

SUMMARY OF RECOMMENDATIONS

1. Ensure all low-income children and youth are enrolled in CHIP/Medicaid
2. Ensure state laws allow health centers to treat unaccompanied homeless youth
3. Implement the Housing and Services for Homeless Persons Demonstration Project for Families
4. Create additional housing opportunities for young adults who are homeless
5. Ensure federal nutrition programs and obesity initiatives include needs of homeless children and youth
6. Ensure Head Start regulations prioritize needs of homeless children
7. Support legislation aimed at reducing barriers for youth exiting the foster care system
8. Support legislation aimed at ensuring homeless children are able to succeed in school

Child homelessness is prevalent, and increasing.

A 2009 study conducted by the National Center on Family Homelessness found that 1 in 50 children are homeless in the United States (1.5 million, or 2% of all children).¹ Similarly, the U.S.

Department of Education found the number of homeless children and youth (preK-12) increased from 679,724 students in the 2006-2007 school year, to 956,914 students in the 2008-2009 school year.² As the economy continues to be depressed, unemployment remains high (especially among low-income workers), and housing costs escalate, many families with children are experiencing homelessness.

There is no standard definition of “homeless youth” given that laws and other policies vary widely about the range of ages the term addresses (e.g., 10-18, 12-21, 16-24, etc.). This policy statement refers to “youth” in a broad context, understanding that no matter the specific ages, young people who are homeless will have needs that are distinct from their children or older adults.

Homeless youth have significant health needs.

Youth experiencing homelessness have similar chronic and acute health conditions common among their housed peers—diabetes, asthma, depression, flu and common colds, respiratory and other infections, pink eye, high blood pressure, migraine headaches, dental pain, etc. At the same time, homeless youth are also at very high risk for other health-related problems such as injuries, sexual and physical abuse, and exploitation by gangs and street violence, making this population especially in need of assistance from a health care

provider. Research indicates that children from low-income families are at especially high risk for mental health and substance use problems but often lack access to necessary treatment. Seventy-five percent of adults with mental health disorders had been diagnosed prior to age 18.³ The increased incidence of attention deficit/hyperactivity disorder (ADHD), depression, and other psychological disorders among homeless youth and children in the foster care system indicate a need for expanded mental health services.⁴ Uninsured and underinsured parents who are unable to access mental health

and addiction services for their children are increasingly dependent on the child welfare system to provide these services. Families experiencing homelessness often lack transportation to enrollment sites and health care facilities, or have difficulty finding medical providers who will see their children, even if enrolled in health insurance programs.

The transition to adulthood should be supported with adequate access to medical care, including treatment for mental illness and substance use disorders, particularly for low-income children and youth. Over eight million children and youth in the United States currently have no health insurance. The most effective and efficient way to ensure that all people—children and adults—receive adequate medical care, mental health services, and addiction treatment is through a universal health insurance program with a single-payer financing mechanism. Until true universal coverage is achieved, however, we must continue to support and strengthen existing safety net programs. While most low-income children and youth under 18 are already eligible for Medicaid and/or the State Children’s Health Insurance Program (SCHIP), there are significant barriers to enrollment for those experiencing homelessness; hence, many children remain un-enrolled. In 2009, the Health Care for the Homeless program served 141,155 children and youth under the age of 19. Of these, nearly half (46%) were uninsured.⁵

Educational opportunities for homeless youth are essential to break the cycle of homelessness. Research shows that children learn better when they have strong mental and physical health. The Head Start program has a long tradition of providing comprehensive and high-quality services that advance healthy development for low-income youth. Changes in Head Start and Early Head Start were enacted as part of the Improving Head Start for School Readiness Act of 2007, but regulations have yet to be issued, delaying implementation.

POLICY RECOMMENDATIONS IN DETAIL

1. Ensure all low-income children and youth are enrolled in CHIP/Medicaid

All children should have access to comprehensive health care. Nearly 40 million children are insured through Medicaid and/or CHIP, which provides a comprehensive set of preventive and primary care services. Unfortunately, 8.3 million children remain uninsured (10% of all children) and of this group, 5 million are eligible for Medicaid/CHIP but not enrolled.⁶ Common barriers to enrollment include complicated enrollment processes that are difficult for many parents to navigate, lack of awareness or familiarity with how to apply/eligibility, the perception that applying is difficult and/or humiliating, or that the program provides limited or poor-quality care.⁷ Recognizing these issues, the Centers for Medicare and Medicaid Services (CMS) awarded 15 states \$206 million to enroll uninsured children into Medicaid last year.⁸ These resources build on similar grants awarded in 2009 to 10 states and are intended to help connect uninsured children to Medicaid and CHIP who would otherwise be without health coverage.

As states grapple with budget deficits and look to reduce Medicaid expenditures as one area to achieve savings, it is important that children do not lose existing coverage and services are not reduced. While the Patient Protection and Affordable Care Act (PPACA) prohibits states from making eligibility or service changes, many states are currently seeking waivers to this requirement. HHS should deny any efforts that reduce access to health care for children and youth, or for their

parents (who are more likely to take their children for care if they themselves are also eligible for services). Congress should also resist making changes to the PPACA that will reduce eligibility for public health insurance programs or curtail service requirements.

2. Ensure state laws allow health centers to treat unaccompanied homeless youth.

Obtaining parental consent for medical care is often not possible for homeless youth. The youth our clinicians and outreach workers frequently encounter come from abusive and/or highly dysfunctional family backgrounds—physical, sexual and emotional trauma is nearly universal. Other times, parents are incarcerated or have disappeared to the streets themselves due to their own addictions problems. It is also not uncommon for teenagers to have been thrown out of the house due to sexual orientation or other reasons. Obtaining parental consent is frequently not possible because youth are unable to find their parent, cannot safely establish communication, or their parents simply refuse to engage in any responsibility toward the teen. These unfortunate situations are compounded by the reality that these youth are prevented from obtaining medical care when they get sick or from managing any ongoing health conditions. Current law requires a youth to develop an emergency condition before care can be administered, which jeopardizes long-term health, is an expensive use of public resources, and makes it more difficult for service providers to meet the needs of the young people they encounter. Current law allows minors to consent to medical care if they are pregnant or have a child of their own, which unfortunately incentivizes teen pregnancy in order to claim control over decision making.

Ensuring state consent laws allow care to be provided to unaccompanied youth would promote a medical home model and reduce emergency room use. A medical home provides access to consistent, comprehensive and ongoing affordable health care from qualified practitioners with an emphasis on prevention and early intervention. It includes health screenings, and management of acute and chronic conditions. The model is cost-effective, and prevents episodic or urgent care visits to emergency departments. Our health care providers are unable to provide a medical home for this group of youth because we currently must refer most requests for chronic and ongoing medical treatment to the emergency room, even if the needed care is minor. We are unable to provide a nebulizer to treat asthma, prescribe antibiotics for a respiratory infection, or administer cough syrup or Advil for common ailments. This practice compromises our effectiveness in engaging youth, limits our efforts to establish medical homes among vulnerable populations, and needlessly contributes to ER use. Ironically, many states have in place numerous initiatives to decrease emergency room utilization, especially for low-urgency visits, but there is no alternative available to health care providers under current law in many states for meeting the needs of unaccompanied youth.

Some states do allow for consent to medical care for homeless/disconnected youth. While laws on minor consent to medical care vary greatly state-to-state, there are 17 states that allow for unaccompanied youth living apart from their parents to consent to medical care; these states include Alaska, Arizona, Arkansas, California, Colorado, Indiana, Kentucky, Maine, Massachusetts, Minnesota, Montana, Nevada, Oklahoma, Oregon, South Carolina, Texas, and Wyoming.⁹ Unfortunately, because of the variability and factiousness of the various services allowed or not allowed, they are not well-understood by adolescents or their providers.¹⁰ The National Conference of State Legislatures (NCSL) should consider developing model legislation and/or recommend all states enact clear laws allowing comprehensive care to be administered to unaccompanied youth.

3. Implement the Housing and Services for Homeless Persons Demonstration Project for Families

The President's 2012 budget proposal included a Homeless Initiative Program that is an HUD/HHS partnership to more effectively and efficiently provide communities with both the housing and services funding needed to end homelessness. This demonstration is constructed on the premise that targeted homelessness assistance programs alone cannot end homelessness. Mainstream housing, health, and human service programs will have to be more fully engaged to prevent future homelessness and reduce the number of families currently homeless. Research suggests that stable housing has a large positive impact for children – when children are not forced to move from place to place and school-to-school, they are more likely to succeed academically.¹¹ Similar research suggests that families that are stably housed are in a better position to prepare for, find, and retain employment.¹² Thus, by working together, HHS, DOE and HUD can help meet the goals of reducing child homelessness, reducing poverty, and fostering employment success.

The demonstration program couples 4,000 Housing Choice Vouchers with TANF and Department of Education resources targeted to families. The Medicaid and TANF elements come from mandatory spending and do not require an appropriations amount, but the HUD vouchers are still uncertain given the funding reductions being targeted in Congress for the FFY 2012 budget. This initiative strategically targets resources to: (1) identify families who are homeless or at risk of homelessness, (2) intervene with the appropriate array of housing assistance, income supports, and services to ensure that the family does not fall into the shelter system or onto the street (or if already homeless that the family is stably housed and does not return to homelessness), and (3) provide the tools necessary to assist the family to build on its resources to escape poverty and reach its highest possible level of self-sufficiency.¹³ The National HCH Council will advocate for the needed appropriations and federal partnerships in order to implement this demonstration project.

4. Create additional housing opportunities for young adults who are homeless

Young adults age 18 to 24 are a transitional age group in that they have achieved the age of majority but still face many barriers to independent living. Many of these young people have children of their own, are uncomfortable or unsafe going to emergency shelters (which tend to serve older populations), and/or are considered “high risk” tenants by landlords. Many states do not allow young adults to sign a lease until they are 21 or older. Many housing or homeless assistance programs are either targeted to children and families, or to older adults, but very few address the needs of young adults in their late teens and early twenties. Many have dropped out of school, have limited employment opportunities, and have histories of trauma that impact their ability to navigate the social services system. Homeless youth benefit from programs that meet immediate needs first and then help them address other aspects of their lives. Programs that minimize institutional demands and offer a range of services have had success in helping homeless youth regain stability. Educational outreach programs, assistance in locating job training and employment, transitional living programs, and health care especially designed for and directed at homeless youth are also needed. In the long term, homeless youth would benefit from many of the same measures that are needed to fight poverty and homelessness in the adult population, including the provision of affordable housing and employment that pays a living wage. In addition to these basic supports, the child welfare system must make every effort to prevent children from ending up on the streets.¹⁴

HHS, HUD, and other federal agencies should provide targeted resources for states to address the unique needs of this population.

5. Ensure federal nutrition programs and obesity initiatives include needs of homeless children and youth.

In 15% of U.S. households, there is limited or uncertain access to adequate food; of these, 500,000 households include children who are receiving insufficient food and nutrition.¹⁵ Poor nutrition and limited access to food has a direct influence on the ability to grow and develop normally, to learn in school, and can have lifelong negative effects. At the same time that food insecurity is growing, obesity among both children and adults is also growing. This is due to the high cost of nutritious food, and the relatively low cost of high-calorie, high-fat foods that are low in nutritional value. Hence, poverty, poor nutrition, hunger, and obesity are inter-related issues, especially for children and youth. Federal programs and initiatives aimed at reducing both hunger and obesity among low-income households are especially vital for children experiencing homelessness.

The Healthy, Hunger-Free Kids Act of 2010 is a re-authorization of the school lunch and breakfast programs (which also includes afterschool and weekend feeding programs). Children experiencing homelessness are automatically eligible for this meal program if they are engaged in school. The Act requires the Secretary of the U.S. Department of Agriculture to issue proposed regulations updating the nutrition standards and reimbursement rates, to issue guidance in 2011 encouraging participating child care providers to offer healthier meals and snacks, to reduce paperwork and simplify program requirements for participation, and to extend the option to serve meals in after-school programs and summer programs to all states. In implementing these changes, state and local agencies and participating providers should:

- Ensure homeless households are not disqualified from participating due to paperwork barriers such as proving proof of income or a mailing address
- Actively engage in outreach and enrollment for those families that qualify
- Allow unaccompanied youth to participate in meal programs
- Prioritize children and youth from homeless households for after-school and summer meals
- Ensure a seamless process for students using meal programs to help reduce stigma.

Implementing these strategies should help ensure homeless students are able to access meal programs, which will not only help reduce hunger and improve health, but will also help encourage continued participation in school.

Nationally and at all state levels, an increased awareness of the high rates of childhood obesity are prompting a renewed emphasis on physical exercise, neighborhood access to healthy foods, and utilization of public programs to help offset food costs. As these programs are implemented, there should be an awareness that the most low-income households may be at a disadvantage to participation. For example, access to appropriate clothes and shoes for gym classes may not be available; transportation to grocery stores that have a wide variety of fruits and vegetables may not be possible (especially if not on a bus route); and eligibility for assistance from the Women, Infants and Children (WIC) program does not include help for older youth. Strategies should focus on increasing eligibility for WIC, creating more opportunities at local Farmer's markets (ensuring these

community food venues reach into the highest need areas), and ensuring participation in school or community activities does not have out of pocket costs that would discourage (or prohibit) participation.

6. Ensure Head Start regulations prioritize needs of homeless children.

The Improving Health Start for School Readiness Act of 2007, enacted on December 12, 2007, provides the U.S. Department of Health and Human Services (HHS) with the authority to re-compete Head Start and Early Head Start grants. This Act contains numerous provisions aimed at children in homeless households, to include the following:

- Align the definition of homeless with the McKinney-Vento Homeless Assistance Act
- Prioritize homeless children for enrollment
- Give more flexibility on the timeliness of paperwork
- Better collaborate with child welfare and other assistance agencies
- Develop outreach and support programs that coordinate with the McKinney-Vento Act
- Establish standards and best practices for serving high-needs populations, such as those without housing
- Provide more training and technical assistance to better meet the needs of participants.¹⁶

The regulations being developed should emphasize the need to ensure access to needed health services for homeless children, to include oral health (especially dental sealants), primary care and behavioral health. These services should include preventive screenings for anemia and well-child exams. Head Start regulations should also ensure sufficient access to nutritious food. The National HCH Council and its members will promote these recommendations as draft guidelines are released.

7. Support legislation aimed at reducing barriers for youth exiting the foster care system

An active bill introduced this year is the Reconnecting Youth to Prevent Homelessness Act of 2011 (S. 961), which is intended to improve training, educational opportunities, and permanency planning for older foster youth and reduce homelessness among young people. Approximately 30,000 children age out of the foster care system each year, but there are currently a number of barriers to helping them achieve independence. This Act proposes to address some of these barriers by making the following policy changes:

- Allows children nationwide to remain in foster care until at least their 21st birthday.
- Extends the timeframe foster youth have to utilize the Chafee Foster Care Independence Program, improving access to education, training, and independent living services; and increases funding authorization for the program
- Makes significant improvements to the Temporary Assistance to Needy Families (TANF) program, such as enhancing efforts to connect families with education, training and housing resources. It also increases the time frame for young parents to qualify for TANF benefits if they are in an education or training program.

- Provides support for states to work together to decrease barriers that prohibit cooperation across state lines for placing foster children in loving homes outside their state of residence.
- Provides support for programs that improve family relationships and reduce homelessness among youth who are lesbian, gay, bisexual, or transgender.
- Ensures that children in foster care receive Social Security benefits they qualify for due to the death of a parent or a disability.

The National HCH Council and its members will work to promote this legislation, as well as any other legislative policy changes that aim to assist youth exiting the foster care system.

8. Support legislation aimed at ensuring homeless children are able to succeed in school

Another active bill introduced this year is the Educational Success for Children and Youth Without Homes Act of 2011 (H.R. 1253 and S. 571), which is intended to remove common barriers homeless youth experience when registering for or attending school. The public school system identified nearly 1 million children and youth experiencing homelessness during the 2008-2009 school year. These students are at a tremendous disadvantage to scholastic achievement compared to their more stably housed peers, but there are many other young people experiencing homelessness who are unable to enroll in school or who have dropped out. This Act proposes to address these problems by making the following policy changes:

- Promote school stability for homeless children and youth by improving the "best interest" school selection process and by making transportation to the school of origin an eligible use of Title I Part A set-aside funds
- Increase school districts' ability to identify and serve homeless children and youth by providing professional development, training, resources, and time to school district homeless liaisons so they can carry out the duties required by the Act
- Increase homeless children's access to early childhood education programs by addressing barriers to stability and requiring public preschool programs to identify and prioritize homeless children for enrollment
- Improve the academic progress and high school graduation rate of unaccompanied homeless youth by addressing guardianship barriers, credit accrual problems and access to credit recovery opportunities
- Improve homeless children and youth's access to summer school, before and after school programs, and other educational opportunities
- Assist homeless students to participate in the full range of academic support opportunities offered by schools by clarifying that the amount of the Title I, Part A homeless set-aside must be based upon a needs assessment that includes objective criteria and is developed in coordination with the school district homeless liaison

The National HCH Council and its members will work to promote this Act, as well as any other legislative policy changes that aim to make needed policy changes to enable homeless youth to succeed in school.

References:

- ¹ National Center on Family Homelessness. 2009. America's Youngest Outcasts: State Report Card on Child Homelessness. Available at: www.homelesschildrenamerica.org.
- ² National Association for the Education of Homeless Children and Youth (NAECY). 2010. A Critical Moment: Child & Youth Homelessness in our Nation's Schools. Available at: http://www.naehcy.org/dl/crit_mom.pdf.
- ³ Kim-Cohen, et. al (2003), Prior Juvenile Diagnoses in Adults With Mental Disorder, *Archives of General Psychiatry*, 60: 709-717.
- ⁴ Warfield, M. & Gulley, S. (2006). Unmet Need and Problems Accessing Specialty Medical and Related Services Among Children with Special Health Care Needs. *Maternal and Child Health Journal*, 10 (2). 201-216.
- ⁵ Health Resources and Services Administration (HRSA), 2009. Uniform Data System Report. Available at: http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/2009/SpecialPopulations/Homeless/2009_homeless_socioeconomic.html.
- ⁶ Kaiser Commission on Medicaid and the Uninsured. February 2011. Health Coverage of Children: The Role of Medicaid and CHIP. Available at: <http://www.kff.org/uninsured/upload/7698-05.pdf>.
- ⁷ Cassidy, A. January 27, 2011. Health Policy Brief: Enrolling More Kids in Medicaid and CHIP. *Health Affairs*.
- ⁸ U.S. Department of Health and Human Services (HHS). December 27, 2010. News Release: States get bonuses for boosting enrollment for uninsured children in Medicaid. Available at: <http://www.hhs.gov/news/press/2010pres/12/20101227a.html>
- ⁹ Faegre & Benson, LLP. (January 15, 2009.) "Unaccompanied Youth and Access to Medical Care." Available at: http://www.naehcy.org/dl/memo_uy_med.doc.
- ¹⁰ Halley, M., and English, A. (December 2008.) Health Care for Homeless Youth: Policy Options for Improving Access. Center for Adolescent Health & the Law, Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health.
- ¹¹ Lubell, J and Brennan, M. (July 2007.) *Framing the Issues – the Positive Impacts of Affordable Housing on Education*. Center for Housing Policy (available at: http://www.macfarlanecostahousing.com/assets/2007/10/4/http_app.brnto4.pdf). See also Lubell, J, Crain, R. and Cohen, R. (July 2007.) *Framing the Issues-the Positive Impacts of Affordable Housing and Health*, Center for Housing Policy and Enterprise Community Partners (available at: http://www.macfarlanecosta.com/assets/2007/10/4/http_app.brnto3.pdf).
- ¹² Ibid.
- ¹³ Further information is available at the U.S. Department of Housing and Urban Development: <http://www.hud.gov/offices/cfo/reports/2011/cjs/has-homeless-demo2011.pdf>.
- ¹⁴ Further information is available at: <http://www.nationalhomeless.org/factsheets/youth.html>.
- ¹⁵ Robert Wood Johnson Foundation. (April 2010.) *Food Insecurity and Risk for Obesity Among Children and Families: Is There a Relationship?* Available at: <http://www.rwjf.org/pr/product.jsp?id=62668>.
- ¹⁶ Further information is available at: http://www.naehcy.org/dl/hs_summ.doc.