being collected. Training sessions and team meetings provided opportunities for staff reflection and feedback, as well as for an orientation to the relevance and benefits of research.

Implications for Research

Although there is a growing evidence base, particularly related to depression care, demonstrating that collaborative care models that integrate behavioral health and primary care can be effective in improving patient outcomes (Katon et al., 1997; Rubenstein et al., 1999), adaptation and rigorous testing of these models with homeless populations are important next steps for research. Comprehensive multimodal interventions such as the HFP respond to an array of families' needs and challenge traditional research models that often call for the isolation of specific intervention components to determine efficacy. Although identification of the "active ingredient" of comprehensive interventions may enable more prudent use of scarce resources and is often called for by research funding agencies, it may be that it is the comprehensive nature of models such as the HFP that make it work, that is, that the sum of the HFP is greater than its parts. Finally, although additional research is needed to test specific interventions that respond to the unique needs of homeless populations, research that guides the successful translation of evidence-based practices into real-world settings is another critical next step. Substantial gaps continue to be common between what is known to be effective practice and what is done in community settings. Efforts to translate effective interventions to community settings are often hampered by barriers that delay or limit adoption of new practices. Developing the science to better understand the factors that facilitate successfully implementing and sustaining evidence-based practice in settings that serve homeless populations presents an important challenge for research.

Conclusion

In summary, the primary health care setting is an ideal gateway from which to organize the provision of comprehensive services for homeless families. Although many Health Care for the Homeless Programs across the country have staffing that includes health and mental health care providers (NHCHC, 2006), the extent and manner in which services are integrated across disciplines or linked to specific outcomes is not well described in the literature. This article fills this gap and contributes to next steps in developing an evidence base for effective interventions. Allowing for the early identification of mental health, substance abuse, and trauma-

related issues in the context of health care delivery, and the engagement of homeless families due to the reduced stigma, the HFP provides an example of a feasible and successful model for meeting families' complex needs. Despite numerous challenges in implementing and sustaining the HFP, its long history and experience demonstrate the feasibility of blending behavioral health and primary care in an accessible setting that responds to the unique needs of homeless families.

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