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Food Insecurity among Homeless and Precariously Housed Children in the United States:

Lessons from the Past

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**Notes on Measurement**

In this document we provide additional details about the measures used in our analysis that, due to space constraints, could not be included in the published version of the article.

Dependent variables: Child and parent food insecurity

\*\* NSHAPC’s reliance on parents for assessments of their children’s food situation, although common practice, is less than ideal (Fram et al. 2011; Nord and Hopwood 2007). This may be especially true for older children (e.g., teenagers) who are not subject to continuous and direct supervision or whose food insecurity is more difficult for parents to detect. Of the children in the NSHAPC families, 17.4% fell in the 13-18 age range, with the remainder 6-12 years old (41.1%) or five and under (41.5%).

\*\* Regarding the question about the daily number of meals eaten by NSHAPC parents, we assume that these parents were more likely than non-poor, stably housed Americans to miss a meal involuntarily because of resource constraints, broadly construed. However, the data do not rule out intentional weight loss efforts, a busy schedule, or other reasons.

Correspondence between NSHAPC and CPS food insecurity measures

\*\* Employing the 1996 CPS data on family households, we compared the ability of our six NSHAPC child and parent food insecurity measures to predict broad categorical memberships based on the full 18-item USDA household food security scale. Among those families meeting the USDA criteria for food insecurity with hunger, 70% were correctly identified as such with the NSHAPC measures. Among those meeting the criteria for food security or food insecurity without hunger, 97% were correctly identified.

Independent variables: Risk and protective factors

\*\* We initially recoded each child under 18 in the NSHAPC families as either five years of age and younger or six and older. This cut point enabled us to identify families who only had younger children (</= 5) present, only older children (6+), or a mix of the two age groups. The cut point aligns with the beginning of mandatory school attendance, which often entails health monitoring and the availability of free or low-cost meals. Once in school, children may also be exposed to adults other than their parents who are concerned about their well-being. Alternatively, such food security-enhancing influences could diminish as adolescence approaches and children experience greater freedom and are increasingly expected to fend for themselves.

\*\* With respect to parental capital, an income variable is available in the NSHAPC client survey. However, preliminary analysis revealed that it had no association with CFI and was irrelevant to the overall pattern of results. For the sake of statistical power, we omitted it (and several other potential predictors) from the final logistic regression models.

\*\* Besides capturing the extent of labor force experience (as distinct from current employment status), the percentage of a parent’s lifetime spent working may be related to the development of skills and the receipt of benefits such as health insurance. It could also reflect personal organization, dependability, and other traits conducive to successful parenting.

\*\* Adult mental health problems are assessed with a multi-item scale combining responses to questions about the recent occurrence of depression, anxiety, psychosis, trouble understanding/concentrating/remembering, violent behavior, suicidal ideation, and use of prescription medications for psychological or emotional problems. The scores of NSHAPC parents reporting current active mental health problems range from 0 to 1 on the scale, with higher values indicating more comorbidity. The alcohol/drug problem index incorporates two separate sets of measures pertaining to alcohol and drug use disorders. Following prior work (e.g., Alterman et al. 2007; Burt, Aron, and Lee 2001; Rikoon et al. 2006), we combined alcohol disorder indicators into a binary measure equal to 1 for respondents with any of the following: (1) scored .17 or higher on the alcohol Addiction Severity Index (ASI); (2) reported drinking to get drunk three or more times a week in the past month; (3) reported alcohol abuse treatment in the past month; or (4) reported drinking three or more times a week in the past month. Respondents were classified as having a drug use disorder if they (1) scored .10 or higher on the drug ASI; (2) reported being treated for drug abuse in the past month; (3) reported using drugs intravenously in the past month; or (4) reported using any of a variety of specific drugs three or more times a week in the past month. The alcohol/drug problem index employed in our analysis equals 1 if respondents qualified for either an alcohol or other drug use disorder.

**References**

Alterman, A.I., Cacciola, J.S., Habing, B., and Lynch, K.G. (2007). Addiction severity index: Recent and lifetime summary indexes based on nonparametric item response theory methods. *Psychological Assessment* 19(1):119-132.

Burt, M.R., Aron, L.Y., and Lee, E. (2001*). Helping America’s homeless: Emergency shelter or affordable housing?* Washington, DC: Urban Institute Press.

Fram, M.S., Frongillo, E.A., Draper, C.L., and Fishbein, E.M. (2013). Development and validation of a child report assessment of child food insecurity and comparison to parent report assessment. *Journal of Hunger & Environmental Nutrition* 8(2):128-145.

Nord, M. and Hopwood, H. (2007). Recent advances provide improved tools for measuring children’s food insecurity. *Journal of Nutrition* 137(3):533-536.

Rikoon, S.H., Cacciola, J.S., Carise, D., Alterman, A.I., and McLellan, T. (2006). Predicting DSM-IV dependence diagnoses from addiction severity index composite scores. *Journal of Substance Abuse Treatment* 31(1):17-24.