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REDUCING DEPRESSION IN HOMELESS PARENTS:  
THE EFFECTIVENESS OF SHORT-TERM SHELTERS

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Andrea DuRant Heitz

June 1999

REDUCING DEPRESSION IN HOMELESS PARENTS:  
THE EFFECTIVENESS OF SHORT-TERM SHELTERS

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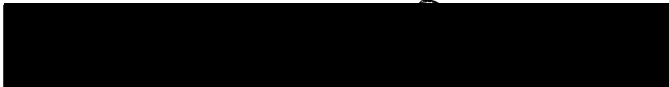
A Project  
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by  
Andrea DuRant Heitz

June 1999

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## ABSTRACT

Families are the fastest growing group among the homeless population (Cohen & Burt, 1990). One of the devastating effects of homelessness is depression. (Lloyd-Cobb & Dixon, 1995). Prior research suggests that transitional housing programs for the homeless can significantly reduce depression if they provide a variety of services which meet their emotional, vocational, housing, and social needs: not just food, shelter and clothing (Albers & Paolini, 1993; Hall, 1991; Gerstel, Bogard, McConnell, Trillo & Schwartz, 1995; Cornish, 1992). This study used a positivist approach to explore the effects of Foothill Family Shelter's program upon the residents' depression. A within-subjects design, consisting of a pre-test and post-test depression inventory was administered to shelter residents. The dependent variable was the depression inventory scores and the independent variable was participation in the shelter program. This study supported the hypothesis that short-term shelter programs can help reduce depression in homeless parents.

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## INTRODUCTION

Throughout American history the homeless have been with us. Traveling the open road and hopping freight cars has been romanticized for us through films, literature, and the media. But the reality of homelessness is not at all romantic, especially for families with children. Friedman (1994) finds that the different definitions of homelessness in the literature do not actually capture the multi-dimensionality of homelessness. Hudson's (1989) definition focuses on a person's inability to negotiate market conditions in a particular locale or more specifically the inability of the person to obtain any type of shelter. The Institute of Medicine (1988) defined homelessness as the inability of the person to have a "fixed, regular, and adequate night time residence." Friedman speculates that the word "homeless" is a catchword, which only focuses on the lack of residence, but fails to include the myriad of problems which usually accompany homelessness. Accordingly, the term "homeless" is as stereotypical and misleading as any other societal label.

The truth is that the homeless population constitutes a group of people experiencing an assortment of problems, of which a lack of residence is just one identifying element (Friedman, 1994). While social work research has studied the plight of the homeless for decades, not enough

research has focused on whether the services being offered to the homeless actually improve their situation (Lindsey, 1998). The interrelatedness and seriousness of problems in the homeless population suggest social workers use a "team-based" or ecological case management model when working with the homeless (Lloyd-Cobb & Dixon, 1995).

The fluctuating nature of homelessness makes it near impossible to measure the population with a great degree of accuracy, but we do know that the homeless number in the hundreds of thousands. We also know that the characteristics of the homeless population are changing from the stereotypic solitary man or woman to a growing number of family groups (U.S. Department of Housing and Urban Development, 1994). Research has also indicated that the numbers of homeless are not decreasing, even though the economy has improved in recent years (National Coalition for the Homeless, 1998). It is also quite possible that the recent passage of federal welfare reform will mean that more families with children will be homeless in the near future, because welfare benefits will terminate before caregivers are able to earn enough to support their family (Lindsey, 1998).

Homelessness is a disastrous event for families. Not only does it interfere with every aspect of the family experience, but it impairs the physical, emotional, and spiritual health of the family members (National Coalition

for the Homeless, 1998). All of the family members are affected and it frequently results in the family members being separated out of necessity. Children are especially negatively influenced because it disrupts their education and development. The frequent moves, lack of safety, lack of available medical care, and frequent absenteeism from school, and lack of nutritious food all result in putting children at risk for depression, alcoholism, and drug dependency in later years (Smith, 1996). Children who experienced homelessness have less of a chance to end the cycle of poverty, and, in turn, may continue the pattern to a new generation.

Families are the fastest growing group among the homeless population (Cohen & Burt, 1990). It is estimated that 1 to 2 million people experience homelessness within one year. Families with children make up around 40% of people who become homeless, while on any one night it is estimated that 20% of the homeless population are families (Shinn & Weitzmann, 1996). Waxman and Hinderliter's 1997 survey of 29 U.S. cities found that children constitute 25% of the homeless people. It is probable that these estimates are higher in rural areas, as research indicates that families, single mothers, and children comprise the biggest proportion of homeless people (Vissing, 1996).

One of the most devastating side effects of being homeless is depression (Lloyd-Cobb & Dixon, 1995; Cohen &

Burt, 1990; DiBlasio & Belcher, 1993). Beck (1976) describes depression as a cognitive triad comprised of negative views of self, negative views of the world, and hopelessness. Research has shown that the circumstances surrounding homelessness make those subject to it at high risk for suffering from symptoms of clinical depression. The DSM-IV characterizes depression as a loss of interest in normal activities accompanied by a depressed mood and a number of other symptoms, such as loss of appetite and feelings of hopelessness for a period to exceed two weeks (American Psychiatric Association, 1994). As homelessness usually occurs in a downward spiral of events, by the time the people are actually out of their homes, their mental energies have been exhausted and they are left with nothing but feelings of hopelessness and despair (Bassuk, 1990). It is also difficult to determine whether depressive symptoms occurred prior to or concurrent with the event of homelessness. But, in either case, it is up to the social worker to follow a biopsychosocial social work philosophy and utilize the community resources available to assist their clients.

Research proposes that transitional housing programs can significantly reduce depression in their homeless clients if they provide: adequate connection to social services; coordination of needs and services; mental health evaluations and interventions; facilitation of goal-

planning; individual and group consultation; promotion of problem solving skills; socialization skills enhancement; parenting classes; nutritional education; medical support; connections to community services; and job training programs (Albers, & Paolini, 1993; Hall, 1991; Gerstel, Bogard, McConnell, Trillo, & Schwartz, 1995; Cornish, 1992). These programs help to counteract the effects of negative view of self and the world. They also instill hope and help relieve symptoms of situational depression in the homeless population. These program practices are also compatible with social work principles, especially those regarding self-determination and respecting the dignity and worth of each individual.

Social workers have long been champions for under represented groups and the present study proposes to further research in the area of depression and homelessness. The current study examined the effect that a short-term homeless shelter's integrated program had upon depression in their homeless parents. Can short-term shelter programs significantly reduce depression in their homeless patrons? In order to discover how to help reduce depression in the homeless population, we must first discover which shelter programs help alleviate symptoms of clinical depression. Then we must look at which elements of shelter programs are helpful in relieving the symptoms of depression. This can be done through comparison of

different programs with different elements, such as homeless shelters with programs and those that only provide basic housing. It can also be done by comparing different shelter programs themselves and trying to determine which segments of the programs help and which do not.

This study looks at one short-term shelter program for families with children and compares the depression scores of homeless parents before and after participation in their integrated program. Therefore, this study is pertinent and relevant in social work research.

#### LITERATURE REVIEW

The homeless are pertinent research subjects for social workers because they are one of the most disempowered and disenfranchised groups of people in our country. But, social work research with the homeless population is difficult for many reasons. One reason is that the extent of homelessness is unknown (National Coalition for the Homeless, 1998). An accurate count of the homeless population is difficult to estimate because of the transient nature of the homeless. Most research samples only consider those that take up "bed nights" in shelters or utilize soup kitchens samples, and fail to accurately estimate the true number of those on the streets and those who are doubling and tripling up with relatives or friends (U.S. Department of Housing and Urban Development, 1994). Moreover, homelessness is most often a

temporary state, not a permanent condition, therefore the numbers are continuously changing. Currently, many researchers state that a "more appropriate measure of the magnitude of homelessness is therefore the number of people who experience homelessness over time," (National Coalition for the Homeless, 1998).

Another problem with obtaining an accurate estimate of the homeless is that operational definitions of homelessness differs between studies. Some studies define homelessness as those without shelter for a particular night(s), while others define homelessness as being without permanent residency (Hudson, 1989; Clarke, 1995). A third problem is that methodologies are varied in research with the homeless. They differ in that some use point-in-time estimates and some use estimates over time. Point-in-time estimates are dependent upon one-time counts in homeless kitchens and shelters, but these can be highly misleading because they imply that the homeless population is static as opposed to fluctuating numbers. Estimates over time try to keep track of estimates over a period of time to better understand the true extent of homelessness, but still miss a significant number of homeless people who never come into contact with social services agencies (U.S. Department of Housing and Urban Development, 1994; National Coalition for the Homeless, 1998).

A recent survey estimate stated that between four and

nine million people, including children, experienced homelessness at some point during the latter years of the 1980s (U.S. Department of Housing and Urban Development, 1994). A 1996 report reviewed homelessness in 50 cities and found that in almost all of the cities, the approximated number of homeless vastly exceeded the number of spaces available at emergency shelters or transitional housing spaces. The report estimated that there were 760,000 people homeless on any one night and that 1.2-2 million people who experienced homelessness during one year (National Law Center on Homelessness and Poverty, 1996).

Not all research supports the view that homelessness is continuing to be an expanding problem in our country. Mathews' article (1992) suggests that the population of homeless shelters is leveling off or even growing smaller. Mathews attributes this, in part, to drug screening implemented by many shelters, implying that the salvageable portion, or non-drug using portion, of the homeless population has been able to get into shelters and off the streets. Many of these same shelters have implemented back to work programs with their sober patrons which have enabled them to find employment and, hopefully, housing. He also suggests that the rapid growth in the homeless population during the 1980s is unlikely to be repeated. According to Mathews, nameless "scholars" report that those who are predicting rises in the homeless populations do so



because they are afraid of losing government funds. He also indicates that the figure of 3 million homeless people touted by the media and homeless advocates during the 80s was greatly inflated, and that a 1988 Urban Institute report found no more than 600,000 homeless on any one night, as if that were an acceptable number of homeless people.

Mathews further recommends that building shelters is not the answer to the homeless population. He quotes a Yale law professor in saying that shelters do not decrease dependency because they attract streets people AND also those who are already housed with relatives and friends. He claims that the best results are transitional housing programs, because rules and assessment requirements keep those who can't pass the assessments on the street and make room for the ones who can move on and get jobs. Fortunately, this narrow vision is not held by social workers who work with the homeless population.

Federal studies, along with social work research, have shown that the significantly largest group joining the ranks of the homeless are homeless families with children (U.S. Department of Housing and Urban Development, 1994; Lindsey, 1998). The vast majority of these families are headed by single mothers (Burt & Cohen, 1989). Traditional soup kitchens and men's dormitories fail to meet the needs of this growing group. Safety and privacy for the adults

and their children is a problem which many homeless shelters fail to address when providing housing for residents. Studies are also showing that the long lasting effects of homelessness do not cease just because a family gets off the streets or into permanent housing (Gold, 1995; Graham-Berman, Coupet, Egler & Mattis, 1996).

Friedman (1994) submits that there are two types of shelters: 1) those that provide for basic needs and social services; and 2) and those that provide for basic needs, social services, and also provide a supportive community environment which helps create informal networks of social support and provides a coping mechanism for dealing with the stress associated with being homeless. Families with children are looking for situations which provide them with more than just basic shelter. They are looking for programs which will allow them and their children a safe place to rebuild their lives and help them gain the skills necessary to becoming self sufficient (Bassuk, 1990).

Homelessness is a condition that imposes severe mental, physical, and social deprivation on a growing number of families with children in the United States today (Wagner, Schmitz, & Menke, 1996). Feelings of failure to provide adequate food, shelter, and clothing for themselves and their children can lead to hopelessness and depression in the homeless population. When feelings of failure begin to outweigh their successes and depression is unchecked,

homeless people often lack the initiative to re-integrate themselves back into the non-homeless community (Belcher, 1988). Traditional dorm style homeless shelters only address the basic needs of their residents and do not address the issue of depression. Homeless families with children have a great need for programs which will provide participants with therapeutic community settings and address the symptoms of depression, along with other family issues. In a study of homeless mothers, Klein (1994) found that over 80% of the mothers showed possible depression, and 68% showed probable depression on the Center for Epidemiologic Study-Depression Scale. Unfortunately, merely providing a family with housing does not address existent mental health problems and does not supply them the tools necessary to attain or maintain self sufficiency. In the long run, providing food, shelter, and clothing is not a long term solution to the problem of depression in homelessness families with children; much more needs to be done.

A growing majority of homeless families are becoming homeless due to economic hardships, a shortage of low income housing, family illness, family dissolutions, substance abuse, domestic violence, and other social problems (National Coalition for the Homeless, 1998). In most of these cases, homelessness becomes one of the precipitating factors to situational depression. Klein

(1994) further states that "Depressive symptomology among homeless mothers is a function of the traumatic events and experiences that produce depression among people in general." In other words, being homeless can almost predispose a person to depression. According to Clarke, Williams, Percy, and Kim's 1995 study on homeless individuals, depression was one of the reasons most often cited for homelessness, along with family problems, loss of a employment, substance abuse, violence, and difficulty forming relationships. For most of the homeless population studied, it is usually a series of life events which ends them up homeless. This downward spiral can have a devastating effect on self esteem and can lead to serious depression.

A significant prevalence of depression has been documented in the homeless population (Mullis, 1988; LaGory, Ritchey, & Mullis, 1990). Depression is a serious problem for any population, but for the homeless it is exacerbated by environmental factors for which they have little control over, such as poor nutrition and unsafe living conditions. When people feel a sense of failure and stress caused by the inability to care for themselves, and by the loneliness and isolation caused by homelessness, it can lead to depression, anxiety, and loneliness (Cohen, Putnam, & Sullivan, 1984). Homeless people have even more limited access to mental health intervention than the

housed population. One study of a random sample of 150 homeless men and women revealed that 73% of the tested sample were potentially clinically depressed (Mullis, 1988). Further, their depression had considerable inhibiting effects on their problem-solving capabilities which does not allow them to resolve their situation and get off the streets.

Not only are the homeless negatively impacted through their homeless status, but also by society's negative attitudes towards the homeless and the stigma attached to the label. Unfortunately, there is still a strong inclination for use of the "bootstrap model" to explore solutions to the problem (Rivlin, 1986). To give the homeless some food, clothing, and shelter for a night or two and send them on their way has traditionally been seen as a "moral" solution to the problem. The majority of homeless people do not choose to be homeless, despite some belief to the contrary. The loss of their previously held status in society can lead to traumatization and depression. It is hard to pull yourself up by the bootstraps when you have no boots.

In DiBlasio and Belcher's 1993 study, researchers suggest that depression and poor health are the two most meaningful factors that contribute to low self-esteem among homeless people. Homeless people are at risk for developing mental health disorders, or for exacerbating

existing problems, because they often have a chronic pattern of being unable to achieve their goals. Inability to achieve goals can lead to feelings of disconnection from society and low self-esteem. This is especially true for homeless people who work but are unable to afford to take care of their families' needs such as permanent housing, food, and clothing. The authors caution that low self-esteem factors may even be mis-diagnosed as dysthymia, depression, or other mental disorders among the homeless.

In order to address the mental health issues of its homeless patrons, outreach services must do more than provide an adequate diet and shelter. DiBlasio and Belcher (1993) found that 75% of 61 homeless subjects were assessed with depression, with 37% of the members having serious depression which required immediate mental health interventions. Social work outreach to the homeless population should provide services that enhance the lives of the homeless, but must first address proper psychosocial and psychiatric assessment, diagnosis, and treatment.

Depression is the most common complaint in any individual seeking mental health care (Gotlib, 1992). It is estimated that more than 17 million Americans experience some form of depression at some point during the year and almost two-thirds are not treated. More than 1 in 5 Americans can expect to get some form of depression in their lifetime (Colorado Health Net, 1998). Myers and

colleagues, (1984) found that approximately 3% of the adult male population and 7% of the adult female population experienced depression over a six month period. Most social work research estimates that the homeless population experiences depression at much larger rates (DiBlasio & Belcher, 1993; Brown & Ziefert, 1990; Burt & Cohen, 1989).

Some researchers believe that addressing the homeless population individual by individual is useless, and that the larger social problems must be undertaken (Rivlin, 1986). Bassuk (1984) cites four societal factors that need to be addressed to relieve the growing problem of homelessness: unemployment, lack of low-cost housing, governmental cuts in benefit payment programs, and long term changes in national policies regarding the mentally ill. While addressing the larger social problem is a necessary focus of social work research, improving the condition of the disenfranchised is also an important goal of social work. There are few groups who are more "disenfranchised" than the homeless.

Research has shown that depression in homeless families can be significantly reduced during stays in transitional housing or family shelters (Gerstel, Bogard, McConnell, Trillo, & Schwartz, 1995). DiBlasio and Belcher (1993) propose that social work outreach programs must do more than meet the obvious needs of food, shelter, and clothing for the homeless. They report that issues such as

self-esteem, nutrition, depression, and social isolation need to be addressed to help cure the symptoms of homelessness. Gerstel, et al. (1995) agrees that community-building effects and other resources provided by shelter life contribute positively to the mental health of homeless families, but contributes most of the improvement to stabilization of housing, not necessarily therapeutic elements of the shelter program. But Albers and Paolini (1993) argue that a combination of cooperative efforts of the shelter staff, social services agencies, the communities, and the homeless families themselves are necessary for broad-based empowerment needed by homeless families. Gold (1995) recommends that longer stays in family shelters can reduce the trauma associated with homelessness, specifically post traumatic stress disorders symptoms in children. Gold also admonishes that merely obtaining permanent housing does not cancel out the trauma of being homeless. Bogard (1996) likewise found that homeless mothers are in need of substantial rehabilitation, not merely housing.

Richardson and Landsman (1988) compared two transitional houses programs to determine what aspects of the program helped promote success among their clients. Clients who completed the transitional housing programs achieved better financial success and ability to maintain housing. Other factors which contributed to the client's



self sufficiently were a strong relationship between the client and the case manager, and interventions that were consistent throughout the shelter stay. They also strongly suggested that it was critical for the underlying issues that lead to homelessness to be resolved during the shelter stay, such as mental health issues, lack of income, affordable housing, and domestic violence. The study's conclusion was that improvements to interventions considerably contributed to client success.

One model of mental health intervention for homeless family suggests that homeless clients should be facilitated both individually and in group situations. The model also suggests that the homeless clients themselves should be an integral part in the shelter functioning, offering insight to potential problems and innovations how to resolve them (Hall, 1991).

Brown and Ziefert (1990) suggest that programs which offer private family apartments, yet have frequent program meetings of the shelter community, foster a sense of community in the homeless clients. This type of program establishes privacy to ensure feelings of safety, yet also minimizes feelings of isolation and loneliness and gives the residents a sense of belonging. This is the first step to reconnecting with themselves and their community and helps to relieve symptoms of depression.

In contrast, LaPointe's 1994 study suggests that

transitional housing does not empower the homeless as supposed, but actually works to disempower the homeless because of rampant stereotyping among the shelter staff. Problems exist not only in the day to day running of the shelters, but within the infra structure of many shelters and transitional housing facilities, including non-profit organizations who often use volunteers. Timmer (1988) found that staff workers in shelters were often untrained and were morally biased to view the residents as deviants. He suggests that one way to counteract this tendency is to integrate the residents into the actual running of the shelter and to have the homeless residents enforce shelter routines and organization in the shelter. Timmer also cautions shelters from resisting the attempt to over-regulate the lives of the homeless clients and enforcing middle class moralities upon them. Tracy and Stoecker (1993) found that there were both "blame the victim" type shelters and shelters who viewed their homeless residents more holistically and took into consideration not just individual, but systemic factors.

Unfortunately, research is also demonstrating that a vicious cycle may exist between homelessness and depression/mental illness for children. Sheilagh Hodgins' 1996 study suggests that some preventative measures can be made against some of the major mental disorders, including major depression. Environmental factors play a large part

in whether familial propensities towards mental illness will exhibit themselves. Thus, by reducing negative environmental factors like homelessness, we can possibly reduce the emergence of depression in certain populations. Even less severe problems, such as adjustment difficulties in children, have been linked to lack of social support systems and maternal depression (Graham-Berman, Coupet, Egler, & Mattis, 1996).

A recent study by Smith (1996) compared a group of homeless school-age children living in temporary shelters with those of a group of low-income housed children. Age and gender were matched for the two groups. Parent reports indicated that the homeless children exhibited more withdrawal, anxiety/depression, and attentional difficulties than the children in permanent housing, with the homeless girls showing more impairment than homeless boys. The homeless children were significantly more depressed than the housed children and had lower levels of self-worth. It was also found that depression in the mother was significantly linked to depression in the child: the more depressed the mother, the more often the child was depressed also. Thus, when homeless parents experience depression, they are not only impaired as individuals, but they also significantly affect their children through impaired parenting practices.

Other factors of homelessness have been linked to high

stress levels and symptoms of mental health problems in populations of homeless mothers and their children. Highly significant is separation of mother and child. Studies have argued that even though homeless families have a multitude of medically related problems, they rarely seek assistance for their *mental* health problems without prior intervention by social services. Further, childhood depression, acting out behavior, and internalization has been linked to maternal depression and substance abuse (Zima, Wells, Benjamin, & Duan, 1996). Flynn (1997) attributes the lack of regular health practices in homeless women to learned helplessness, low self-esteem, and depression. Once again, depression is found to be of significance in the welfare of homeless families, both for the depressed parent and for the overall welfare of the child. Helping to improve the depression in the parents should lead to improved situations for the children.

#### PROBLEM FORMULATION

A number of studies have demonstrated a link between homelessness and depression. The depression causes a triad of hopelessness, negative view of self, and negative view of the world in the homeless people (Beck, 1976). These characteristics make it almost impossible for depressed homeless people to do what they need to do to get off the streets. When the smallest activities in daily life, such as bathing, grooming, and eating, become nearly impossible,

tougher tasks such as looking for housing or jobs become virtually impossible. The depression creates a vicious cycle for the homeless population, which most homeless people do not have the resources to stop.

Research shows that transitional housing programs which include case management, links to social services, mental health interventions, social skills, training, and other supportive services can help reduce the symptoms of depression in the homeless people. But to better understand which aspects of the programs are the most beneficial, it is necessary to study different programs with various types of programs and compare them to see how they affect the depression in their residents.

There is clearly a need for social work research to explore the issue of depression in the homeless population and find out whether homeless shelter programs can help alleviate depression and what elements of shelter programs are effective.

Foothill Family Shelter, a 90-day transitional housing program in Upland, California, has attempted to address some of the needs of homeless families with children through their integrated program. The program at Foothill Family Shelter uses an holistic approach to providing services to the homeless families and tries to provide a well rounded program. A social worker provides both individual and group case management to the eight families

who reside at the shelter for up to ninety (90) days. The social worker also performs psychosocial assessments and makes any necessary mental health referrals or interventions. Foothill Family Shelter has a structured shelter program which combines education, socialization, problem solving, budget planning, counseling, social skills enhancement, and individual accountability in an attempt to promote empowerment for shelter residents.

Foothill Family Shelter's program provides each family with a pre-furnished, two-bedroom apartment. All adult residents must agree to drug screening and a mandatory savings plan which requires that they save 30% of their income while at the shelter. Compulsory bi-weekly group meetings address issues on parenting, grief and loss, connection to community services, low-income housing information, chemical dependency, and other informative and psycho-educational issues. In addition, each shelter family is assigned a volunteer team of community advocates which aids them in facilitating goal-planning and budgeting while they are at the shelter. The shelter also works hand in hand with the school district and county health departments to make sure the needs of the entire family are met while they are at the shelter. Foothill Family Shelter combines social work case management, mental health interventions, a structured shelter program, and community involvement into a program which allows the residents to

rebuild connections to their communities in a safe, supported, and positive environment.

Consequently, this researcher studied whether Foothill Family Homeless Shelter's program helped reduce symptoms of depression in their homeless parents according to a depression instrument. This study was based on two assumptions demonstrated in the literature:

- 1) depression is very prevalent among homeless parents; and
- 2) that more than food, shelter, and clothing is necessary to reduce the symptoms of depression in homeless parents with children who stay in homeless shelters or transitional housing.

#### METHODOLOGY

This study used a post-positivist approach to evaluate the effectiveness of Foothill Family Shelter's program upon reducing depression in the parents who participated in the 90-day program. This study is exploratory in nature, and should not be generalized to the population of homeless parents.

Participants: The participants consisted of 105 adult persons who applied to Foothill Family Shelter or participated in the shelter program between June, 1998, and May, 1999. All participants gave informed consent to volunteer for the research (Appendix A) and were debriefed after participation (Appendix B). Approximately 84% (n=88) of the participants were women and close to 50% (n=50) of

the participants were between the ages of 26-35 (Table 1.0). Over half of the participants had 3 or less children. The distribution of ethnicity was about one-third Caucasian, one-third African-American, and one-third Hispanic/Latino and other. Considering that throughout the United States that African-Americans, Asian, Hispanic/Latinos, and "other" categories together constitute less than 30% of the population, these figures indicate that there is a larger than average number of minorities applying to the shelter (U.S. Census, 1992).

**Table 1.** Frequency and Percentage Table of Variables

Variable	Designation	Frequency	Percentage
Sex	Male	17	16.2
	Female	88	83.8
Age	18-25	17	16.2
	26-35	50	47.6
	36-45	30	28.6
	46-55	7	6.7
	56 and older	1	1.0
Number of Children	1	17	17.1
	2	26	24.8
	3	30	28.6
Number of Children	4	19	18.1
	5	5	4.8
	6 or more	7	6.7
Ethnicity	Caucasian	36	34.4
	African-Amer.	33	31.4
	Latino	26	24.8
	Asian	3	2.9
	Other	8	6.7
Time Homeless	Less-2 months	47	47.8
	Less-4 months	30	28.6



**Table 1.** Frequency, etc. (Cont.)

Variable	Designation	Frequency	Percentage
	Less-6 months	10	9.5
	Less-8 months	4	3.9
	Nine/more mos.	14	13.3
Employment Status	Yes	26	24.8
	No	49	46.7
	Missing Data*	30	28.6
Looking for Job	Yes	38	36.2
	No	37	35.2
	Missing Data*	30	28.6
Past Treatment For Emotional Problems	Yes	29	27.6
	No	46	43.8
	Missing Data*	30	28.6
Emotional Problem Treated	Depression	13	12.4
	Subst.Abuse	14	13.3
	Other	5	4.8
	None	43	41.0
	Missing Data*	30	28.6
Taken Meds For Emotional Problems	Yes	10	9.5
	No	65	61.9
	Missing Data*	30	28.6
Type Meds Taken	Anti-depressant	8	7.6
	Anti-anxiety	1	1.0
	Other	2	1.9
	None	64	61.0
	Missing Data*	30	28.6

Note\* These data were not requested by the shelter prior to this researcher joining the project, thus the data are not available.

Foothill Family Shelter only accepts families with children. Thus, all the adult participants of this study were parents, or persons who acted in parental capacity and

had primary custody of children. For the purpose of this study, they all will be referred to as "parents". This study consists of two comparison groups: those who applied to the shelter and went through the integrated program; and those who applied and were not selected for the program. The sample of homeless parents was obtained through availability and in no way constituted a random sample which can be generalized to the entire homeless population.

The group of participants who applied to, were accepted into the shelter, and went through the integrated program will be referred to as "residents" and consisted of 38 participants. The time span of the study was from June, 1998, to May, 1999. The residents were separated into two groups: 25 participants were those with pre-test-post-test scores who went through the program during the time span of this study; and 13 participants were residents who had been out of the shelter for at least six months (See Table 2.0). The pre-test-post-test group was used to determine whether the shelter program helped reduce depressive symptoms according to depression index scores. To explore whether or not the program had any lasting effect upon the depression scores of the residents, the post-six residents were also given the depression inventory.

A larger sample of parents (n=67) who applied to the shelter but were not selected to go through the program, will be referred to as the "baseline" group. This group,

along with the rest of the participants, helped the researcher to learn more about the characteristics and demographics of the people who applied to the shelter during the period of this study. Statistical comparisons between the baseline group and the post-test group were also explored.

**Table 2. Total Participants For Test Groups**

Group	Total
Baseline (Applicant Only)	n=67
Pre-test-post-test (Resident)	n=25
Post-six (Past Resident)	n=13

Depression Index - Reliability and Validity: The depression inventory used in this study was the Center for Epidemiologic Study-Depression Inventory, (Appendix C) hereinafter CES-D (Radloff, 1977). The simply stated language of the CES-D was very appropriate for this homeless population. The CES-D is a well-known, and often used index of acute depressive symptoms experienced over a 7-day period (Melchior, Huba, Brown, and Reback, 1993). It was designed to measure current levels of depressive symptomatology in noninstitutionalized adults and was constructed from a pool of previously validated depression indices (Clark, Aneshensel, Frerichs, & Morgan, 1981). It

was originally designed on a 4 factor model denoting depressed affect, positive affect, somatic and retarded activity, and interpersonal difficulties (Radloff, 1977).

It has been widely used in countless research studies and reflects acceptable validity and reliability (Margolis & Robins, 1996). Radloff (1977) reported an alpha reliability coefficient of 0.85 overall, using Cronbach alpha. Clark, Aneshensel, Frerichs, & Morgan (1981) found a Cronbach's alpha of 0.91 for women and 0.86 for men, with an overall 0.90 rate. Knight, Williams, McGee & Olaman, (1997) found the alpha reliability rating of 0.88 and good validity for the 4-factor model, chi square=673.66, goodness of fit=0.91. Myers & Weissman (1980) reported that in the community setting with a base rate of 5% depression for the population, the CES-D has diagnostic efficiency ratings as follows: Sensitivity for correct diagnoses=.64; specificity for those without depression correctly diagnosed=.94; negative predictive power=.98; positive predictive power=.33; classification of those correctly diagnosed with major depression=.93. Some gender differences have been found, with females having higher scores than males and more likely to exceed cutoff scores for identifying clinical depression (Berganza & Agular, 1992). But Kessler, McGonagle, Zhao, and Nelson, (1994) found that the gender bias reflects gender prevalence rates of depressive disorders in national epidemiological

studies.

The CES-D is a self-report depression scale for research in the general population, and as such, can be used without special permission (Appendix D). The CES-D is a 20 item likert-type depression scale developed by the National Institute of Mental Health Center for Epidemiological studies. A Likert scale is a type of format that is frequently used in contemporary survey questionnaires. The Likert scale asks closed ended questions, which are often used in self-administered questionnaires as well as interviews because they provide greater uniformity of responses and are more easily processed (Rubin & Babbie, 1997). The response categories are "None," "1 or 2 days," "3 or 4 days", and "5 or more days this last week," and asks the respondent how many of the 20 statements apply to them within the last seven days.

The CES-D has a range of 0 to 60, and Radloff (1977) indicated an original maximum of 16 points or higher indicating possible clinical depression. Some studies have shown that this cutoff point can be inappropriately low for adolescents or for different cultural groups (Knight, Williams, McGee & Olaman, 1997; Cho, & Kim, 1998). Because of the heterogeneity of the sample from Foothill Family Shelter, for the purpose of this study the cutoff rate of 18 or higher was used as indication of depression.

Design: The pre-test-post-test design using the CES-

D was an appropriate design for studying the effects of a treatment program upon depression in the homeless population. In a recent study at a veterans hospital for the homeless, a similar design was used to study the effects a 3 month treatment program had upon the depression of the veterans (Lloyd-Cobb & Dixon, 1995). The program focused on individual and group counseling, concentrated on preparing clients for community reintegration, building social skills, developing a support system, enhancing their employability, and to help them learn coping skills. The Veteran program has similar elements as the one at Foothill Family Shelter. In the Lloyd-Cobb and Dixon study (1995) paired t-tests for correlated means were conducted on the pre-test-post-test scores of each instrument. Results were statistically significant, indicating that the program was effective in helping the homeless veterans reduce feelings of anxiety, depression, and loneliness and helping them gain confidence in their problem solving abilities.

The CES-D has been used countless times with great validity and reliability with the homeless population. In Cohen and Burt's 1990 study of chemical dependency and mental problems in the homeless, the CES-D was used to estimate current mental illness or levels of depression in homeless persons. In this point-in-time study, the sample was 1704 homeless users of soup kitchens in three U.S. cities that had a homeless population of 100,000 or more.

Each participant was personally interviewed. Mental illness and/or current level of depression was assessed by use of the CES-D, along with self reported history of mental hospitalization, and self reported suicide attempts. The participants with a history of hospitalization for mental health problems had the highest mean scores on the CES-D and those who reported the most depressive symptoms in the interview also had the highest CES-D scores. Thus, the CES-D correlated very well with the findings from the personal interviews and mental health histories.

The CES-D has been used very effectively with the homeless population to determine whether stays in shelters or transitional housing has been effective in reducing depression. A 1995 study by Gerstel, Bogard, McConnell, Trillo, and Schwartz used the CES-D in a study with homeless families and indicated that homeless parents experienced "significant reduction in levels of depression during their stays at family shelters." Their findings suggested that the therapeutic interventions alone were not necessarily responsible for the improvement in their scores, but that the community-building aspects of the shelter were equally important factors in the reduction of depression.

Procedure: Foothill Family Shelter began giving pre-test and post-test depression inventories to their clients for the purpose of outcome measures in June, 1998.

Permission was granted by the Foothill Family Shelter to use the existent data and continue to use their applicants and residents who volunteered for the study (Appendix E). This researcher joined the ongoing research, after receiving human subjects approval from the university (Appendix F) utilized previously existing data, and continued to gather more data through May 7, 1999.

The post-positivist design was implemented by administering the Center for Epidemiologic Studies Depression Inventory to all adult volunteer applicants who applied to or went through the shelter program between June, 1998, and May, 1999. All participants in the study gave voluntary informed consent, (Boyle, 1997; Lloyd-Cobb & Dixon, 1995). The design consisted of three steps: 1) administration of the depression inventory when they applied to the shelter; 2) administration of the depression inventory when they exited the shelter; and, 3) administration of the depression inventory to residents who had been out of the shelter for six months or more.

For the baseline group, (applicants only) the depression inventory was administered only once, when they applied to the shelter. For the pre-test-post-test residents, the participants acted as their own control in a before and after design. In addition to completing the depression inventory when they applied to the shelter, this group was also administered the depression inventory when



they neared completion or immediately after they completed the program. The qualifications for the post-six group only consisted of having been out of the shelter for six months or more at the time of administering of the depression inventory.

The depression inventory (CES-D) was administered by a member of the shelter staff (who was not affiliated with this study) when the potential residents filled out applications for the shelter. The shelter staff followed a written protocol provided by this researcher which allowed for matching of the participants pre-test and post-test depression inventories (Appendix G). All applicants to the shelter were given a chance to volunteer for this study. Acceptance into the program was not affected by agreement to volunteer for the study and the depression inventories were not available to the review committee who determined which applicants were admitted into the shelter. Names were used for the purpose of matching the before and after depression inventories of the residents only, and were deleted before the inventories were actually scored and tabulated by the researcher. Thus, anonymity was assured to the participants. Once the residents of the shelter neared completion of their 90-day stay in the shelter program, the depression inventory was administered again and matched to their original depression inventory. Scoring of the depression inventories was done by the

researcher by hand after all data collection had taken place.

Statistical Analysis: All analyses were conducted using SPSS for Windows. In each comparison, the dependent variable was the test score on the depression scale and the independent variable was participation in the shelter program in this two-tailed hypothesis.

Paired t-tests were performed on the pre-test and post-test scores of the residents who participated in the program, with the subjects acting as their own control as designated in a within-subjects design, to see if participation in the shelter program significantly reduced depression according to the depression scale. Similar studies have run t-tests on the before and after test scores using interval level data.

Since all those who applied to the shelter were not always chosen to be admitted, the number of the "baseline group" (n=67) was much larger than the actual number of residents who took part in the pre-test and post-test study (n=25). The baseline group's demographic characteristics were explored to find out more about the homeless people who applied to the shelter. Comparative analysis between the mean scores of the baseline group and the post-test group were also performed using one-sample t-tests, with the test value set at the post-test mean.

To examine whether the shelter program had long term

effects on the parents who participated in its program, the depression inventory was also given to residents who had been out of the shelter for more than six months, n=13. The mean scores of the former residents (post-six group) were compared to the post-test mean using one-sample t-tests. As with the other groups used in this study, the post-six sample was based upon convenience and availability and does not represent a random sample of former residents.

Thus, the literature advances the idea that no one factor alone, whether it be shelter, food, clothing, mental health counseling, or building of socialization skills, helps alleviate depression in homeless parents, but that it is the total therapeutic community environment that aids them. The results of this study support the literature and strongly indicate that short-term shelter programs can significantly reduce the symptoms of depression in their residents.

## RESULTS

Of the 92 participants who took the depression inventory when they applied to the shelter, 84% (n=78) of them scored 18 or higher on the CES-D, with 18 being the cutoff for clinical depression symptoms for the purpose of this study. Of the 25 participants who were selected to participate in the shelter program, 96% (n=24) of them scored 18 or higher on the CES-D when they applied to the shelter. The mean score for the baseline group was 26.62

and the mean score for the pre-test resident group was 32.3. Both groups are well above the cut-off of 18 and meet the criteria for being categorized "depressed."

After participating in the shelter program, 100% of the residents had a reduction in their CES-D post-test scores, with 60% (n=15) of the residents scoring below the 18 point cut-off for clinical depression. The mean post-test score was 15.16, which is an average reduction of 17.14 points.

Paired t-tests between the means of the pre-test and post-test scores indicated that there was a significant reduction in depression inventory scores,  $t(9.324, 24)$ ,  $p < .000$ , in the two-tailed test (Table 3.0).

The paired sample correlations for the pre-test and post-test pairs was .432, with a significance of  $p < .031$  (Appendix H). Cohen's (1988) system for interpreting the strength of a relationship is based on the square of its correlation (Appendix I). In this case, the square of the correlation is .1866, which Cohen designates as a medium to large relationship.

**Table 3. Paired Samples Statistics**

Pair	Paired Differences					
	Mean	Std. Dev.	Std. Error Mean	t	df	Sig. (2-tailed)
Pre-test/ Post-test	17.12	9.18	1.84	9.324	24	.000

A one-sample test comparing means between the baseline group mean of 26.61 and the test value mean of the post-test score of 15.16 was significant,  $t(7.878, 64)$ ,  $p. < .000$  (Appendix J).

A further one-sample test between the post-test mean of 15.16 and the test value mean of the post-six group of 11.76 was significant,  $t(2.686, 24)$ ,  $p. < .013$  (Appendix K).

In summary, 100% of the 25 residents who participated in the 90-day shelter program had a significant reduction in their depression scores, with 60% of them ( $n=15$ ) scoring below the depression cutoff score of 18 according to their "after" score.

#### DISCUSSION

These results provide strong evidence in support of the premise that short-term shelter programs can have a significant impact in reducing symptoms of depression in parents who participate in the shelter programs. Specifically, Foothill Family Shelter's integrated program contributed to significantly reducing symptoms of depression in their residents from June, 1998, to May, 1999.

The results strongly indicate that depression was a significant factor among the homeless parents who participated in this study. Eighty-four percent (84%) of the participants scored 18 or higher on the CES-D. Recent statistics have suggested that 1 in 5 adults will suffer

from depression at some point in their lifetime (Colorado Health Net, 1998). The study sample indicated that more than 4 out of 5 of the parents who applied to the homeless shelter tested in the clinically depressed range. This research supports prior studies which indicated that the homeless have a significantly higher rate of depression than the general public (DiBlasio & Belcher, 1993; Brown & Ziefert, 1990; Burt & Cohen, 1989.)

All of the twenty-five residents who participated in the shelter program had significant reductions in their rates of depression according to the CES-D scores. That in itself shows that shelter programs are extremely positive forces in the lives of families who utilize them. The "before" pre-test mean score was 32.3, which is fairly high on the 60 point CES-D scale, and according to Prescott, McArdle, Hishinuma, Johnson, Miyamoto, Andrade, Edman, Makini, Nahulu, Yuen, and Carlton (1998) any score over 30 would be considered an high-risk score. The "after" post-test mean score was 15.16, which is below the cutoff score of 18. This suggests that the independent variable, which was participation in the shelter program, was at least partially responsible for an average reduction of 17.14 points in the scores on the CES-D. Considering the entire scale is only 60 points, the variance accounted for an average 28.9% reduction. Prior to the program, 96% of the 25 residents scored 18 or above on the CES-D, while after

the program, 60% (n=15) of the post-test scores came in below 18, the cut-off point for depression. Thus, when they left the shelter program, over half of the residents were no longer considered clinically depressed according to the CES-D, and all had a significant reduction in their scores.

This tends to indicate that a large portion of the depressive symptoms experienced by these particular homeless parents was situational in nature and did not constitute chronic mental illness. This is contrary to the stereotype that homeless people are mostly drug abusers and the mentally ill. It is also a strong argument for putting more money into shelter programs which address depressive symptoms. Although we are not certain which particular aspects of Foothill Family Shelter's program may have contributed to reducing depression, we do know that overall, the program significantly reduces depression in its residents. From the shelter statistics, (Foothill Family Shelter, 1998) we also know that between 80-85% of the families leave the shelter for permanent housing, and thus, are reconnected to their communities.

This researcher believes that the reduction in depressive symptoms may be aided by an "acculturation" factor that is promoted by some homeless shelter programs. Acculturation is the modification of one's cultural experience as the result of contact with a new culture, or the process of adaption to a new culture (Philipchalk,

1995). Maybe in the process of adapting to the shelter program, they are shedding their culture of homelessness and adapting a culture of being housed, which includes enforced adherence to a daily and weekly schedule and positive reinforcement for personal accountability.

The statistics also suggest that the shelter program may have some lasting effect on its participants. In comparing the post-test mean scores to the post-six mean scores, there is an indication that depression scores continue to stay low, with most scores lowering even further than when immediately out of the shelter. This makes sense if we view homelessness as a traumatic event. As time passes, the impact of the trauma lessens. Unfortunately, this study did not have a long enough time span to have collected before, after, and six months post scores for each participant. Therefore, we can only surmise as to the long term effects.

Limitations of the Study: There are many limitations to this research, and it should be considered exploratory in nature and not directly generalizable to the homeless population at large. The sample population of this study was very small and does not represent a true reflection of Foothill Family Homeless Shelter's residents for race, age, ethnicity, gender, or family composition. Not does it represent a true reflection of the larger homeless population. Thus, extreme caution must be taken when



generalizing to other homeless populations. The sample was one of convenience and was in no way randomized. The conditions under which the depression inventories were given were difficult to control because they were administered by the shelter staff under informal circumstances. The results of the depression inventories were also based on self report without confirming sources. It was assumed, to a certain degree, that promises of confidentiality and anonymity may have reduced distortion to the responses.

Because there were so many variables in the shelter program being studied, it was difficult to pinpoint which factors were instrumental in relieving the symptoms of depression in the shelter residents. Although each participant had a baseline or pre-shelter level, it was still difficult to gauge to any degree of certainty, whether their depression was truly situational and greatly aided by the shelter, or just a brief respite in chronic mental illness. It was also difficult to determine whether or not the reduction in depression scores represented a "halo effect" or a false outcome. Because the depression inventory was administered twice to the same group of people, it is possible that some demand characteristics or "test-wiseness" were factors in the study.

According to the theory of cognitive dissonance (Festinger, 1957) it is also possible that the residents'

desire to believe that their 90-day stay at the shelter was worthwhile may have slanted their scores to indicate that there was improvement. Festinger theorizes that participants would unconsciously report scores that would favor a positive outcome because it would cause too much distress to believe that no change had occurred. It was also difficult to tell whether people were telling the truth when they responded to the depression inventory or whether they were underplaying or overplaying their situation. It is possible that participants thought their responses might be linked to being accepted to the shelter, or might influence the benefits they derive from the shelter in the future, such as referrals for housing or jobs.

Recommendations: Unfortunately, this study does not tell us what elements of the program help reduce the symptoms of depression. But this study has significant heuristical value, in that there is further evidence which shows that shelters with integrated programs have success in significantly reducing depressive symptoms in their participants. Further analysis comparing various shelter programs with different elements is necessary to determine which elements are most helpful. Also, studies for longer periods of time would help show overall patterns for particular shelter and help determine whether the programs have lasting effects on depression.

## IMPLICATIONS FOR SOCIAL WORK

Depression is a debilitating illness which can greatly impair people and inhibit them from achieving their goals. Some of the symptoms of depression include the inability to concentrate and to perform daily routines such as personal hygiene or going to work. When homelessness is exacerbated by depression, the simple tasks of getting out of bed and getting dressed become monumental. Goals, which require much more stamina and are more emotionally challenging such as attempting to find housing when finances are extremely limited, become impossible.

Society continues to apply the "bootstrap" model of self-help when criticizing homeless persons. If they would just apply themselves and get a job, they too could achieve the American Dream. But, they do not take into consideration the plight of homeless parents with children. How many of us are willing to leave our children huddled underneath a freeway overpass while we go look for work? Maybe the nation should take the example of Massachusetts, which subsidizes rent or mortgage payments for persons who lose their jobs, for up to one year after the job loss. We need a safety net with smaller holes to ensure that families stay off the streets.

The plight of homeless parents is one that affects us now and will affect us all in the future. How many adults and children are we "throwing away" merely because

circumstances have rendered them homeless? Without the interventions needed to reduce their symptoms of depression, it is likely that the cycle of homelessness will be passed from generation to generation. More research is needed to demonstrate that depression seriously impacts the lives of homeless parents and that by addressing their depression, we will help get them off the streets and on the road to finding housing, jobs, etc. Unless more shelters which address the issues of depression are made available to this growing group of American, we will continue to see a downward spiral of depression and homelessness take root among low-income families.

As social workers, our position is not only to help the families who are marginalized from mainstream society, but to work as social advocates to promote community, state, and federal action to meet their needs. One of the ways we can do this is by continuing research which highlights the needs of certain populations along with some idea of how to help them.

APPENDIX A  
INFORMED CONSENT FORM

The study in which you can now participate is designed to investigate the relationship between homelessness and depression. This study is being conducted by Andrea DuRant Heitz under the supervision of Dr. Morley Glicken, Professor of Social Work at Cal State San Bernardino. This study has been approved by the Human Participants Review Board of California State University of San Bernardino. The University requires that you give your consent before participating in a research study.

In this study you will be asked to read a one page questionnaire and circle the answers that apply to your feelings during the past week, and fill out information regarding your age, ethnicity, etc. Filling out the questionnaire and demographic page will take approximately 10 minutes of your time.

Volunteering to be a part of this study is in no way associated with acceptance into the shelter program. The information from the survey, along with demographic material (age, gender, ethnicity), will only be used in this study and will not be used by the shelter staff.

Please be assured that all of the information will be held in strict confidence by the researcher. Names will be used for matching purposes only and will be deleted prior to scoring the survey. No names will be used in the final results or revealed to any source.

If you have any questions about the study, or if you would like a report of its results after June 1999, please contact the shelter office at (909)920-5568 or Dr. Morley Glicken at (909)880-5501.

Please understand that your participation is totally voluntary and you are free to withdraw at any time without penalty.

If you choose to participate, please check the box and date below.

By placing a mark in the box provided, I acknowledge that I have been informed of and understand the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

I agree to participate.  
(Please check the box)

\_\_\_\_\_  
Date

APPENDIX B  
DEBRIEFING STATEMENT

The study you are participating in is designed to investigate the relationship between depression and homelessness. All information collected will be kept confidential. If any of the questions you have been asked to complete cause you any emotional stress which might require discussion with a professional mental health worker, please contact Miriam Gandell, at (909)920-5568, who can refer you to local counseling centers. You may receive the final findings of the study by contacting Dr. Morley Glicker, Professor of Social Work at Cal State San Bernardino and project advisor at (909)880-5501 after June, 1999.

APPENDIX C

CENTER FOR EPIDEMIOLOGICAL STUDIES DEPRESSION SURVEY

Please read the statements below about some of the ways people act and feel. On how many of the LAST SEVEN DAYS did this statement apply to you? Please **CIRCLE THE NUMBER** that applies best to you.

	<u>None</u>	<u>1 or 2 Days</u>	<u>3 or 4 Days</u>	<u>5 or More Days This Last Week</u>
A. I was bothered by things that usually don't bother me.	0	1	2	3
B. I did not feel like eating; my appetite was poor.	0	1	2	3
C. I felt I could not shake off the blues even with help from my friends and family.	0	1	2	3
D. I felt that I was just as good as other people.	0	1	2	3
E. I had trouble keeping my mind on what I was doing.	0	1	2	3
F. I felt depressed.	0	1	2	3
G. I felt that everything I did was an effort.	0	1	2	3
H. I felt hopeless about the future.	0	1	2	3
I. I thought my life had been a failure.	0	1	2	3
J. I felt fearful.	0	1	2	3
K. My sleep was restless.	0	1	2	3
L. I was happy.	0	1	2	3
M. I talked less than usual.	0	1	2	3
N. I felt lonely.	0	1	2	3
O. People were unfriendly.	0	1	2	3
P. I enjoyed life.	0	1	2	3
Q. I had crying spells.	0	1	2	3
R. I felt sad.	0	1	2	3
S. I felt people disliked me.	0	1	2	3
T. I could not get "going".	0	1	2	3

APPENDIX D  
PERMISSION TO USE CES-D



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health  
Bethesda, Maryland 20892

Dear Colleague:

Thank you for your inquiry regarding the CES-D Scale. We are always happy to have the scale used by qualified researchers. The scale is in the public domain, therefore, it may be used without copyright permission.

If the CES-D scale is used in your study or research, we would appreciate receiving copies of your results. We are trying to maintain records of the scale's effectiveness and the various areas in which it is most useful.

Please feel free to call us if you have any questions. Our number is (301) 443-~~2224~~.

16/6

Sincerely,

*Laura H. Brumbaugh (L.H.)*

Epidemiology and Psychopathology  
Research Branch  
Division of Epidemiology and  
Services Research  
National Institute of Mental Health  
National Institutes of Health

Enclosures



APPENDIX E  
LETTER OF PERMISSION FROM FOOTHILL FAMILY SHELTER



**Foothill Family Shelter, Inc.**

(Formerly St. Mark's Homeless Shelter)

**Board of Directors**

Ken Smith, *President*  
V.P. China Valley Regional  
Bank of America, NT & SA

Julie M. Toerner, *Vice Pres.*  
Attorney at Law  
Montclair

Helene Blummer, *Treasurer*  
Partner  
Mellon, Johnson & Rearson, CPA

Gloria Romero, *Secretary*  
Director, School-to-Career  
Chaffey College

Pat Beechler, E.A.  
Tax Accountant  
Lucas Horsfall, Murphy & Pindron,  
LLP CPAs, Pasadena

Frank Busam  
Vice President  
Rain Bird Sprinkler Mfg. Corp.

Carl Forman  
Representative  
St. Mark's Episcopal Church

Jef Headwall  
President  
Upland Lighting

Paul Hofer  
Hofer Ranch

Kim Lauer  
Business Development Officer  
Metro Commerce Bank, Upland

Bill Myers  
Store Manager  
J.C. Penney Outlet Store  
Ontano Mills

Paula Pachon  
Management Analyst  
City of Rancho Cucamonga

Dean Parker  
Operation Service Manager  
GTE

Francis Passarelli  
CEO  
Hazpak, Inc.  
Environmental Services

Desoraan Record-Gomez  
Special Education  
San Bernardino County Schools

L.K. "Skip" Runner  
President  
Taibot/L.K. Runner Insurance

Loren Sanchez  
Superintendent  
Upland Unified School District

Jane Savage  
Community Volunteer

Bonnie Smothers  
Teacher

Tina Weaver  
Daisy Wheel Computer Supplies

Keith Yamamoto  
Priest & Representative  
St. Mark's Episcopal Church

Member Agency of the  
Mt. Baldy United Way

October 23, 1998

Andrea DuRant Heitz  
1761 Phillips Drive  
Pomona CA 91766

Re: Master's Research Proposal

Dear Andrea:

Please be advised that your request to do a research study on depression and homelessness at the Foothill Family Shelter has been approved by the Board of Directors. It is our understanding that your research project focused on depression and homelessness. Please keep us advised as to the status of your research project.

Sincerely,

Miriam Gandell  
Executive Director

167 N. Third Avenue, Suite D Upland, California 91786  
TEL (909) 920-5553 + FAX (909) 946-1860

APPENDIX F  
HUMAN SUBJECTS APPROVAL



CALIFORNIA STATE UNIVERSITY  
SAN BERNARDINO

The California  
State University

May 18, 1999

Ms. Andrea Heitz  
Department of Social Work  
California State University  
5500 University Parkway  
San Bernardino, Ca. 92407

DEPARTMENT  
OF  
SOCIAL WORK  
COMMUNITY  
ADVISORY  
BOARD  
909/880-5501

Dear Ms. Heitz:

The Departmental Institutional Review Board in Social Work, an institutional arm of the University Institutional Review Board has approved your research project entitled, "Reducing Depression in Homeless Parents: The Effectiveness of Short Term Shelters."

Please notify the departmental review board if any substantive changes are made to your research proposal or if any risks to subjects arise. If your project lasts longer than one year, you must reapply for approval at the end of each year. You are required to keep copies of the informed consent and data for at least three years.

Best of luck with your research.

Sincerely,

A handwritten signature in cursive script that reads "Morley D. Glickan".

Morley D. Glickan, DSW  
Professor of Social Work

APPENDIX G  
PROTOCOL

Protocol for Administration of  
Center for Epidemiological Studies Depression Inventory

- Ask client if they would be willing to participate in study.
- Have them read, initial, and date the informed consent form.
- Have them complete the demographic page.
- Have them complete the CES-D.
- Give them the Debriefing Statement.
- Log their name and number for matching purposes later.
- Put their paperwork in the manilla folder labeled “results”.

APPENDIX H  
 PAIRED SAMPLES STATISTICS

Paired Samples Statistics

Pair	Mean	N	Std. Deviation	Std. Error Mean
Pre-test	32.2800	25	9.9227	1.9845
Post-test	15.1600	25	6.3290	1.2658

Paired Samples Correlation

Pair	N	Correlation	Sig.
Pretest-Posttest	25	.432	.031

Paired Samples Test

Paired Differences						
Pair	Mean	Std. Dev.	Std.Err. Mean	t	df	sig. (2-tail)
Pretest-Posttest	17.12	9.1892	1.8360	9.324	24	.000

APPENDIX I  
COHEN'S MEASURE OF CORRELATION STRENGTH

Cohen's Measure of Correlation Strength

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Strength	Correlation ( $r^2$ )
small	.01 to .09
medium	.09 to .25
large	.25 or more

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APPENDIX J  
 BASELINE TO POST-TEST STATISTICS

Sample Statistics of Baseline Group

	N	Mean	Std. Dev.	Std. Error Mean
Baseline	65	26.6154	11.7230	1.4541

One-Sample Comparison to Post-test Mean Value

Post-test Mean (Test Value) =15.16				
	t	df	Sig. (2-tailed)	Mean Difference
Baseline	7.878	64	.000	11.4554

APPENDIX K  
POST-TEST TO POST-SIX STATISTICS

Sample Statistics of Baseline Group

	N	Mean	Std. Dev.	Std. Error Mean
Baseline	65	26.6154	11.7230	1.4541

One-Sample Comparison to Post-test Mean Value

Post-test Mean (Test Value) =15.16				
	t	df	Sig. (2-tailed)	Mean Difference
Baseline	7.878	64	.000	11.4554

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