Literature Review on
Spaces and Services for Children and Youth
in Emergency Shelters for Homeless Families

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1. Introduction

1.1 SCOPE OF THE REVIEW

The focus of this literature review is on the spatial and service needs of children and youth in emergency shelters for homeless families. It does not address the broader range of issues related to family or children's homelessness, e.g. such as the causes of family homelessness, homeless youth, and the role of the child welfare system in child protection and support services. Nor does it examine the role of social housing policies and programs that address the housing needs of lower-income families, children, and youth.

A search was conducted of the Canadian, U.S., Australian, and European (English and French language) literature on family shelters. Some European countries, especially those with strong income support and social housing programs, such as Holland and France, do not have emergency shelters for families (Deben and Greshof 1997, Moreau de Bellaing et Guillon 1995, and Prolongeau 1993). Emergency shelter provision is made for homeless families in Britain, as well as Canada, Australia, and the United States.

1.2 DEFINITIONS AND MEASURES OF HOMELESSNESS

Definitions of homelessness vary, as do the methods used by researchers to measure homelessness. As administrative data collection systems of shelter programs continue to develop, the amount and quality of such data on those people who use shelters is increasing. Due to the definitional and methodological challenges in measuring the full or broader extent of homelessness and conducting research on homeless persons (see Peressini et al. 1995 and Bentley 1995 for a review of these issues), many researchers have limited their focus to shelter populations, sometimes referred to as the 'sheltered homeless'.

Use of shelter data does allow for statistical analyses and measures of service users over longer time periods (as well as at points of time). However, this approach narrows the scope of the analysis by restricting attention to those who seek and are successful in obtaining service.

In addition, there are other limitations in using shelter usage data to measure family homelessness. For example, as noted by several U.S. researchers, homeless families are more likely than single adults to 'double up' and to avoid using shelters (Baker 1994, Dornbusch 1994, Berlin and McCallister 1994, and Shinn and Weitzman 1994). Other researchers have argued that shelters exclude some of the most needy or troublesome families, such as those with severe mental illness or substance abuse problems (Rossi 1994a, Jacobs 1994). To what extent these factors affect shelter use by families in Canada is unknown.

1.3 STATE OF CANADIAN RESEARCH

A number of municipal task forces or reviews of local homelessness have been conducted over the past few years in Ontario (covering Toronto, Ottawa, Peel Region, and Waterloo) and Alberta (covering Calgary and Edmonton). In most of these reports, little of the information documented the specific service needs of homeless families. These primarily exploratory studies have described local homelessness and have focused on policy strategies for its prevention. Services for children or families in shelters have not been addressed in these municipal reports, other than the problematic use of motels to accommodate homeless families in Toronto. One of the many background reports for the Toronto task force on homelessness provided excellent data on shelter usage in that city (Springer et al. 1998). Based on shelter administrative data, the analyses distinguished patterns of shelter usage by homeless families from 1988 to 1996.

The Canadian literature does include several national studies of designated family violence shelters which contain descriptive and/or evaluative data on the capacity or usage of shelter facilities, as well as the types of services offered to adults and children (Statistics Canada 1999 (1) and (2), and Canada Mortgage and Housing Corporation 1995 and 1999).

A study on the shelter experiences of homeless families in Toronto was conducted in 1997, based on interviews with eight homeless mothers, having twenty children among them, who stayed in two family shelters in Toronto. The study also included observational data by family shelter service providers (Anstett 1997).

In addition, there are anecdotal studies and interview data on homeless mothers in Toronto and Vancouver (Carragata and Hardie 1998, O'Reilly-Fleming 1993, and Baxter 1991).

With so few studies on family homelessness, we have little knowledge about the living conditions or facilities and services available for children and youth staying in Canadian family shelters other than designated family violence shelters. More specifically, there is no systematic data on the spatial and service needs of children and youth in family shelters.

1.3.1 Predominance of U.S. Research

Since a 25 percent increase in the number of families seeking emergency shelter was observed in New York City in 1981, research on family homelessness has increased in the U.S., leading to a considerable body of research on family shelter conditions and services.

Most of the empirical studies have attempted to assess the various characteristics of family shelter users and their differences from single adults. Newer studies have addressed certain aspects of shelter life based on interviews with parents, almost always mothers, and, far less often, their children. The latter studies have included investigations of the health, psychosocial, and educational status of children in family shelters, along with parenting issues.

Research on shelter facilities, services, and programs for families and children and youth is in the early descriptive phase, with very little work of an evaluative nature.

2. Extent of Family Homelessness

Increased shelter usage by families has been reported in several Canadian cities. In Toronto, families and youth are the fastest growing segments of the population of shelter users (Springer et al. 1998). In Ottawa, there has been an increase in the number of shelter 'bed nights' occupied by children (Region of Ottawa-Carleton 1999). Beyond Toronto, Peel Region also reported an increase in the number of families with dependent children using shelters (Region of Peel, 1999). An increase in the number of homeless families in Calgary has also been noted (City of Calgary Community and Social Development Department, 1997).

The numbers of women and children accompanying them to designated family violence shelters across Canada also increased from 1993 to 1998. According to survey counts from a single, set day in 1993 and 1998, the number of children in these shelters increased by 65 percent, from 1,636 to 2,509 (Statistics Canada 1999). According to the Transition Home Survey, 42,830 dependent children stayed in the 413 family violence shelters during a twelve month period in 1997-98. Twenty-two percent of women staying in these shelters gave non-abuse reasons for seeking shelter, the majority of these giving 'housing problems' as the reason. These statistics may indicate that as many as 500 children a day and 9,422 children per year stay in designated family violence shelters for reasons related to 'housing problems', including homelessness.

Without a systematic measure of homelessness among families in Canada, it is not possible to determine to what degree the increase of family and dependent children and youth shelter users in particular communities is unique or representative. However, the quickly increasing number and proportion of homeless families in some Canadian municipalities raises concerns about children staying in family shelters and the short- and long-term impacts on them.

What follows is an outline of the various partial counts of family homelessness reported in available urban and national studies.

2.1 CHILDREN AND YOUTH IN SHELTERS FOR HOMELESS FAMILIES

Of the Canadian municipalities or regions that have conducted investigations of local homelessness, several noted the number of families or family members using emergency shelters. Their definitions of family have varied, as have the methods of measuring homelessness. Generally, the counts have included point-in-time shelter usage, i.e., number of users on a particular day or night. In some cases, annual counts were also reported, i.e., number of users over a twelve month period. Families and children using designated family violence shelters were sometimes included in these counts, sometimes not.

The lack of consistent methodology makes it very difficult to analyze the data. While the figures included some double counting between municipal and national data, gaps in reporting are another serious failing. Despite the limitations, it gives some indication of the extent of family homelessness in the late 1990's:

- In Toronto, 5,300 children (under the age of 18) used shelters during 1996 (Springer et al. 1989), and 1,681 parents and children stayed in shelters on September 14, 1998 (Golden et al. 1998).

- In Ottawa, 375 families used two family shelters during 1998 (Region of Ottawa-Carleton 1999), and 120 children reportedly used shelters in the summer of 1999 (Lisle 1999).

- In Brampton and Peel Region, 689 family members used three family shelter facilities in 1998, and the number of 'bed-nights' almost tripled over the previous year, from 595 to 1670 (Region of Peel 1999).

- In Waterloo Region, 44 families with dependent children who used emergency shelters participated in a recent study (Dietrich et al. 1999).

- In Calgary, on the night of May 23, 1996, 28 families used shelters, including 55 children up to 14 years of age and 41 youth aged 15 to 19 (City of Calgary Community and Social Development Department 1997).

- In Edmonton, on the night of March 18, 1999, 32 families stayed in emergency shelters, including 51 children (Edmonton Task Force on Homelessness 1999).

- During a twelve-month period in 1997-8, 42,830 dependent children were admitted to 413 family violence shelters. As many as 9,423 of these children may have stayed in these shelters with their mothers because of housing problems that include homelessness. (Statistics Canada 1999).

In sum, therefore, we estimate from these sources, that up to 50,000 children annually, accompanied by parents are homeless and stay in emergency housing in Canada

2.2 NON-URBAN AND RURAL FAMILY HOMELESSNESS

According to Daly (1996), it is falsely assumed that rural homelessness is non-existent in Canada. *When rural people encounter a housing problem they have few alternatives, short of doubling up or moving out of the community. No emergency shelters are available except in cities* (Ibid.: 147). This often means that rural areas do not have a problem of homeless families because these families move to nearby cities.

Vissing's (1996) research on homelessness in small U.S. communities revealed that there were few emergency shelter facilities in small towns and virtually none in rural areas. Most homeless families stayed with friends or relatives, or lived in cheap motels and makeshift conditions, such as sleeping in vehicles, tents, and trailers. Compared to their urban counterparts, rural homeless persons were much less likely to be found in shelters (11 versus 37 percent), and they were more likely to be sheltered by family or friends (41 versus 11 percent).

3. Characteristics of Homeless Families

Until recently, data on family shelter users in Canada was limited to that contained in isolated agency reports (Fallis and Murray 1990) and a few internal reports by the City of Toronto. Two evaluation studies and biennial 'transition home' surveys have provided data on family violence shelter use (Transition Home Surveys in 1993, 1995, and 1998; and Canada Mortgage and Housing Corporation 1995 and 1997). In addition, there is data on shelter use by families in Toronto (Springer et al. 1998).

3.1 DEMOGRAPHICS

One of the most obvious characteristics of families using shelters is the disproportionate number of single parents, the vast majority of whom are women. Fallis and Murray (1990) reported that in 1980, the majority (72 percent) of families in Canadian shelters was one-parent. From 1988 to 1996, the relative proportion of one-parent families using shelters in Toronto decreased, although they remained in the majority, about 60 percent (Springer, 1998).

Studies conducted in the United States and the United Kingdom have generally found that one-parent families constituted a disproportionate number of homeless families (Bassuk 1990, Johnson et al. 1995, and Cumella et al. 1998). This pattern was also noted for non-urban and rural areas of the United States (Vissing 1996, Rife et al. 1992).

Single-mother families are definitely disproportionate among the homeless when compared to the general population, but may not be when compared to other poor families. McChesney (1993) found the representation of single-mother homeless families was sometimes similar to that of other poor families on a city-by-city basis. Her meta-analysis suggested that single-mother (and minority) families were over-represented in some U.S. cities, but not others.

An evaluation of 78 family violence shelters (Project Haven program shelters) found that the users were younger women (average age 32 years), and 58 percent of them brought children to the shelters (CMHC 1995). Of those who brought children, 40 percent brought one child, 36 percent brought two children, 15 percent brought three children, and 9 percent brought four or more children.

There are no Canadian data on the ethno-racial status of homeless families specifically. Aboriginal persons are over-represented among shelter users, 28 percent in Edmonton and 5 percent in Toronto, as compared to those respective urban populations (Edmonton Task Force on Homelessness 1999, Mental Health Policy Research Group 1998). African- or Caribbean-Canadians are also over-represented among homeless people in Toronto (Mental Health Policy Research Group 1998).

3.2 SHELTERED FAMILIES IN TORONTO

A recent analysis of nine years of Toronto shelter data (which included families accommodated in both family violence and conventional shelters, including motel placements) showed that families tended to be transitional users of hostels, usually staying for uninterrupted periods of two weeks to six months. The typical length of stay was two months (Springer et al. 1998).

Springer et al. (1998) found a number of changes in shelter usage from 1988 to 1996:

- the number of homeless children doubled, from 2,680 to 5,300 (under age 18, both accompanied and unaccompanied by a parent);
- the size of families increased from 2.97 to 3.27 persons;
- the number of family admissions to Toronto hostels doubled, from 9 to 18 percent;
- the capacity of family shelters tripled, from 700 to 1,437 beds;
- over the nine-year period, family members made up 31 percent of the people in the shelter system and used 41 percent of the total bed nights; and
- the proportion of total shelter beds occupied by families increased from 33 in 1988 to 46 percent in 1996.

The typical sheltered family consisted of a mother and one dependent child. About half of the families included one child; one-third had two children; one-sixth had three or four children; and three percent had five or more children.

Only 10 percent of families were chronically homeless (i.e., they used shelters for more than one year), but this will probably increase since fewer homeless households were able to exit the shelter system by obtaining subsidized housing. The number of sheltered households placed in subsidized housing dropped from 22 to 8 percent (Ibid.).

3.3 FAMILY VIOLENCE SHELTERS IN CANADA

Family violence is a significant cause of homelessness for women and youth. From 1996 to 1998, the number of admissions to Toronto shelters due to familial abuse or breakdown almost doubled, from 14 to 26 percent (Springer et al. 1998).

Australian and U.S. researchers have noted the extensive histories of family violence and severe relational disruptions among many homeless families, especially mothers (McCaughey 1992, Weitzman, Knickman, and Shinn 1992, Khanna et al. 1992, and Browne 1993).

In 1998, there were 470 facilities identified and included in the 1997-98 Transition Home Survey (Statistics Canada 1999 (2)) About two-thirds of these were first stage or emergency shelters; the remainder included second stage facilities, women's emergency centres, safe home networks (usually in small communities), and family resource centres (in Ontario only).

Women in the 25-34 age group are most likely to use these shelters. Most of the women (80 percent) admitted to family violence shelters had children, and most of those women (76 percent) brought their children. These children were almost evenly split between boys and girls. About three-quarters of the children were under 10 years old. Almost half of them (43 percent) were under 5 years of age, and an additional 30 percent were aged 5 to 9 years. Those aged 10-15 years made up 18 percent, while the smallest group (3 percent) was aged 16 and over. For the remaining 7 percent, age was unknown (Ibid.).

Almost one-third of the resident women who had been abused were also protecting their children from abuse: 28 percent of them from psychological abuse, 14 percent from physical abuse, 13 percent from threats, 9 percent from neglect, and 4 percent from sexual assault (Statistics Canada 1999 (1)).

3.4 SCHOOLING AND EDUCATION

> *My son has been in four schools this past year.*
> Homeless mother in Toronto shelter (Anstett 1997: 73).

There is no Canadian data on school attendance or performance of homeless children and youth staying in family shelters.

U.S. researchers have found that children's homelessness had a strong impact on the number of different schools attended, and school transfers were a common educational barrier for homeless children (Rafferty 1991 and Wiley and Ballard 1993).

A national report revealed that 23 percent of homeless children and youth in a large number of states did not attend school during periods of homelessness (U.S. Department of Education 1995). Barriers to homeless students' education remain a problem. Lack of transportation, and lack of co-ordination between service providers, government agencies, and schools, continue to prevent homeless children and youth from enrolling in and attending school (Wall 1996 and Anderson et al. 1995).

Stigma against homeless children and youth presents a more subtle barrier than obvious ones such as lack of transportation. Gibel (1996) demonstrated that non-poor, housed children in grades six through twelve had more negative attitudes toward their homeless peers than those who were poor but housed. These negative attitudes were reflected in the children's choices for association. Gibel noted that this could contribute to school failure.

Masten et al. (1993) found that the self worth and academic confidence of homeless children declined with age and were lowest among adolescents (up to 17 years of age).

Rafferty and Shinn (1991) reviewed several U.S. studies that showed homeless children were more likely than other children to perform below grade level in reading and mathematics, and were more likely to have repeated or be repeating grades.
Danseco et al. (1996) found that when domestic violence was the precipitating event for the families' homeless situations it contributed to children's poorer academic performance, particularly in reading and spelling, i.e., language abilities.

3.5 CHILDREN'S PHYSICAL HEALTH

> *There's a lot of lice. I had a hard time getting rid of it. Right now the boys have rashes all over them. I had pink eye. Yesterday, there was a boy in here with ringworm on his face.... People [here] don't flush toilets. The boys have colds right now.*
>
> Homeless mother in Toronto shelter (Anstett 1997: 108).

There has been no systematic research on the physical health status of children and youth staying in family shelters in Canada.

Studies of the health status of homeless adults, however, have revealed significant problems. For example, Ambrosio et al. (1992) found that upper respiratory ailments and various infectious diseases occurred at a higher than average rate among homeless single adults who frequented shelters in Toronto. It is quite possible that similar health problems may be found among homeless families, including children and youth.

A recent report by the Medical Officer in Toronto identified a range of health problems faced by young homeless women and their babies. Basrur (1998) estimated that up to 300 babies are born to homeless women annually in Toronto, almost of third of them to teenagers. It is unclear what proportion of these women stayed in shelters rather than in shift accommodation or slept rough.

Basrur noted that lack of adequate prenatal care, along with other risk factors, such as physical and sexual assault, substance abuse, and HIV infection, resulted in extremely high rates of premature delivery, and she estimated that more than 10 percent of these babies do not survive.

The babies born to young homeless women face high risks of acute and chronic illnesses. As children, they are more likely to have developmental delays due to low birth weight, lack of attention and stimulation, and increased risk of physical neglect and abuse from their overwhelmed parents (Ibid.).

Researchers in the United States have found very high rates of pregnancy among teenagers staying in family shelters (Wright 1991, Mills and Ota 1989).

Rafferty and Shinn (1991) found that, compared to housed women, homeless women had significantly more babies with low birth weights and a higher infant mortality rate. Homeless children had about double the rate of pediatric disorders, elevated lead levels, and more hospital admissions than housed children.

High rates of both acute and chronic illness among homeless children have been reported in the U.S. and the U.K. literature. Wood and Valdez (1991) determined that homeless families in Los Angeles had less access to health care than other poor families due to their lack of insurance, lack of a regular primary care provider, and other barriers such as lack of transportation and not knowing where to go for care. Dornbusch (1994) found that homeless children received less medical care than did poor, housed children, but only children who had lived in inappropriate accommodation (such as garages, cars, parks, and empty buildings) had more chronic illness than a control group of poor, housed children.

In his review of various studies, Wright (1991) concluded that homelessness is an independent and consequential risk factor for children in its own right, apart from poverty.

> [T]he health disorders faced by homeless children are not exotic or unusual ... they are, rather, the same health problems all children face. By far the most common disorders observed among the children are minor upper respiratory infections, followed by minor skin ailments and ear disorders, then gastrointestinal problems, trauma, eye disorders, and lice infestations. In all these cases, differences in the rates of disorder between homeless boys and girls are relatively minor. Differences between homeless children and children in general, in contrast, are often large and in some cases dramatically large. Although the general pattern of illness among homeless children is not atypical of children's illness in general, the comparative rates of occurrence are often inordinately elevated (Ibid.: 83).

Based on the medical records of homeless children in 16 major U.S. cities, Usatine et al. (1994) found that factors such as trauma, overcrowding in shelters, unusual sleeping accommodations, poor hygiene, and poor nutrition contributed to acute health problems. The most common of these were upper respiratory and ear infections, skin and gastrointestinal ailments, and trauma — the same illnesses that have been found in earlier studies.

3.6 DEVELOPMENTAL DELAYS

There has been no Canadian research on developmental delays among homeless children, but U.K. and U.S. studies suggest this may be a problem.

In the U.K., Cumella et al. (1998) found that children in homeless families have delayed communication skills. U.S. studies have also found that, compared with the general population of children of a similar age, a higher proportion of homeless children in shelters had delayed development (Rescorla et al. 1991; Bassuk and Rosenberg, 1990).

Such relationships may be associated more specifically with poverty than homelessness or shelter use. Rafferty and Shinn (1991) found that developmental delays among homeless children were more prevalent compared to children in the general population, but not compared to poor children who were housed.

3.7 BEHAVIOURAL PROBLEMS

Anstett (1997) found that virtually all of the twenty children/youth, in the homeless families he studied, ranging in age from 4 months to 20 years, had difficulties adjusting to shelter life. The younger children tended to regress, and the older youth tended to become more independent or go their own way.

Without any additional Canadian data, we have relied on U.S. studies to indicate the likelihood and form of behavioural problems among children in family shelters.

One of the most consistent findings reported by parents was the increase of children's externalizing or disruptive behaviours in shelters (Holden et al. 1995). Masten et al. (1993) found that the prevalence of behavioural problems, especially antisocial behaviour, was greater among homeless children and youth aged 8 to 17 years compared to a sample of poor housed children.

The types of behavioural problems reported have included sleep disturbance, eating problems, aggression, and hyperactivity (Cumella et al. 1998). Based on small sample studies, the incidence of behavioural problems among sheltered children has been reported at 30 percent and 90 percent (Cumella et al. 1998, Vostanis et al. 1996).

Danseco and Holden (1998) found a relationship between homeless children's behaviour and parental stress. Children whose parents were highly stressed also exhibited more behavioural problems and a trend toward poorer adaptation.

3.8 CHILDREN'S PSYCHOLOGICAL HEALTH

Some children find it more difficult to cope with living in a shelter than others do, perhaps especially those who are also dealing with the trauma of family violence. Baxter (1991) interviewed a Vancouver woman who was shaken by the 'nervous breakdown' exhibited by two of her children when the family became homeless — one of them tried to jump out the window of the shelter. Anstett (1997) also reported a child's suicide attempt in Toronto.

There have been no Canadian studies on the psychological health of children in family shelters, but U.K. and U.S. studies suggest that the problems may be considerable. Several studies have found that homeless children had more psychological problems than housed children (Bassuk and Rosenberg 1988, Rafferty and Shinn 1991, Holden et al. 1995, and Cumella et al. 1998). But there is no agreement as to whether they have more psychological problems than other poor housed children (Cumella et al. 1998, Rafferty and Shinn 1991).

Studies also differ in their assessment of the severity of homeless children's psychological problems. In a British study, Vostanis and his colleagues (1996) relied on the results of standardized psychological tests to determine that over half of the 50 children in a family shelter had scores that fell within the clinical or psychiatric range. U.S. researchers, Holden et al. (1995) argued that the majority of homeless children studies did not display clinically significant mental health problems (Holden et al. 1995).

3.8.1 Children's Identity and Relations

Qualitative research conducted with children staying in family shelters has revealed that children's sense of identity is threatened by the loss of their home, a fundamental organizing structure in their lives. They are deeply affected by the shame of poverty and their parents' feelings of powerlessness and hopelessness. Despite their various losses, they still look for play opportunities (Walsh 1992).

Percy (1997) found that children in shelters, like others, sought caring relationships from their parents or others. School-aged children, aged 6 to 12 years old, were primarily concerned with having fun and being with people they liked, while older children focused on 'feeling cared for' and having secure relationships. What mattered most to homeless children were their parents, making new friends, and having fun — in other words, positive experiences of growth and support (Percy 1997 and Heusel 1990).

3.8.2 After-effects

One small-scale study suggested that children varied widely in their vulnerability and resilience to homelessness. Eighteen months after leaving a family shelter and being re-housed, Berck (1992) found that some formerly homeless children appeared to have adjusted, while others' social and educational functioning were severely impaired.

3.9 PARENTS' SOCIAL NETWORKS AND SUPPORT

Families that request emergency shelter services are not only economically desperate; they are more likely to be single parents, i.e., single mothers, and are more likely to have experienced abuse and violence and severe relational disruptions.

Bassuk (1990) suggested that for most sheltered homeless mothers, interpersonal conflict, substance abuse, illness, or divorce had previously fragmented supportive relationships with friends and family. Other studies have confirmed that homeless mothers typically lack adequate social support systems (Letiecq, Anderson, and Koblinsy 1998; Khanna et al., 1992; and Bassuk, Rubin, and Lauriat, 1986), have lower levels of social integration, and fewer attachments or social supports than housed mothers (Cumella et al. 1998).

Other studies, however, have disputed this conclusion. Shinn, Knickman, and Weitzman (1991) argued that although homeless mothers in shelters have histories with high levels of disruptions in their social relationships, many are likely to have had recent contact with relatives and friends. This may be because they are trying to avoid using shelters by relying on their social network. Shinn and Weitzman (1994) concluded that when families became homeless, they are not socially isolated, but their social networks have little to give.

3.9.1 Parent-child Relations

Anstett (1997) found that homelessness and shelter life impose great stress on mothers and their children staying in Toronto shelters. Many of the children tend to become uncooperative, both at school and at the shelter. One of the mothers he interviewed expressed her frustration in maintaining a responsible parental role when spatial restrictions made disciplinary distinctions for more than one child impossible (Anstett 1997: 95):

> *[My] fourteen, nine, and eight-year-old [children] all have different needs that need to be addressed, and you can't do that in one room. I have a problem disciplining [them] because if you discipline one, you discipline them all. If one has to go to bed, then they all have to go.*

There is no additional data on parent-child relations in family shelters in Canada, but it is likely that Lindsey`s (1998b) U.S. study is relevant. When she explored shelters' effects on family relationships, her results confirmed those of previous studies. Mothers reported increased closeness with and interaction with their children, but a disruption in their roles as disciplinarians and providers/caretakers. The mothers attributed the latter to their own emotional state and that of their children, the type and rigidity of shelter rules, and their reliance on service providers and other residents.

4. Service Needs of Homeless Families

4.1 GAPS IN SERVICE CO-ORDINATION

Reports on homelessness in Edmonton, Toronto, and Calgary have pointed to the need for co-ordinated access to shelter services as a fundamental problem (Edmonton Task Force on Homelessness 1999, Golden et al. 1998, and City of Calgary Community and Social Development Department 1997). In Toronto, the lack of service co-ordination for families was specifically targeted as a problem that requires quick redress (Golden et al. 1998).

A recent review of the shelter system in Toronto found that a mixture of voluntary, provincial and municipal resources have been used creatively in "cobbling together" a range of services for homeless people, but that the limits of an ad hoc approach have been reached (Eakin and Thelander, 1998). "There is no one place to ask questions, to get answers, and, most importantly, no management group with an overview of the whole system" (Ibid.: 5).

Among the problem areas identified, Eakin and Thelander (1998) pointed to the lack of a central focus for the patchwork of services, uncoordinated planning, an outdated service model that fails to adequately differentiate the needs of families, and fragmented funding and management.
The need for service co-ordination for homeless families is not unique to Canadian communities. The same problem has been noted in Australian and U.S. reports (Council to Homeless Persons 1997, Molnar 1988, Macro Systems 1991a and 1991b).

One extensive U.S. evaluation of services for homeless families with children found a range of weaknesses in the co-ordination of services in the five cities reviewed (Macro Systems 1991). At the public agency level, there was very little co-ordination among agencies in dealing with the problems of homeless families, and while information and referrals to services were offered, there was very little integrated service delivery. Cities had only service provider- or advocate-driven co-ordinating mechanisms. Comprehensive services planning, such as case management, was a major service gap, along with lack of follow-up services and outcome evaluation of programs.

Based on the results of another survey of over one thousand family shelters in the United States, Weinreb and Rossi (1995) concluded that there was no co-ordinated system in place, but rather a diverse group of loosely connected programs. Family shelters tended to be smaller than those for singles, and their staff were not generally well-trained, yet they offered a wide range of services for residents. While family shelter staff commonly conducted needs assessments when admitting families, there was less stress on the needs of children than adults, and staff were generally less able to estimate the prevalence of special needs among children than adults. Mandatory participation practices, whether intended or not, led to a kind of mechanical discipline rather than the development of mothers' autonomy and empowered independence (Ibid.).

This U.S. study noted that the domestic violence shelter system was separate from the homeless shelters system, with weak or invisible links between them. Family violence shelters were typically funded through different mechanisms, had different administrative systems, and conducted intake and referral through autonomous networks. There were service implications to this split system since the homeless shelter system often received the overflow from overburdened family violence shelters. None of the homeless shelters were able to keep their location confidential or offer protection to women fleeing abusive relationships, which are typical service components of family violence shelters (Ibid.).

4.2 UNEVEN SERVICE PROVISION

Services to address family violence in Canada are funded through provincial and territorial social services programs. Policies vary across Canada with respect to the models of services adopted. In some jurisdictions, funding is channelled through the family violence shelter networks which serve as the principal point of service. In other jurisdictions, services are funded through community-based agencies (rather than through the shelters themselves) and shelter clients utilize services outside the shelters. In recent years, the Province of Ontario has shifted toward this latter model of service which has raised some concerns from within the shelter sector itself. The Ontario Association of Interval and Transition Houses (OAITH) has noted that over half of the family violence shelters in the Province have reported a decline in the overall level of service they have been able to provide to women and children since 1995 (Ontario Association of Interval and Transition Houses, 1998). Reduced funding for staffing has led to increased use of volunteers and untrained staff in Ontario family violence shelters.

The Ontario Association of Interval and Transition Houses (OAITH) has noted that over half of the family violence shelters in the Province have reported a decline in the overall level of service they have been able to provide to women and children since 1995 (Ontario Association of Interval and Transition Houses, 1998). Reduced funding for staffing has led to increased use of volunteers and untrained staff in Ontario family violence shelters.

Some Toronto shelter staff have reported that service provision levels in conventional family shelters are generally lower than in family violence shelters (Anstett 1997). One homeless mother who had experience with both types of shelter confirmed this. She described how inadequate staffing levels limits the support shelter workers can provide (Ibid.: 58-9):

> *If you're falling apart someplace, [the staff] don't really have time [for you]. There's too many other people, too many other things they have to do. So, they're running around doing all the essential things. But you can be standing in front of them and falling apart, saying, "I need someone to talk to right now!" They're like, "Five minutes!" They try to be supportive, but they have other things they have to do, too. They get overworked, and they get cranky with people.*

Weinreb and Buckner (1993) described the majority of U.S. service programs for homeless families as short-term, targeted at immediate needs, and shaped to a significant degree by resource limitations, ideologies, and opinions rather than by evaluative research.

Beyond assistance with obtaining housing and welfare benefits, there were large disparities in the services provided, such as the amount of on-site vs. community-based service; use and quality of case management; assessment and treatment services for mental health, substance abuse, or victimization problems; and capacity to assist with parenting skills and supportive relationships. Smaller communities with fewer services for homeless families were generally able to provide only minimal support services.

4.3 EDUCATIONAL SERVICES

In Toronto, the concentration of homeless families in a small area has contributed to significant pressure on school services for homeless children (Hoy 1999).

> They experience greater classroom disruption, teachers are stretched too thin and local school programs like English as a Second Language and Special Education cannot keep up with community needs. This compromises the quality of education for all children in the community (Ibid.: 7).

Occasional influxes of high numbers of immigrants and refugees have added to the concentration of families, increased neighbours' concerns, and strained access to local community-based services and appropriate settlement services. Concerted service system planning, which includes specific education and settlement service issues and builds on existing linkages, was proposed as the most feasible approach to address the needs of families using the motels as well as community residents.

4.4 OTHER SERVICES

Anstett (1997) stressed that the role of child advocates, available in some Toronto shelters, was a critical one in assessing children's needs and providing appropriate services for them. He also recommended the provision of counselling for children, day care, and mental health nurses.

Anstett's (1997) call for mental health nurses in shelters suggests there is a lack of assessment and service provision for children's psychological problems in Toronto family shelters. This problem has been identified in a U.S. study which found that only a minority of homeless children with identifiable mental health problems in U.S. shelters had received counselling or participated in special education services (Zima et al. 1994).

4.5 SERVICE NEED DIFFERENTIATION

Homeless families are not a homogeneous group; they have varied and distinctive needs. Family shelter workers in Toronto have noted an increase in the number of high need, chronically homeless families who require more support services over a longer period of time. They have also observed increases in parental drug use and mental health problems, as well as developmental and learning disabilities and mental health problems among children (Anstett 1997).

According to Eakin and Thelander (1998), a small number of high-risk families bounce in and out of Toronto shelters because ongoing support services are not available. They argued that the increased use of motel accommodation in Toronto for the overflow of families made it more difficult to provide support services to these families.

Weitzman et al. (1990) distinguished homeless families in New York City according to their tenure history prior to requesting shelter. They concluded that extensive social service interventions were probably unnecessary for the large group of families who had managed to stay in a stable housing situation for a period of years prior to the shelter request. They argued that programs for domestic violence counselling, substance abuse treatment, parenting services, and physical and mental health care should be extended to the smaller group of families who had experienced a longer and more disruptive slide into homelessness. And for families who had never maintained their own household, they suggested that a wide range of services were required, including subsidized housing coupled with day care services and job training.

Anstett (1997) recommended that more intensive service programming be developed for long-term homeless families, offered in second stage or transitional shelters. It is unknown whether or how service provision is altered based on length of stay in Canadian shelters.

An evaluative study of U.S. programming for homeless families concluded that the duration of shelter stay has important implications for service delivery (Macro Systems 1991).

> If families are staying in the emergency shelter system for as little as 30 days, then putting resources into support services and dedicated services on-site at emergency shelters seems inappropriate. Families are in crisis, not receptive to intensive services, and view their situation as temporary. Further more, it is unlikely that major changes in a family's dynamics or problems can be accomplished in such a brief time. Even links to mainstream services are hard to establish since families may often leave the shelter before an intake appointment can be scheduled (Ibid.: 39).

Applying this logic, an increase in certain services, such as child care, was recommended as more appropriate than others, such as parenting instruction, especially during short-term stays of up to two months (Macro Systems 1991).

It is not clear to what extent services of various kinds actually assist homeless families and their children. There are indications that the views of homeless mothers and service providers are not in sync (Lindsey 1996; 1998a). While some shelter programs are designed to offer extensive educational and parenting services, the long-term impacts may be minimal. Phillips et al. (1988) found that the programs offered in a services-enriched family shelter resulted in signs of positive change for homeless families during their shelter stays, but the gains were lost once the families moved back into the community.

5. Spatial Types and Needs

5.1 TYPES OF SHELTERS

Canada: An evaluation study of 78 Canadian emergency or first-stage family violence shelters reported an average of six hostel units in these shelters with roughly 15 beds and three cribs for babies. Most of these shelters contained communal living areas and kitchens as well as contained administrative offices, common living rooms, kitchens, laundry rooms, and smoking areas. Some had counselling offices, playrooms for children, and television rooms. A few of them had outdoor play areas, large rooms for group counselling, and quiet rooms for clients. About 70 percent of the residents stated that the design features were suitable for children (CMHC 1995).

The three family shelter types in Toronto have been described as (Golden et al. 1998: 50-1):

1. Shelters for women and young children operate mostly on a communal model. Staff prepare meals and residents eat together. Residents share washrooms and sometimes sleeping areas and there are usually common living rooms and playrooms for the children. Staff and counsellors are available on site.
2. For couples or families with older male children, a number of family shelters provide small private rooms with limited cooking facilities or communal kitchens for residents to prepare their own meals. Families are given money to buy food and are responsible for shopping and cooking. There are some common living spaces and playrooms for the children. Staff and counsellors are available on site.
3. Motel rooms are equipped with a microwave, a small fridge, and a supply of kitchen utensils. Families in motels are given money to buy food and they prepare their own meals. Although families in motels generally have more privacy than other shelter residents, there are few, if any, common spaces or play areas for the children. No staff or counsellors are available on site, although they make regular visits.

In Toronto, a substantial proportion of homeless families is accommodated in motels rather than dedicated shelter buildings (about one thousand). There is anecdotal evidence that the larger space, greater privacy, and individual facilities for cooking and bathing provided by motel facilities is preferred by homeless families (Caragata and Hardie 1998, O'Reilly-Fleming 1993).

O'Reilly-Fleming (1993) made a quite favourable assessment of a Toronto shelter that had been converted from a motel during the early 1990s.

> Each room contains a double bed, microwave, fridge, washroom, television, telephone, and bunk beds for children. Although such arrangements are crowded, the units are clean and spacious and many look out onto a grassy area that is being converted for use as a playground. There is a central kitchen area with large freezers for those cooking chores that cannot be accomplished in the rooms. ... Unlike previous facilities food is not provided for the residents, rather they give a per diem related to family size. ... Caseworkers provide assistance with applications and counselling for families having marital problems. There are simple rules of behaviour which centre on abuse of alcohol, drugs, or the perpetration of violence... Individuals are given the responsibility of handling their own food shopping and preparation so they do not become institutionalized (Ibid.: 84-5).

The factors that O'Reilly-Fleming appeared to favour were the provision of normal domestic facilities, such as a separate washroom, telephone, and kitchen appliances that allow for familial preparation of meals.

For some families the lack of close contact with shelter staff, and perhaps even other homeless families, leads to social isolation. Anstett (1997) reported that motel accommodation is more socially isolating for parents and children than accommodation in dedicated shelter buildings. While this was detrimental for some families, it also prompted others to initiate or maintain more contact with housed friends and family and rely more on non-shelter services. For the latter families, he suggested this was an advantage that facilitated the transition back to community living.

Australia: McCaughey (1992) reported that in Melbourne, family shelter services were limited to one floor of a congregate shelter for single adults, mostly men, with whom various facilities are shared. In addition, a single apartment rented, by a social service agency, and a few temporarily unoccupied public housing units were used as emergency accommodation for families. This level and form of accommodation for homeless families was considered inadequate (Ibid.).

England: In England, congregate shelters are reserved for single individuals, and homeless families are accommodated in hotels (bed-and-breakfasts) that have rooms under contract to the local municipal authority. Moore et al. (1995) discovered that families with children make up three-quarters of the homeless population sheltered this way; the rest are single adults and couples. More than 1,100 homeless families were reported to live in hotels in London alone. Almost half were single-parent families. About one-third of the homeless persons in hotels are children. In some cases, the entire hotel was reserved for homeless families or persons, but most of the hotels mixed tourists or guests with homeless families. Most of the hotels accommodated under 20 homeless residents, a minority sheltered more than 60 residents, and one housed 402 residents.

There are, as a rule, no special facilities for children in these hotels, and some of the hotel managers themselves have worries and complaints about the children's health, school non-attendance, and children running unsupervised on the fire escapes and road. A comparison of hotel and hostel staffs' attitudes revealed that fewer hotel staff agreed that their hotel had enough space to satisfy residents' need, and more hotel staff believed that homeless people in their hotel were in some way to blame for their situation. Most homeless hotel residents in this study were young women waiting for subsidized housing. They evaluated their hotel relatively highly for the privacy (i.e., a separate room for their children), safety, and control over daily activities. On the other hand, compared to homeless persons who stayed in hostels, squatted houses (generally very young persons), or slept rough (mostly men), those in hotels (i.e., predominantly young parents) had the highest level of mental stress and felt quite isolated (Ibid.).

United States: There has been no systematic assessment of the various types of shelters that accommodate homeless families and the living conditions within them, however, several researchers have described various aspects of the shelters they have studied (Thorman 1988, Rossi 1994a, and Liff 1996). In the United States, especially in New York City, homeless families may be sheltered in congregate shelters (usually at initial entry and for short periods of time); 'welfare' hotels (for longer stays); or transitional housing facilities (for stays of up to two years). Although the distinction is not very clear, the former two types are considered emergency shelter and provide only basic services (Rossi 1994a).

Congregate shelters are generally barracks- or dormitory-style and offer little or no privacy, sometimes just a bed sheet hung between cots. They generally have shared cooking and washing facilities, and common space for recreation, socializing, and childcare. The level of regimentation is high. Some of the smaller emergency shelters are large detached houses, with the bedrooms used for accommodating families and the larger rooms for shared activities (Liff 1996).

Hotel facilities contracted by the municipality are generally preferred over congregate shelters by homeless families because they provide more privacy (one or more rooms) and control over daily activities, although no stoves are provided, and no cooking in the rooms is allowed (Ibid.). Parents typically have safety concerns for their children, and the shelter buildings have often been described as old and dilapidated, in dirty and dangerous surroundings (Thorman 1988). There are rarely any special facilities for children, and drug dealing and violence sometimes take place in proximity to (or even within) the hotels.

Transitional housing facilities offer the best material conditions, frequently a self-contained apartment or at least private rooms, but require significant time commitments to therapeutic and educational program activities. There are generally special facilities or programs, including day care and school support, for children (Liff 1996). According to a 1992 shelter survey conducted by the Better Homes Foundation, 40 percent of U.S. family shelters are of the transitional type (Rossi 1994a).

5.1.1 Shelter Models in New York

Shinn et al. (1990) investigated the characteristics of nine 'alternative' shelters in New York that exemplified three models: apartment shelters, rooming house shelters, and domestic violence shelters. The apartment shelters were large, accommodating at least 50 families, while the rooming house shelters had from 8 to 12 families each, and the domestic violence shelters had 8 to 18 families each. Despite the differences in models, Shinn and her colleagues found no evidence that any model was better than another. Respect for residents, considered a central criterion, was somewhat higher in the rooming house and domestic violence models than in the larger, apartment model, although all facilities scored high.

Separate apartments permitted families far more individualization of space, privacy, and respect for cultural differences, especially regarding diet and food preparation.

Counselling was provided in all of the alternative shelters, usually by the caseworker who co-ordinated services. The larger shelters usually offered more extensive professional counselling than the rooming houses. The domestic violence shelters had the most extensive counselling for residents. All of the alternative shelters provided housing advocacy, and one domestic violence shelter offered legal advocacy. Several shelters followed residents who had moved into permanent housing with aftercare services.

Compared to the City's welfare hotel shelters, the alternative models offered more services (food, supplies, and human services) and better co-ordination of services.

The three general types of shelters (congregate, hotel, and alternative) differed most in the provision of social services. The alternative shelters offered more services (i.e., childcare, adult education services, health and parenting classes, on-site schools for children, Boy Scouts, and jobs for teens in an after-school program for younger children). They also provided better co-ordination of services, usually through case managers assigned to families. In hotel shelters, different agencies often supplied multiple services and large caseloads resulted in uneven service provision.

5.1.2 Residents' Views of Ideal Shelter

The type of shelter in which they stay affects the level of stress experienced by homeless parents and children. Based on a review of the positive and negative qualities of U.S. shelters as reported by homeless families, Liff (1996: 144) determined that the ideal shelter would "be safe, provide adequate facilities such as enough beds and a kitchen, be located in a residential neighbourhood, provide caring and helpful staff and provide opportunities for social interactions."

6. Evaluations of Shelter Services

6.1 FAMILY VIOLENCE SHELTERS IN CANADA

Family violence shelters provide a range of services for children. Individual counselling for children was the most prevalent service provided (CMHC 1995). Of the 332 shelters surveyed by Statistics Canada in the Transition Home Survey in 1993, 75 percent of them provided individual counselling; 58 percent provided childcare or babysitting; 54 percent provided group counselling; and 14 percent provided school classes or tutoring.

The 1997-98 Statistics Canada Transition Home Survey found that most family violence shelters offered children indoor and outdoor recreational spaces (80 percent), three-quarters of them offered individual counselling, and about half offered group counselling and programs for children who had witnessed or experienced violence (Statistics Canada 1999 (2)).

Second-Stage Housing: In a 1997 evaluation of the Next Step Program for second-stage housing, residents reported high satisfaction with the security and physical characteristics of this housing (CMHC 1997). Residents also reported positive outcomes for themselves and their children from second-stage housing, for example, their children were happier, were doing better in school, made new friends, and were easier to get along with after moving to this housing.

> Although my children were very young, I was happy to see the changes that occurred [while living in the second-stage shelter]. My oldest [two years old] was quite aggressive and the childcare worker helped him find ways to deal with the anger, and helped me find ways to deal with him.
>
> Resident quoted in CMHC (1997: 39).

Despite the overall high levels of general satisfaction with Next Step and other second-stage housing, some concerns were expressed by women in some second-stage housing. These included concerns about the lack of facilities and services for children for some second-stage housing.

As compared with first-stage shelters, second-stage housing in Canada provides longer term housing, more private space, and specialized provision of services (but not permanent housing). To this extent, Canadian second-stage housing is similar to the U.S. model of transitional shelters. But in significant ways it differs from the U.S. model. Canadian second-stage housing exclusively serves women and their children who have experienced domestic violence. Also, it is not as service-intensive as U.S. transitional family shelters. Some services for residents in Canadian second-stage housing are provided by the referring emergency (first-stage) shelter or by referral to other agencies in the local community.

Most second-stage housing in Canada provides counselling for women, referrals to other services, accompaniment services, and support groups. Nearly two-thirds of them reported that they provide counselling services for children, including counselling for children who have witnessed violence, and only 38 percent provided childcare.

This is unlike the multi-service programming of U.S. transitional shelters where day-care and extensive educational and training services for parents and children are not only integrated with other support services, but generally residents' attendance in them is a prerequisite to staying in the shelter. In Canadian second-stage housing, a third of the women were enrolled in formal training or education courses, presumably on an entirely voluntary basis (CMHC 1997).

6.2 U.S. FAMILY SHELTERS

An evaluation of living conditions and services in 24 U.S. family shelters (based on a sample of three shelters selected in each of eight U.S. cities of varying sizes--two large metropolitan cities, four medium cities, and two small cities--and geographic areas) included 172 resident interviews (up to ten interviews at each shelter with randomly selected families) (McLaughlin and Wolf 1992).

The average sheltered family consisted of a mother with two children; and the average shelter stay was for six and half months. (According to data from earlier national surveys of shelters in the United States, the length of shelter residence by families had increased from three months in 1988 to more than six months in 1992.) About a third of the families had previously stayed in another shelter, and a tenth of them had stayed at the same shelter before. Almost a fifth of the families were homeless due to family violence.

The average occupancy capacity of the shelters was 49 beds. The majority of residents did not have a private room, but only one-third said they were dissatisfied with the lack of privacy. One resident out of five reported that belongings had been stolen from them in the shelter. Over one-quarter of the respondents said they disliked the shelter's rules. The shelter environments were determined to be generally satisfactory, however, 20 percent of the families said they were concerned about family safety.

Services provided for children included day care, local Head Start programs, "Reading is Fundamental" programs, and recreational programs.

Sixty percent of the families received case management, usually involving weekly meetings with a counsellor or social worker. Most shelters were able to connect children with a local public school within 48 hours of entering the shelter. Only one-quarter of the shelters had access to a day care program or facility.

While most of the shelter directors (22 out of 24) said that the families' needs were being met, over one-third of the residents said they wanted more services. It is not clear whether they meant more of what were available or additional services. The four most-requested services were on-site childcare and babysitting, housing assistance services, and on-site high school equivalency classes.

The report recommended that child care services be provided for parents looking for work, that cleanliness and security be improved where necessary, and that effective practices be implemented to prevent family separations due to admission restrictions for older males. (Ibid.)

7. Service and Program Directions

7.1 IMPROVED LOCAL SERVICE CO-ORDINATION

Several municipal reports have identified that better co-ordination of shelter services is required for homeless persons in general, and homeless families in particular (Edmonton Task Force on Homelessness 1999, Golden et al. 1998, and Calgary Homelessness Initiative 1998). Anstett (1997) recommended the introduction of a central intake system for homeless families in Toronto.

Improved service co-ordination for sheltered children and youth is an even more complex undertaking than for adults. It requires the involvement of additional agencies, such as schools, not traditionally associated with services for homeless persons.

7.2 SHELTER CAPACITY

Shelter capacity for homeless families in Canada has increased (Springer et al. 1998 and Statistics Canada 1999 (2)). Many family violence shelters are crowded and very heavily used. The vast majority of them experience full occupancy at some time during the year (CMHC 1995).

Large Families: The size of homeless families in Toronto has increased, and in 1996 almost 20 percent of them had three or more children (including 3 percent with five or more) (Springer et al. 1998). The inability of shelters to accommodate large or extended families has been reported in Edmonton (Homelessness in Edmonton 1999). The 1995 CMHC evaluation of first-stage family violence shelters found that 14 percent of the clients had three or more children, including 5 percent with four or more children. The proportions of larger families staying at these shelters were higher for Aboriginal families, 20 percent of them having three or more children. Very large families (with ten or more children) are not uncommon for some shelters. In these cases, children are accommodated in several bedrooms (or in some cases, in common areas) (CMHC,1995).

Anstett (1997) suggested that more flexible provision of rooms or suites is required to better accommodate large families and better accommodate those with teen aged children.

7.3 AD HOC MOTEL USE AND CONCENTRATION IN TORONTO

There is no documentation to indicate that any Canadian municipalities, other than the City of Toronto, consistently rely on contracted services with motel owners to accommodate homeless families. Ottawa-Carleton initially accommodated homeless families in motels during the early 1980s, then opened two family shelters "to better provide support services, centralize facilities, improve control over the use of emergency housing and to accommodate fluctuation in emergency housing demand" (Region of Ottawa-Carleton 1999: 29). Other municipalities may make occasional use of motels to accommodate a small and fluctuating number of homeless families.

The use of motels to shelter homeless families was first authorized by the Municipality of Metropolitan Toronto in 1986 to deal with overcrowding in existing family shelters and offer more privacy. It was initially intended for short-term use. However, the practice has continued and increased during the 1990s. Motels located in Burlington and Hamilton have also been used since 1997. Approximately 1,100 people are accommodated in Toronto area motels each month, with an additional 140 people located in motels outside the city because of insufficient low-cost local motel space (Hoy 1999).

According to Golden et al. (1998), 92 percent of Toronto's family shelter capacity is currently located in Scarborough (now part of Metropolitan Toronto), which accommodates families in one large family shelter and thirteen motels.

Upon review of motel use and its concentration, the Toronto City Council is considering the following recommendations (Hoy 1999):

- To phase-out the use of motels over a three to five year period, contingent on provincial funding for replacement affordable housing units for homeless families.
- To spread family shelter capacity more evenly across the city.
- To better co-ordinate service, improve service access, and enhance the quality of services available to homeless families.
- To seek additional resources in local schools, including children's counsellors, where sheltered children are concentrated.
- To enhance accountability by establishing standards for motels used as emergency family shelters and develop a new process for the management and issuance of motel contracts, including consultation to respond to community interests.

The City of Toronto is also planning to determine and monitor standards for appropriate indoor and outdoor play space for children, appropriate private space for children to sleep and complete homework, cooking safely in small spaces, and average lengths of stay.

In addition, the introduction of exclusive contracts with some motel operators is expected to ensure that homeless families are accommodated alongside other families, rather than other motel clients, and make it easier to secure enhancements to motel properties and enforce contract compliance (Hoy 1999).

7.4 EDUCATION

Anstett (1997) recommended that better co-ordination between schools and family shelters is required to keep moves between schools to a minimum and to assist with students' transitions.

In the United States, homeless children's school attendance has been recognized as a serious problem. Legislation was passed to provide homeless children with equitable access to education and to reduce barriers (Title VII, subtitle B of the Stewart B. McKinney Homeless Assistance Act of 1987, with amendments in 1990 to provide additional funds for states to provide direct services for students).

U.S. researchers Wall (1996) and McChesney (1993) have suggested that schoolteachers and administrators can provide a supportive and stable environment for homeless children by being sensitive to their special needs and concerns. And because some shelters do not provide environments conducive to studying and completing homework, schools can assist by developing on-site opportunities during or after school (Wall 1996).

Some U.S. transitional housing projects have provided in-house educational programs, including early childhood education and accelerated after-school learning programs for children (Homes for the Homeless, 1993). Early childhood education, such as the Head Start Program, has been found to significantly improve developmental problems among homeless children. Full-day Head Start programs have been offered in some shelters (Koblinsky and Anderson 1993). Some educators (Swick, 1997) consider such integrated service provision exemplary.

Wall (1996) has argued instead that schools remain ideal settings for developing and co-ordinating the array of educational and social services that homeless students require.

> Because schools are a universal part of children's and families' lives, providing services in these systems can be less stigmatizing than services in private and public institutions that are identified with offering such assistance (Ibid.: 139).

However it is accomplished, there is a need to better link educational agents and services to programs for homeless families.

8. Summary

Increases in family shelter use and the need for more co-ordination of services for homeless families have been reported in several Canadian municipalities. Provision of services for children appears to be uneven, and better co-ordination between shelters and educational agencies and services is needed.

There has been considerable research in the United States and the United Kingdom showing that children and youth in family shelters are more likely to have higher rates of impairment in academic and social functioning; and physical and mental health. One of the most consistent findings reported by parents is the higher rate of children's externalizing or disruptive behaviours. No similar Canadian research has been conducted.

There has been little evaluative research on the effectiveness of the various service programs for families and children (Burt 1997). It is still the case, as Molnar et al. (1990) argued a decade ago, that the state of homelessness among families is being treated as a 'black box' of which we know little about the mediating or process variables.

8.1 GAPS IN KNOWLEDGE

There are several areas in which the lack of Canadian research limits the scope of an assessment of spatial and service needs of dependent children and youth staying in emergency shelters for families. These include the following:

- **Inventory information:** The only national data on spaces and types of services available for children and youth in shelters for homeless families refers to designated family violence shelters. There is no comprehensive documentation on the number, size, or location of other shelters serving homeless families with children, nor on the types of services they provide to children and youth.

  It is impossible to assess the basic adequacy of shelter services for children and youth without at least a descriptive inventory of all shelter services and a systematic assessment of service use and need by community or region.

- **No data on the health status of dependent children and youth staying in emergency shelters for homeless families:** Some might suggest that the poor health status of sheltered children in U.S. is irrelevant to the Canadian situation due to our universal access to health care services. The fact that similar research results hold in Britain where there is also a universal national health program suggests that we cannot assume there is no similar problem in Canada.

  Questions about the health status of sheltered children and youth will remain unanswered until Canadian research results are available.

No data on school attendance and academic functioning of sheltered children and youth: It is fairly obvious that both the crisis of family homelessness and the physical move to a family shelter put children's school attendance and performance at some risk. To what degree this occurs in Canada in unknown.

- **No data on effectiveness of various services for children and youth in family shelters:** Shelters vary in the range and amount of services provided to adults and children. The operating assumption appears to be that more services are offered where resources are available. There is no data on which services or what level of services are most beneficial for children and youth, or alternatively, what types and level of service are sufficient. Program evaluation research has not been conducted in relation to sheltered children and youth.

- **No data on any subsequent effects on dependent children and youth who have stayed in shelters:** In no country have longitudinal studies been conducted to investigate the long-term impacts of homelessness on children and youth. Only a matched cohort study could answer questions about the impact of homelessness itself, apart from poverty, family disruption, abuse and family violence, and other factors such as parental substance abuse.

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