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Youth Growing Up in Families Experiencing Parental Substance Use Disorders and Homelessness: A High-Risk Population

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Abstract

Objectives: We sought to understand the stressors, the parent–child relationship and family processes, and experiences with services among families experiencing parental substance use disorders (SUDs) and homelessness.

Methods: We conducted a total of 41 in-depth semistructured interviews with parents with a history of SUDs and homelessness ($n=16$) and housing support staff ($n=25$) from May 2017 until January 2018. Participants were recruited from transitional housing facilities across the Los Angeles metropolitan area, which served families experiencing homelessness and parental SUDs. The interviews were audio-recorded, transcribed, and themes coded with Dedoose.

Results: We found a high burden of trauma and guilt among parents, and a fear of SUD disclosure. We found challenges with family processes important for SUD prevention, including communication, discussion of substance use, and family and youth goal setting. We also discovered unique stressors related to navigating housing and services within the community.

Conclusion: Our findings demonstrate the need for a family-based SUD-preventive intervention for youth growing up in families with parental SUDs and experiencing homelessness, to address the heightened SUD risk. In addition, findings from our study can inform clinical and housing services for this important population.

Keywords: homelessness, family homelessness, qualitative, parental substance use

Introduction

Overview

Youth who have a parent with a substance use disorder (SUD) and who are growing up in families experiencing homelessness face a compounded risk of developing a SUD themselves. Families comprise over one-third of the homeless population in the United States (Meghan et al. 2018). Further, in addition to facing economic uncertainty, families who are experiencing homelessness have high rates of parental SUDs. There is, however, a dearth of research on SUD prevention among youth growing up in families experiencing homelessness. This article describes the risk of SUDs among youth growing up in families experiencing parental SUDs and homelessness. We explore the experiences of parents, the parent–child relationship, and communication about substance use prevention within the context of family homelessness and parental SUDs. In addition, we provide a rationale for the need for family-based-preventive interventions to prevent SUD use among youth in families experiencing homelessness and parental SUDs.

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Family and environmental risk factors for SUDs among youth in families experiencing homelessness

Youth in families experiencing homelessness face multiple environmental risk factors for developing SUDs, including poverty, parental mental illness, community violence, trauma, family conflicts, family separation, and domestic violence (Roosa et al. 1990; Cicchetti and Lynch 1993; Gewirtz et al. 2008; Bassuk et al. 1998; Maclean et al. 1999; Anooshian 2005; Grant et al. 2003; Gershoff et al. 2007; Yoshikawa et al. 2012). Families who are homeless also grapple with significant economic and housing uncertainty, which may exhaust the family's ability to cope with any additional problems, such as youth substance use or mental health problems.

The *family environment* of youth experiencing homelessness is often complicated by substance use. There is a high prevalence of parental SUDs among families experiencing homelessness. One study reported that 74% of mothers who were experiencing homelessness had used drugs (Rog et al. 1995). A study of youth who had experienced homelessness revealed that two-thirds of parents had a mental illness or SUD (Gewirtz et al. 2008). Parents who are experiencing homeless and have cooccurring SUDs may be less likely to seek treatment due to fear of losing their children (Sznajder-Murrary and Slesnick 2011).

Over time, parental substance use is linked to deleterious effects on their children, who can go on to face academic, social, and mental health problems (Johnson and Leff 1999). Further, youth exposed to a parental SUD and homelessness face even greater risks of developing their own SUDs. Parental SUD is a well-recognized risk factor for youth engaging in substance use (Kumpfer 1987; Biederman et al. 2000; Lieb et al. 2002). Research demonstrates earlier onset of use and a higher prevalence of SUDs at a younger age among youth with parental SUDs compared to peers (Alford et al. 1991; Hussong et al. 2008). Parent substance use was found to directly predict later substance use problems in a sample of women experiencing homelessness, suggesting an imitative process and a need to address parenting behaviors to prevent adverse outcomes in the next generation (Stein et al. 2002).

Substance use among youth in families experiencing homelessness

Substance use is widespread among youth who are experiencing homelessness (Chen et al. 2006; Martijn and Sharpe 2006). One study found that compared to youth who are housed, the prevalence of drug abuse was 10 times greater for males and 17 times greater for females among youth who are homeless (Whitbeck et al. 2004). Substance use among youth who are homeless has been associated with coping or trying to escape stressors (Adlaf et al. 1996).

Most research, however, has been conducted among youth who are unaccompanied by caregivers. There is a dearth of research on youth living in families who have experienced homelessness. One study found that 18% of youth living in families experiencing homelessness had used one substance, and 10% used two to three substances (Bannon et al. 2012). Another study found that 18% of youth who lived in families that had recently experienced homelessness and were currently in supportive housing had used substances or alcohol (Gewirtz et al. 2008).

A framework for a youth SUD family-preventive intervention

Adolescence is a critical risk period for the development of a SUD, thought to be related to youth's susceptibility to the effects of parental modeling, access to substances, and peer influences (Biederman et al. 2000). Youth SUDs are linked to later SUDs in adulthood, school failure, delinquency, sexual risk-taking behavior, motor vehicle accidents, mental health problems, and increased mortality (Fagan and Pabon 1990; Weinberg et al. 1998). Among youth already dealing with homelessness, developing a SUD can have devastating effects on their future life trajectory, underscoring the need for preventive programs for this population.

Family intervention programs are successful at preventing substance use and poor mental health outcomes in youth (Kumpfer et al. 2003; Liddle 2004; Liddle et al. 2004; O'Connell et al. 2009). The 2009 Institute of Medicine report on prevention of mental health problems in children advocates for family interventions that strengthen parenting to prevent youth behavioral problems (O'Connell et al. 2009). Family-level interventions for families with a parental SUD are found to be exceedingly more effective at preventing youth substance use than working with the child alone (Kumpfer et al. 2003). Although there is a large body of family-preventive interventions to prevent SUDs (Kumpfer 1999; Prado and Pantin 2011; Prado et al. 2012), few address the unique needs of families with parental SUDs who are also dealing with the additional stressors of homelessness, seeking housing, and the large burden of trauma.

Research gap

There is a research gap in substance-use preventive interventions for youth with parental SUDs in homeless families. Typical family intervention services within homeless settings consist of case management, which does not typically address the family's developmental or mental health needs (Bassuk et al. 2014). Other programs have focused on parenting skills, which do not usually directly address youth substance use or mental health (Perlman et al. 2012).

One of the few studies evaluating youth substance use and family processes in homeless shelters found that youth who used two to three substances were almost 5 times more likely to have low levels of parent-child communication, parental monitoring, and within family support compared to youth in shelters who did not use substances (Bannon et al. 2012). These findings indicate a likely role of family processes in youth substance use in families experiencing homelessness, and the authors recommended providing family-preventive services in homeless settings. However, the study used cross-sectional data and was not able to investigate the contextual factors of how family processes affected youth substance use within the homeless environment, and did not focus on families with parental SUDs.

To address this research gap, we conducted 41 in-depth qualitative interviews with housing support staff and parents with a recent history of homelessness and parental SUDs who were living in transitional housing in the Los Angeles metropolitan area—an area of the country undergoing a homelessness and affordable housing crisis. Our purpose was to understand the stressors, the parent–child relationship and family processes, and experiences with services in the context of youth experiencing parental SUDs and family homelessness.

Methods

Participants

We conducted individual semistructured interviews with parents with a history of SUDs and experiencing homelessness, and

housing support staff, from May 2017 until January 2018. Parents and housing support staff were recruited from transitional housing facilities throughout the Los Angeles metropolitan area. According to the 2018 national point-in-time count, families comprised 33% of the total homeless population in the United States, and >90% of the individuals in families experiencing homelessness were sheltered (Meghan et al. 2018). Transitional housing is a temporary form of supportive housing that can last up until 2 years, and provides structure, support for mental health and SUDs, skills training, and case management within a supervised facility. Families living in transitional housing often experience significant psychosocial challenges and are in need of services (Shinn et al. 2016). We chose to recruit families from transitional housing facilities given this is a population that often faces significant stressors, including parental SUDs. Transitional housing facilities were chosen for recruitment if they served families experiencing homelessness and parents with a history of SUDs.

Parents. Fliers were handed out at the transitional housing facilities, and research team members gave brief presentations at parent meetings and town halls at the housing facilities, inviting parents to participate in the study. Twenty-eight parents volunteered to participate and completed the eligibility screener, and 15 primary parents (54%) screened eligible and consented to participate in the study. The screening eligibility criteria included self-report of (1) being ≥18 years of age; (2) experiencing homelessness for the past 2 years (meaning living in a place not meant for humans to live, an emergency shelter, a domestic violence shelter, or in transitional housing); (3) being the guardian of and living with a child between the ages of 10 and 18, including when homeless; (4) being an individual with a history of SUD or alcohol use disorder (AUD) within the past 3 years; and (5) being free of the SUD or AUD for the previous 6 months. If individuals met the eligibility criteria, they were formally screened for having a SUD or AUD with the Drug Abuse Screening Test and Alcohol Use Disorders Identification Test (Skinner 1982; Babor et al. 2001). A significant other (secondary parent) of the primary parent interviewed was eligible and invited to participate in an interview if they met the study eligibility criteria of experiencing homelessness for the past 2 years, were ≥18 years of age, were a guardian and living with a child between the ages of 10 and 18, and their significant other had a history of an AUD or SUD in the past 3 years. One secondary parent volunteered to participate, screened eligible, and consented to participate in the study.

Housing support staff. To recruit the housing support staff, fliers were distributed at transitional housing facilities, and supervisors of the housing support staff provided lists of referrals (supervisors were not told who participated). Presentations were provided to staff members at housing facility meetings, and staff were directly approached and offered to participate voluntarily in the interviews. Staff were screened for eligibility, including being English speaking, able to participate in a 60-minute interview, and had worked with parents with a history of SUDs and homelessness. Staff included case managers (six), a chaplain (one), childcare providers (four), executive directors (two), a finance manager (one), program managers (nine), receptionist/services triage (one), and a mental health provider at a facility (one). Verbal informed consent was obtained to conduct the interviews with housing support staff.

Procedures

Trained research team members conducted in-person individual semistructured interviews with parents ($n = 16$) and housing support staff ($n = 25$) in a private setting at the transitional housing facilities. Each parent was asked about his or her (1) family's experiences with a SUD and family homelessness; (2) coping with stress; (3) family and service needs; (4) experiences with key family processes, including speaking to youth about substances; (5) barriers to services; and (6) recommendations for improving services and providing a substance-use-preventive intervention for families experiencing homelessness. Housing support staff were administered a parallel interview guide that asked about their experiences working with families with a history of homelessness and a parental SUD. In addition, parents and staff filled out a brief demographic survey. Participation was voluntary and included an incentive (parents received US$25 and staff received $20). Interviews were audio-recorded and transcribed.

The study was approved by the University Institutional Review Board (IRB). As this was a vulnerable population where parents had a history of SUDs, some families had histories of child-protective services (CPS) involvement, and there are documented high rates of CPS involvement and fear of referrals among families experiencing homelessness, the research team strove to be sensitive to the concerns and fears of parents, while also maintaining the role of a mandated reporter. To address this sensitive issue, the research team had a detailed child abuse protocol in place for the study that was approved by the IRB.

First, all research staff were trained in what situations constitute child abuse and neglect, including in the context of parental substance misuse and family homelessness. As part of the protocol, if any research staff member suspected abuse or neglect of a child, they were trained to first consult with the Principal Investigator (PI)—a child and adolescent psychiatrist to discuss the case. Next, the PI could consult with the University Suspected Child Abuse and Neglect team, and/or the Los Angeles Department of Children and Family Services, to determine if a report needed to be made to CPS.

Second, to address the potential concerns about reporting among parents, the research team strove to be transparent with parent participants in describing their roles and duties as mandated reporters and what information met criteria for a mandated report. It was clearly detailed in the consent documents and during the consent process with parents that research team members were mandated reporters and what the reporting requirements were.

Third, due to potential and valid concerns among parents about maintaining housing in their transitional housing facilities, it was also clearly explained to parent participants and documented in the consent documents that research team members would not break confidentiality to staff at the transitional housing facilities.

Data analysis

All interview transcripts were reviewed by members of the research team for identifying initial themes based on the interview guide. The constant comparison method from grounded theory was used to identify main themes between parents and housing support staff (Glaser and Strauss 2017). First, two team members independently reviewed the transcripts for main themes and met to discuss the initial themes. Three research team members met to discuss the themes and underwent an iterative process of discussion, collapsing, and developing a consensus about mutually agreeable codes. Next, a detailed codebook was developed based on the themes, and two team members coded all transcripts. Any disagreement about quotes was resolved by discussion with the

team leader (R.I.-M.). Coding was conducted using qualitative data analysis software Dedoose (Dedoose 2017).

Results

Of the 16 parents interviewed, the average age was 40 years; 94% were female, 38% identified as Black/not Latino, 38% as Caucasian/not Latino, 13% as 2+ races/not Latino, and 13% as Latino. Of the 15 primary parents surveyed for an AUD or SUD (only the primary parents interviewed were formally screened for an AUD or SUD), 80% had a positive screen for alcohol use problems, 80% had a positive screen for drug use problems, and 60% had a positive screen for both. The median length of the current episode of homelessness for the parents was 14 months. Of the staff interviewed, the average age was 40 years; 92% were female, 32% were Latino, 32% were Black/not Latino, 28% were Caucasian/not Latino, 4% were Asian/not Latino, and 4% were 2+ races/not Latino. The average length of time they had worked with individuals experiencing homelessness was 7.5 years, and 64% had a bachelor's degree or higher (Table 1).

We organized our findings into three areas with subthemes: (1) parents' inner environment, (2) the parent–child relationship, and (3) the greater environment. In the realm of parents' inner environment, we examine the parents' experiences and feelings related to substance use and the consequences of use. For the parent–child relationship theme, we describe key family processes in the context of experiencing family homelessness and parental SUDs. Finally, in the area of the greater environment, we describe the environmental factors contributing to family stress, services use, and the need for greater support.

Table 1. Sample Characteristics

Provider (n = 25)	
Age (mean, years)	40
Time providing homeless services (mean, years)	7.5
Female	92.0%
Education	
Bachelor's or higher	64.0%
Race/ethnicity	
Latino	32.0%
Black/not Latino	32.0%
Caucasian/not Latino	28.0%
Asian/not Latino	4.0%
2+ races/not Latino	4.0%
Parent (n = 16)	
Female	94.0%
Age (mean, years)	40
Number of children in custody (mean)	3
Recent episode of homelessness (median, months)	14
Race/ethnicity	
Black/not Latino	37.5%
Caucasian/not Latino	37.5%
Latino	12.5%
2+ races/not Latino	12.5%
Relationship status	
Living with partner	25.0%
Positive screen for alcohol use problems[a]	80.0%
Positive screen for drug use problems[a]	80.0%
Positive screen for alcohol use problems+drug use problems[a]	60.0%

[a]Results reflect $n = 15$ as eligibility for secondary parent did not require formal screening tools.

Parents' inner environment

Trauma is pervasive. Most parents interviewed described traumatic and painful events in their past. Several parents described their children witnessing horrific domestic violence episodes. Others detailed becoming separated from their children as a result of CPS, or being forced to use substances and engage in survival sex. Many parents described using substances in response to trauma: two families described the death of an infant leading to substance use. One mother described her descent into using substances after the traumatic loss of her infant son: ''My first son passed away. I was very young, I was 15. He passed away at 6 months. And I never got help for that. I never got therapy, I didn't process it, I was a mess. That's when I started smoking weed. And then after that it was the meth for about a year'' (Parent 1).

Guilt over substance use permeates all parenting. In addition to having to grapple with painful memories and events, parents reported feeling intense guilt over the past. For example, one mother described her guilt over her SUD and losing her housing: ''I regret letting all that time go by. And my addiction and my homelessness…I would've gotten my kids back…my housing back. And rid of the addiction, but I didn't. It took me 9 years to do it'' (Parent 9).

As a result, a strong theme of guilt emerged. For many participants, this guilt infused into domains of parenting: they worried about setting limits, tried to make up for past actions, or were held back from communicating about the past events. One mother described recognizing this guilt and efforts to escape this feeling among other mothers at her transitional housing facility: ''I feel like a lot of mothers should sit down and talk to their kids and just be real instead of running, because your kids know what they [parents] did'' (Parent 11). Staff also recognized the effect of guilt on parenting: ''I've met with adults and late teens and the child will forgive you…But the parents never forgive themselves, so their communication is different than a parent who is learning to forgive themselves'' (Staff 2). Although staff recognized that guilt and remorse were pervasive among their clients, staff also found these topics difficult to address with parents.

Parents are afraid to disclose SUDs. Throughout the interviews, participants highlighted a palpable fear among parents about disclosing substance use and asking for help for their SUD. Participants described fears among parents about CPS becoming involved, losing their children to foster care, losing their housing eligibility, or going to jail. One mother, forced to use methamphetamine while pregnant by her boyfriend who was sexually exploiting her, described worrying about her use during the pregnancy, yet was too afraid to ask her physician for help:

> ''I was Googling about using meth when pregnant and what was the risks. I wanted to know how my baby would be and if my baby is going to be born deformed…I was afraid that if I told my doctor, I'd get a DCFS case…So I was like, 'I'm not going to tell my doctor'. … I prayed on my way to the hospital that even if I test dirty, 'God, don't let them take my kids'. And the lady that came, she said 'I'm not going to take your kids, but I'm going to get you help. You need to check into a program'. I said, 'Okay'. … A lot of us we don't

know about programs. Like I didn't know about outpatient treatment and inpatient treatment had it not been for that social worker…I didn't know that there was options'' (Parent 14).

Parents described fear of being judged by programs or losing their housing. One mother described, ''We just feel like you know, we living on the edge…I could get put out at any moment'' (Parent 6). Others worried about what others thought of their past substance or alcohol use: ''I think that a lot of these programs honestly like to pigeon hole. Like you're homeless because you're a drug addict'' (Parent 1).

Further, many of the parents interviewed abstained from using substances because they were in transitional housing programs that did not permit substance use, but they were not engaged in treatment programs. Staff worried about the lack of support when parents left the housing program and faced further stressors: ''If they are not able to find…housing or be able to get back to where they have their support in the transitional housing, then they tend to go back onto… whatever the substance was, whether it's drugs or alcohol or whatever'' (Staff 14). This fear of disclosure placed parents at a heightened risk of relapse given the lack of supports in place.

Parent–child relationships

In the interviews, parents described the impacts that prior substance and alcohol use, homelessness, or separation had on their relationships with their children. Several key family processes are highlighted.

Communication breakdown inhibits families from moving forward. Most of the parents interviewed described difficulties communicating as a family. Many of the parents attributed this breakdown in communication to difficulty speaking about past events, or as a result of past traumatic events. Some parents described feeling closed off from their children and felt counseling could help them talk with each other. One mother of a teenage girl, who witnessed her undergoing domestic violence, worried that her daughter was not confiding in her. She felt they needed to talk about the past events: ''I think we need counseling… I think we do need to bring all this up so we can be okay'' (Parent 3). Another parent whose teenage daughter had been removed and placed in foster care when she was in treatment for her SUD felt that she could not talk about why things had happened without feeling blamed.

While a few parents described being very open about the challenges the family was facing, others worried about sharing too openly about stressful situations in their past or current family issues, such as the topic of parental incarceration. This was difficult for many families who were living in the close quarters of transitional housing. As one mother who was dealing with a restraining order against her children's father explained, ''I'm learning not to adult [talk about adult issues] in front of my kids, which isn't always easiest when we're all living in one room right now'' (Parent 8).

Talking about substance use can be hard. Parents were asked in the interviews about talking to their children about substance use, including the prevention of risky behaviors. There were a range of responses. Ten of the 16 parents described talking to their children about substances, while 6 parents had not spoken to their children about substances, including their own substance use or substance use prevention. Of the parents who spoke to their children about substance use, two had been in substance use treatment facilities where formal programs were in place to help communicate with their children about substance use. One mother of an adolescent female described having to explain the consequences of using substances to her child due to individuals visibly engaging in substance use around their shelter:

> ''When we were living at [facility], we had to walk through all this to get to the door and you smelled this, you smelled that, you seen this, you seen that. You seen people shooting needles, like the bus stop. I had to take them to go to school, they used to be selling stuff like little batteries and nice good stuff for cheap. And I'd turn around and look and he [individual selling goods] was just shooting himself in the arm and I was like, 'I am not buying nothing else from him never in my life, no. Let's go'. …I said, 'That's why I want you to always stay focused, stay with a straight mind and stay in school where it don't have to end up like this. I don't care what you're going through, this is not going to help''' (Parent 12).

Among the parents who had spoken to their children about substances, there was a sense that children should have an awareness of the risks. In fact, several parents felt that parents should be honest about their own use, what one mother referred to as ''the dark elephant in the room'' (Parent 8). One mother who had been open about both her and her husband's drug and alcohol use felt that honesty was the best form of prevention. She urged, ''Don't hide what happened. They're gonna find out anyway. To be honest with you, sooner or later someone is going to go to, 'Did you know your mom was a pothead?' It might as well come from you, you know… And for me anyways…it seems to hit home more with the kids if they know that you know, mom did it too, and here she is telling me what she went through, and how it affected her life. And you know, maybe I won't go down that road, maybe I don't need to'' (Parent 1).

Overall, even parents who discussed substances with their children felt that having support in doing so could be helpful. Several parents wished to have a class to help them learn how to talk to their children about substances and the consequences of use.

The parents who had not communicated to their children about substance use prevention described being afraid to talk to their children because of their own guilt and embarrassment or wanting to shield their children. One parent felt it was inappropriate. Some parents felt that their children would not use drugs or alcohol because they had witnessed their parents or others using. Staff echoed these concerns and difficulties; many staff interviewed felt that parents needed additional tools to communicate to their children about substance use prevention.

The only goal that matters is housing: for everyone. During the interviews, parents were asked about the process of setting goals as a family. Overall, parents described that the primary goal for the family was securing housing. For example, one mother, who was living with her younger children but was separated from her oldest daughter, described how stable housing was the first step that the family needed to reach their goals: ''I need my own place where we can all be back together…. I want a better job in the area… I have a lot of ideas and a lot of stuff I need but it takes one step at a time'' (Parent 12). A common theme throughout the interviews was that of the family, including the children, working together to find housing. One mother explained how she enlisted her teenage son for help when she was receiving residential substance abuse treatment, as he wanted to stay in his school district:

> ''I caught myself asking my fifteen-year-old for help before I left [treatment facility] … I would ask my son, 'So if you see a for-rent

> sign around where you live, let me know'. Because he wanted me to live in the area where he was at, continue going to the same high school…He would go out and look for places sometimes, and he would call me whenever he saw a for rent sign. And I would call it'' (Parent 9).

Like other parents however, this mother worried that she had placed too much stress on her child by involving him in the goals: ''Sometimes I feel like oh they worry too much about how much we're going to spend …maybe I'm doing wrong by letting them know how much money I got or where it's going and like they're very stressed about that situation…''

A few parents were working on other goals with their children in transitional housing, such as going to college, or planned to work on other life goals with their children. Several of the facilities offered help for setting individual and family goals. One facility made goal setting part of the program, yet a staff from this facility noted that the children made their own goals with the help of their tutors instead of parents, and families did not set goals together. One staff highlighted the need for setting family goals beyond housing, by giving an example of how it impacted the focus on school: ''Some children are in lack when it comes to schooling because the family is like, 'I need to just focus on getting housing, getting housing, getting housing, getting housing''' (Staff 6). This strong need for securing permanent housing often superseded all other family needs.

The greater environment

Households are in a pernicious environment. In addition to grappling with their past trauma, and alcohol and substance use, these families faced the harsh environment of homelessness. Most families described the challenges of securing long-term housing. Only one of the families interviewed—a Veteran family—had a housing voucher in hand. Other families described being on long waiting lists, or that they did not qualify for housing programs. One mother explained, ''I been on some waiting lists for housing vouchers. I actually was just in the process of getting approved for low income [housing subsidy] through LA City's housing authority. But I was disqualified because of my criminal background'' (Parent 6). Some parents described facing racial discrimination when they were searching for housing, or being unable to find a unit they could afford or were suitable for children: ''The places they send me are like areas that are not really safe… I went to a couple and they were roach-infested…and they were expensive…'' (Parent 9).

The second issue that many families faced was a concern about having enough time in transitional housing to successfully transition to permanent housing. Although all of the families interviewed were living in transitional housing at the time, some parents feared they did not have enough time in the housing facilities to get back on their feet, including finding a job, obtaining all the services they needed, or even focusing on their coping and emotional well-being as a family. They worried about lack of support when they entered permanent housing and the risk of becoming homeless again. For example, some parents were offered rapid-rehousing programs, in which they would receive rental assistance for 6 months, and then be expected to pay full market rent. One mother, who was in recovery, reunited with her children after entering transitional housing, and recently had a baby, knew she needed longer term support to pay her rent: ''She [case manager] found me an apartment the same day I got accepted here [transitional housing facility]. But six months down the road, I would have to pay the full rent, which would have been $1250. I didn't know what my income was going to be with all the kids. So I didn't want to set myself up for $1250 rent. Six months down the road would have been January and I had my baby in December'' (Parent 14). Some programs expected families to leave transitional housing and find permanent housing within a relatively short period of time—such as 4 months. One mother commented on this: ''You cannot get back on your feet in four months. You can't. A lot more people leave here [transitional housing program] homeless than they do housed. Giving families more time to get stuff together, it would help them out a lot'' (Parent 4—Secondary Parent). Staff also felt that the housing programs available to parents were not sufficient to meet their needs. One staff with extensive experience working with individuals experiencing homelessness and SUDs explained the need to support families: ''They need to take them off the streets for 24 months, train them, help them, support them, and then work with them during that time for permanent housing. Now with the rapid rehousing, where are you going to put them? You can't get anyone housed in 90 days. It's impossible'' (Staff 14).

These families need more support. All parents interviewed had access to case managers, who assisted the families with obtaining social services and housing, although in varying degrees. Although some parents found the services very helpful, many felt that services could be more supportive and responsive to the family needs. One mother reported this feeling of not being supported: ''No matter if you're doing everything the right way, I feel like everything is a test. They want to see you fail'' (Parent 14).

Several parents brought up the need for service providers to have more awareness regarding how stressful experiences can impact children and lead to behavioral problems. For example, some families feared they would be asked to leave transitional housing due to poor behavior among their children, or their child acting out at school. One mother, who referred to the women around her in transitional housing as ''broken,'' given their trauma histories, explained, ''I think all programs should have their guidelines, but when you dealing with women and—broken women and children, it should be a whole another ballgame. Like you just need to, you know, have your certain guidelines but be flexible with certain situations'' (Parent 6). This mother felt that rigidness with rules, including disciplining children at the facilities, was harmful to families dealing with trauma symptoms or reminders. Some recommended that case managers have more of a mentorship and advocacy role when working with families who had undergone trauma.

Finally, although mental health need was high among the families interviewed, they frequently described poor access to services. The majority of the parents interviewed described mental health problems or behavioral problems among their children, including autism, behavior difficulties at school, or bipolar disorder. Although some children were actively receiving mental health services, such as services in the community through the department of mental health, or services delivered by interns at the facility, others were in need of appropriate services. One mother, whose child had been exposed to domestic violence, and likely had post-traumatic stress disorder and depression, detailed that she had been unable to find her daughter a child psychiatrist who took Medicaid in their area. Parents also described the need for on-site family therapy and counseling for their children. One parent wanted to better understand the behaviors of her children through family therapy after

they were returned to her care from foster care. Another parent wished to have on-site counseling services available at the facility for her children: ''They have the counseling for the moms here, but they don't really have counseling on site for kids. And there's a lot of kids here that could really use counseling'' (Parent 8).

Discussion

Our qualitative interviews with parents with a history of SUDs and family homelessness, and housing support staff, found that families struggled with their own experiences related to substance use and their extensive trauma histories, several family processes critical to SUD prevention, and external stressors.

First, our interviews revealed that parents with a history of SUDs and homelessness face tremendous challenges, not only related to unstable housing and their economic situation but also severe histories of trauma and guilt tied to their SUD. Our findings of significant trauma in this population align with findings in the literature that demonstrate an association with trauma and SUDs in adults experiencing homelessness (Stein et al. 2002; Zlotnicket al. 2004). This further highlights the need for trauma-informed services among parents with SUDs who are experiencing homelessness. In our sample, the level of guilt and shame related to parents' SUDs or the consequence of their SUD (i.e., family separation) was profound and impacted parents' ability to connect, bond, and effectively parent. This impact on family connectedness is concerning, given that family bonding and parental discipline are protective factors for preventing youth substance use (Kumpfer 2002; Kumpfer and Bluth 2004).

Second, regarding family processes critical to SUD prevention, we found that communication was often challenging among families. Although communication is often an issue among families facing trauma and stressful situations, the unique experiences of homelessness, parental substance use, and potential family separation seemed to intensify communication problems among the families we interviewed. We found that parents wanted to improve communication with their children, but for many of these families, the burden of traumatic events, and shame related to their substance use or descent into homelessness, held them back and contributed to a decreased feeling of closeness. This finding is concerning for youth already at risk of SUDs, given that parent–child communication is a key protective factor against youth substance use (Kumpfer et al. 2003). In addition to overall challenges to communication, we found that $\sim$40% of the parents interviewed did not feel comfortable talking about substances or substance use prevention with their children. Among parents who did communicate about substances, many did not have formal guidance in doing so. Further, this problem was likely exacerbated by many parents being afraid to disclose their SUD history to their case managers or providers working with them, who could provide support and guidance. Yet, communicating parent attitudes and values regarding substance use, parental monitoring, and parental authority regarding substances are associated with decreased substance use among youth (Sloboda and David 1997; Jackson 2002).

Third, when asked about goal setting, another family process critical to SUD prevention (Kumpfer 2002; Benard and Slade 2009), interviews revealed that families tended to focus on the goal of finding housing, with children often helping their parent with this goal. This is not surprising, given the overwhelming stress that families who are homeless endure, and the tendency for parentification and taking on adult roles among youth in families experiencing homelessness (Polillo et al. 2018). However, the lack of focus on youth goal setting is troubling, given that having goals, especially academic goals, and feelings of self-efficacy can be protective for youth (Benard 1991). Kumpfer (2002) has argued that parents helping children achieve goals and dreams are critically important in substance use prevention.

In addition to the stressors encountered within families experiencing homelessness and parental SUDs, the families interviewed experienced a high-stress external environment, including a lack of affordable housing options and a need for more support in transitional housing. Findings from the Family Options Study demonstrated significant improvement in housing stability among families who received permanent housing subsidies, compared to rapid rehousing, transitional housing, or usual care (Gubits et al. 2016). However, only one family in our study had access to a housing voucher, while other families were ineligible, faced housing discrimination, and had concerns about how to obtain permanent housing. Families also expressed their concern about entering rapid rehousing, including feeling that they did not have enough supports to succeed. Given that families with a history of parental SUDs and experiencing homelessness are a particularly vulnerable population, efforts should be made to increase the provision of permanent housing subsidies to this population. Further, despite the fact that project-based transitional housing programs should have increased support services for families, research does not demonstrate improved psychological well-being for families receiving these short-term housing services (Gubits et al. 2016). Indeed, many families and providers in our study expressed their concern that families did not have enough time or support within transitional housing programs, and advocated for longer time periods in the program.

Our findings support the need to develop family-based SUD-preventive interventions delivered within transitional housing settings that are trauma informed, and tailored for families with parental SUDs and homelessness. Focusing on family communication is of critical importance for this population, especially given potential stressors that families may have endured, such as family separation, parental incarceration, and residential disruption. In addition to concentrating on family communication, our findings indicate the need to support parents in substance use prevention through communicating about substance use, and their values and expectations, while acknowledging that parents may carry excessive shame and guilt over their own use.

Our findings also highlighted a need for preventive interventions to focus on youth goal setting. The pressing structural needs of families who are homeless—such as obtaining permanent housing or employment—cannot be ignored. Yet, in line with risk and resilience models for youth, providing family interventions and services within transitional housing that also help families work on youth goals can be highly protective for these families and improve mental health outcomes (Kumpfer 2002). Indeed, successful family-preventive interventions, such as teens and adults learning to communicate, have incorporated youth life goals into the sessions among similar high-risk populations of families living with a parent with HIV and in poverty (Rotheram-Borus et al. 2001).

Finally, it is important for family-preventive interventions to take into account the context of families who are homeless, including the pressure for obtaining permanent housing. On a policy level, there is a need for increased access to permanent supportive

housing for families with parental SUDs. On a family-preventive intervention level, these families would benefit from a case management component included in an intervention, such as approaches for working with case management and advocating for their needs. Further, it is important for case managers and housing providers to understand the impact of family and parental trauma on child behavior and outcomes.

Based on our qualitative interviews, our research team is developing, refining, and testing a family-preventive intervention for youth who are experiencing family homelessness and have parents with SUDs. We will draw on the core components of several trauma-informed family-preventive interventions found to protect against youth substance use, including building family coping and connectedness, promoting family communication—including communicating expectations for youth, and goal setting, while taking into account the context of family homelessness and the need to address case management and housing needs. However, more research is needed on family interventions delivered to youth who are experiencing family homelessness within housing facilities, and ways that providers of housing services can reduce youth risk and support families, as well as the best policies for housing interventions for families with parental SUDs.

Limitations

Our study had several limitations. Data were limited to families living in transitional housing programs in a large, urban city. In addition, we conducted our study in a region of the country facing a homelessness crisis, and where considerable resources have been mobilized to address homelessness. Other areas of the country such as in a rural setting, or where families are less likely to live in transitional housing, or less housing resources are available, may have different experiences, limiting the generalizability of our findings. Although we sought to include mothers and fathers in the study, our sample was predominantly composed of mothers who were heads of the households, with the exception of one family where a father was interviewed, reflecting the general demographics of parents experiencing homelessness. Further research is needed to determine the experiences of fathers with a history of SUDs and who are homeless. Despite these limitations, our findings add to the literature by conveying the voiced experiences of parents who have experienced a SUD and family homelessness, and housing support staff.

Conclusion

Despite the prevalence of youth with a parental history of a SUD and experiencing family homelessness, there is still a lack of research focused on family-based SUD prevention efforts among this high-risk population. Although there is a large body of research demonstrating the role of family processes in substance use prevention, this research does not focus on the unique aspects of families who are living without a home of their own, and host to the stressors of homelessness, in addition to the effect of substance use within the family. Our findings of the unique challenges families with parental SUDs and that are experiencing family homelessness face—a high burden of trauma and guilt among parents, challenges with several family processes critical to SUD prevention such as communication and goal-setting, and significant stressors related to housing and services within the larger environment—can inform preventive interventions and the larger structural services and policies for families experiencing homelessness.

Clinical Significance

Our findings suggest the need for family-based SUD prevention interventions delivered within housing facilities for families who are experiencing homelessness and with a history of parental SUDs. On a family level, addressing family processes critical to SUD prevention, including communication skills, recognizing the role of trauma and guilt, and acknowledging the stressors of the greater environment are needed to promote protective factors and prevent substance use among a generation at increased risk. On a structural level, increased access to housing subsidies, heightened understanding that families with parental SUDs and trauma may need longer time to secure housing, and tailored trauma-informed services that recognize the impact of parental SUD on child behavioral health outcomes are necessary to support this under resourced population.

Disclaimer

The content and views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the U.S. Department of Veterans Affairs, the National Institutes of Health, or the U.S. Government.

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