Ending Child Homelessness in America
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Approximately 1.5 million children experience homelessness in America each year. The current economic recession and staggering numbers of housing foreclosures have caused the numbers of homeless families to increase dramatically. The impact of homelessness on families and children is devastating. Without a place to call home, children are severely challenged by unpredictability, dislocation, and chaos. Homelessness and exposure to traumatic stresses place them at high risk for poor mental health outcomes. Despite the pressing needs of these children, federal policy during the last decade has focused primarily on chronically homeless adult individuals—to the exclusion of the families. In 2010, however, the U.S. Interagency Council on Homelessness issued a comprehensive plan to eradicate homelessness for all people through interagency collaboration and aligning mainstream services. A key goal is to prevent and end homelessness for families, youth, and children within 10 years. This policy-focused article describes several tools that can be used to help achieve this goal, including: general principles of care for serving homeless families and children; BSAFE—a promising practice that helps families access community-based services and supports; and the Campaign to End Child Homelessness aimed at action on behalf of homeless families and children at the national, state, and local levels.

Not since the Great Depression have significant numbers of families been on the streets in the United States. In the 1980s, families accounted for < 1% of all homeless people; over the last three decades their numbers have increased and they now comprise 32% of the overall homeless population (U.S. Department of Housing and Urban Development [HUD], 2009). This number includes more than 1.5 million American children every year who stand at the nexus of poverty, the economic downturn, the housing crisis, and homelessness—1 in every 50 children (The National Center on Family Homelessness, 2009).

Most studies to date have investigated the impact of homelessness on children by comparing those who are homeless to their low-income housed counterparts or to middle-class children (Bassuk et al., 1997; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993; Rog & Buckner, 2007; Rubin et al., 1996; Weitzman, 1989). These studies explored similarities and differences in the intensity of needs between these subgroups. Although valuable in their contributions, focusing on differences between these groups of children obfuscates the pressing needs of homeless children and diverts attention away from the urgency of creating responsive solutions. Whether homeless children are better or worse off or suffer more or less than other children may answer one set of questions but obscures others. Unlike previous articles that have explored the impact of homelessness on children (Bassuk et al., 1997; Buckner & Bassuk, 1997; Buckner, Bassuk, Weinreb, & Brooks, 1999; Masten et al., 1993; Masten et al., 1997; Rog & Buckner, 2007; Rubin et al., 1996; Weinreb, Goldberg, Bassuk, & Perloff, 1998) or reviewed the research literature (Rog & Buckner, 2007; Samuels et al., 2010), this article describes homeless children’s circumstances and needs within the context of federal policies. The article concludes by discussing some current practices and policies aimed at ending child homelessness.

Structural Factors Contributing to Family Homelessness

Often when we think about predictors of homelessness, we focus on factors related to individual vulnerability such as the recent birth of a baby or hospitalization of a parent for a mental health problem (Shinn et al., 1998; Weitzman, 1989). However, individual factors tell us only who is more likely to be affected by structural issues. The lack of affordable housing and extreme poverty are the primary drivers of homelessness (Bassuk et al., 1996; The National Center on Family Homelessness, 2009). From 2001 to 2007, the affordable rental housing stock decreased by 6.3% or 1.2 million units (Collinson & Winter, 2010; U.S. Interagency Council on Homelessness [ICH], 2010).
About 6 million Americans have “worst case housing needs” putting them at increased risk of becoming homeless. They devote more than 50% of their income to housing, far more than the 30% considered reasonable. Yet, they still live in substandard units and have limited resources for other necessities, such as food and heat (HUD, 2009; The National Center on Family Homelessness, 2009). Complicating this picture is the unavailability of adequate numbers of housing vouchers and the difficulty in converting these vouchers into decent housing (Khadduri, 2008). With the current economic recession and high rates of housing foreclosures, many of these families are likely to lose their homes. In fact, between 2007 and 2008, the numbers of homeless families increased by 9% (HUD, 2009). Once a family becomes homeless, it is often a long road back to residential stability and community connections.

Families headed by women alone are particularly vulnerable in this housing market. Their numbers have dramatically increased over the last few decades. They are 2.5 times as poor as other families, and they are poorer than the disabled or the elderly (U.S. Census Bureau, 2008). Women heading families alone have multiple roles as parents, breadwinners, and homemakers. However, they generally have inadequate child care, insufficient child support, and inadequate access to poverty programs, such as Temporary Assistance for Needy Families (TANF), that might improve their circumstances. Given this picture, it is not surprising that 84% of families experiencing homelessness are headed by single women (HUD, 2007).

**Who Are Homeless Families?**

Who are these families and what are they experiencing? A typical sheltered family is composed of a single mother with two or three children, often younger than 6 years old (HUD, 2009). They are disproportionately of color (HUD, 2009). In general, the mothers do not have high school diplomas and have poor job skills and limited work opportunities that pay a livable wage. Many are victims of domestic violence. They have many more medical, mental health, and substance use problems compared to their housed counterparts (Bassuk et al., 1996; Weinreb, Buckner, Williams, & Nicholson, 2006).

Regardless of the pathway into homelessness, it is a traumatic experience. The lack of a home to call one’s own combined with disconnection from community supports and services can be devastating (Goodman, Saxe, & Harvey, 1991). For many mothers, the experience of becoming homeless is another major stressor amid many traumatic experiences that are interpersonal, intentional, recurrent, and severe—and may have extended over their lifetimes. Rates of exposure to violence both interpersonally and in the community are very high (Bassuk, Dawson, Perloff, & Weinreb, 2001; Bassuk, Perloff, & Dawson, 2001; Bassuk et al., 1996; Browne & Bassuk, 1997; Guarino & Bassuk, 2010; Medeiros & Vautlon, 2010). Based on a longitudinal study conducted by The National Center on Family Homelessness, 92% of homeless mothers have experienced some form of severe physical or sexual abuse, mostly in familial or intimate relationships (Bassuk et al., 1996). Forty-three percent of homeless women reported being sexually abused by the age of 12—usually by multiple perpetrators (Bassuk et al., 1996). Violence continues into adulthood, with 63% reporting severe physical assault by an intimate partner and 27% requiring medical treatment (Browne & Bassuk, 1997; Guarino & Bassuk, 2010).

Not surprisingly, many homeless mothers struggle with various emotional issues. Compared to the overall female population, homeless mothers have three times the rate of posttraumatic stress disorder (PTSD), at least 4 times the rate of major depressive disorders, and twice the rate of drug and/or alcohol dependence—substances often used to medicate the distress of PTSD and depression (Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk et al., 1996; Guarino & Bassuk, 2010). Between one fourth and one third of homeless mothers report at least one suicide attempt in their lifetime (Bassuk et al., 1996; Medeiros & Vautlon, 2010; Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, & Holupka, 1995). These challenges compromise their ability to form safe, trusting relationships, work consistently, and parent effectively (Guarino & Bassuk, 2010). Women who are homeless and have experienced recurrent traumatic stresses also have difficulty accessing help and support for themselves and their children (Guarino & Bassuk, 2010).

Chronic depression is especially common in women of childbearing age and peaks among women between the ages of 18 and 29 years. Current rates of depression in homeless mothers (52%), mothers parenting young children, and parenting teens (40%–60%) are 4 to 5 times greater than women overall (12%; Knitzer et al., 2008). Lifetime rates of major depressive disorder in homeless mothers have been documented to be as high as 85%, at least 4 times that of the overall female population and approximately twice that of poor women (Weinreb et al., 2006). Depression is a treatable disorder (Knitzer et al., 2008) but when overlooked, its consequences can be devastating for both the mother and her children (Knitzer et al., 2008; Weinreb et al., 2006; Weissman & Olfson, 1995).

Maternal depression poses often unrecognized risks to the healthy development and school readiness of young children (Guarino & Bassuk, 2010). Depression is associated with poor socioemotional outcomes and cognitive deficits in children (Gurian, 2003). Yet, the mother’s depressive symptoms are often viewed as acceptable and normative—and are therefore ignored. The health and well-being of a child is inextricably linked to the health and well-being of his or her parent (Guarino & Bassuk, 2010). The quality of the parent–child relationship has a profound effect on a child’s self awareness, relationship with others, socioemotional development, and school adjustment (National Scientific Council on the Developing Child, 2004). These experiences may result in elevated levels of stress hormones that may affect brain development and future coping skills (National Scientific Council on the Developing Child, 2004). In addition, researchers have documented that children who have a parent with a mental health issue are at greater risk of developmental delays, and psychological and academic difficulties (Guarino & Bassuk, 2010; Nicholson, Biebel, Hinden, Henry, & Stier, 2001).
The Needs of Homeless Children

Who are the children experiencing homelessness? According to HUD, 51% of children in shelters and transitional facilities are < 6 years old—and they are disproportionately African American and Native American (HUD, 2009). Ninety-seven percent of homeless families move, many up to three times in the year before entering shelter (Bassuk et al., 1997; Masten et al., 1993; The National Center on Family Homelessness, 2009). Others have lived in a variety of doubled-up and overcrowded housing arrangements with relatives or friends. For many children, moving frequently also means they are compelled to change schools (National Research Council and Institute of Medicine, 2010). Mobility, especially when it is repeated, “can disrupt children’s routines, their consistency of care and health care, and their relationships, as well as learning routines, relationships with teachers and peers, and the curriculum to which they are exposed” (National Research Council and Institute of Medicine, 2010, p. 7). School attendance may be erratic.

Research indicates that homelessness and residential mobility leads to poor school performance, repeating grades, dropping out, and lower rates of high school graduation. These findings are most pronounced when children have moved three or more times (National Research Council and Institute of Medicine, 2010; Reynolds, Chen, & Herbers, 2009). It is not surprising that proficiency rates for homeless children in reading and math are on average 16% lower than the scores for all students and that fewer than one in four homeless children graduates from high school (The National Center on Family Homelessness, 2009).

Many homeless children live in unsafe and chaotic environments, and are exposed to a variety of traumatic stressors (Guarino & Bassuk, 2010). Although data are sparse about homeless children’s exposure to violence, we know that at least one quarter have witnessed violence in their families, and many more have witnessed violence in their communities (Buckner, Beardslee, & Bassuk, 2004). More than one third of children who are homeless have been involved in a child protection investigation (Guarino & Bassuk, 2010; The National Center on Family Homelessness, 1999). In addition to violence, almost one fourth of all homeless children have been separated from their families (Guarino & Bassuk, 2010; The National Center on Family Homelessness, 1999, 2009). Rates of separation increase once families are homeless and the rates of reunification are low. In 1988, Cowal reported that 44% of children in families who had been in shelter in New York City for 5 years had been separated from their families (Cowal, Shinn, Weitzman, Stojanovic, & Labay, 2002). Mother’s drug dependence, institutional placement (predominately for substance use), and domestic violence independently predicted a greater likelihood of separation (Cowal et al., 2002), but homelessness itself has a larger effect than any of these factors alone (Barrow & Lawinski, 2009). The impact of separation on the family is significant. Caring attachments between adults and children are fundamental to human development (Guarino & Bassuk, 2010). When a child’s bond with her primary caretaker is precipitously disrupted or inconsistent, the child is likely to suffer long-term negative effects, such as behavioral difficulties and an inability to form supportive trusting relationships that may extend into adulthood (Bassuk, 2007).

Once homeless, specific events occur that further traumatize or destabilize these children. Homelessness for a child is more than the loss of a home. It disrupts every aspect of life. At a time when children should be developing a sense of safety and security, trust in their caregivers, and freedom to explore the world, they are severely challenged and limited by unpredictability, dislocation, and chaos. They begin to learn that the world is in fact unsafe, that their parents are understandably stressed and preoccupied, and that scary and often violent things happen around them. These experiences are not lost on children—even the youngest. Ongoing chronic stress can have profound and lasting effects that may still be manifested in adulthood (Bassuk, 2007).

Cowan’s (2007) research has demonstrated that homeless-specific trauma accounts for a statistically significant variance in the mental health outcomes of sheltered children. Homeless children lose their sense of place, friends, pets, possessions, and sometimes their families (Bassuk, 2007). Once sheltered, they often share their room and even their bed with the rest of the family. They must live among strangers and adjust to unfamiliar rules of shelter life. Friedman (2000) describes how parenting in shelters occurs in public, creating additional stresses for mothers and children.

The realities of homeless children’s circumstances—poverty and traumatic stress—can result in poor mental health outcomes, including high rates of behavioral problems, delayed developmental milestones, emotional dysregulation, attachment disorders, and anxiety and depression (Bassuk et al., 1997; Guarino & Bassuk, 2010; The National Center on Family Homelessness, 1999). Twenty percent of preschoolers have emotional problems requiring treatment (Bassuk & Friedman, 2005; The National Center on Family Homelessness, 1999, 2009). By age 8, one third have at least one major mental health disorder (Bassuk & Friedman, 2005; Buckner & Bassuk, 1997; The National Center on Family Homelessness, 1999, 2009). Almost 10% have learning disabilities compared to 6.6% of non-homeless students (Garcia Coll, Buckner, Brooks, Weinreb, & Bassuk, 1998; Medeiros & Vaulton, 2010; The National Center on Family Homelessness, 1999). Despite the intense needs of children experiencing homelessness, many studies have documented the inadequacy of services, lack of responsiveness by providers, and many barriers to access (Buckner & Bassuk, 1997; Medeiros & Vaulton, 2010; The National Center on Family Homelessness, 1999, 2000). Twenty percent lack regular medical care, more than half visit hospital emergency rooms each year, one third receive no help for emotional problems, and almost one third do not receive the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or Food Stamps, even though they are eligible (Buckner & Bassuk, 1997; The National Center on Family Homelessness, 1999, 2009).

Rog and Buckner (2007), in a review of the research literature, described two generations of studies. The first, spanning the late 1980s, described various studies that explored a range of problems experienced by homeless children. These included health issues, developmental delays, mental health and behavioral difficulties, and academic problems (Alperstein,
Rappaport, & Flanigan, 1988; Bassuk & Rubin, 1987; Miller & Lin, 1988; Rescorla, Parker, & Stolley, 1991; Wood, Valdez, Hayashi, & Shen, 1990). These studies spawned a second wave that investigated the impact of homelessness on children by comparing homeless children to their low-income housed counterparts, and to the general population. The results tended to be inconsistent; effects due specifically to homelessness were inconsistent and harder to detect (Rog & Buckner, 2007). Overall, researchers were able to document a “poverty-related effect” on children’s mental health and behavior. On various mental health variables, low-income children—whether homeless or housed—looked worse than children in the general population (Rog & Buckner, 2007). Poverty seems to have adverse effects on children’s health, development, behavior and mental health through various mediating and moderating variables (Samuels et al., 2010). Masten et al. (1993) emphasized that it is difficult to isolate individual variables leading to specific negative outcomes since homeless children are often exposed to multiple adverse events. It is essential to consider the impact of cumulative risk factors (i.e., multiple traumatic stressors) on children, with homelessness being one of these factors.

Homeless children have high rates of exposure to interpersonal and chronic community violence (Bassuk, Dawson, et al. 2001; Bassuk, Perloff, et al., 2001; Bassuk et al., 1996; Browne & Bassuk, 1997; Buckner et al., 2004; Cowan, 2007; Guarino & Bassuk, 2010). However, studies have not been completed specifically documenting rates of PTSD among homeless children. Many manifest high levels of distress related to this exposure as well as to the stressors related to homelessness. In general, post-trauma responses are shaped by developmental factors and are evident in children of all ages (Bassuk, Konnath, & Volk, 2007). PTSD symptoms are not as clear-cut in children as in adults, especially in those who are very young (0–3 years old). Young children may be irritable, have difficulty sleeping, be fearful of being alone, and show delays in learning and toileting. Post-trauma responses in older children are characterized by emotional dysregulation, insecure or disorganized attachments, and sometimes, the classic symptoms of PTSD—hyperarousal, numbing and avoidance, and intrusive memories (Breslau et al., 1998; Osofsky, 1995).

Addressing Traumatic Stress in Children Experiencing Homelessness

Recently, the traumatic stress field has adopted the term complex trauma to refer to multiple traumatic events that are recurrent or ongoing and of long duration. They are generally interpersonal, often generated by someone important in the caretaking system, usually occur when the child is young, and are often associated with attachment disorders (Cook et al., 2005). Traumatic events include physical, emotional, and educational neglect, maltreatment, and abuse (van der Kolk, 2005). The Adverse Childhood Experiences (ACE) study gave additional credence to this perspective by documenting the high rates of multiple severe traumatic experiences during childhood and their detrimental effects on physical health and mental health later in life (Felitti et al., 1998).

Given the high rates of chronic interpersonal violence, along with the stress associated with daily survival in an often unsupporative system, the experience of many homeless children and their mothers fit the definition of complex trauma (Guarino & Bassuk, 2010). Although research documenting the prevalence and nature of attachment disorders in homeless children has not been completed, empirical studies have demonstrated high rates of attachment difficulties in maltreated children, especially when the perpetrator is a caregiver and the abuse occurred early in life. Furthermore, parental interpersonal violence as well as multiple out-of-home placements of children are primary risk factors for impaired attachments (Main, 1996).

The symptoms of complex trauma extend well beyond PTSD and reflect complicated adaptations to trauma in areas, such as affect, attention, self-image, impulse control, and somatization. Many of these children have complex presentations and carry multiple diagnoses in addition to PTSD (van der Kolk, 2005). Although there is no clear clinical consensus about the best treatment for complex trauma, the core components of any intervention should involve both the child and the caregiving system, and include attention to safety, self-regulation, information processing, relationships, and strategies for integrating traumatic experiences (Cook et al., 2005). General treatment approaches include trauma-sensitive individual therapies as well as parent-child or family therapy. In addition, many trauma-specific treatments are available for children (see http://www.nctsn.org). Various interventions that have been piloted and implemented with homeless children and youth include parent-child interaction therapy (PCIT), child-adult relationship enhancement (CARE), and trauma systems therapy (TST; Guarino & Bassuk, 2010; SAMHSA’s National Registry of Evidence-Based Programs and Practices, 2009; Saxe, Ellis, & Kaplow, 2006). PCIT is an evidence-based practice for young children that is aimed at improving the quality of the parent–child relationship and focuses on changing patterns of interaction (Guarino & Bassuk, 2010). CARE is a trauma-informed modification of PCIT and can be used by nonclinical providers. It provides strategies for responding to the behaviors of traumatized children (Guarino & Bassuk, 2010; National Child Traumatic Stress Network, 2008). TST is a comprehensive model for treating traumatic stress in children and adolescents by specifically addressing the child’s environment and systems of care. TST helps traumatized children regulate their emotions and behaviors by diminishing the ongoing stresses and threats in the social and caregiving environments (Saxe et al., 2006).

In an effort to improve the context in which housing and services are provided to homeless families and children, the National Center on Family Homelessness developed and piloted the Trauma Informed Organizational Toolkit for Homeless Services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009). This toolkit helps programs to become more trauma sensitive by providing concrete guidelines for incorporating trauma-informed practices into community-based programs (Guarino et al., 2009).

Resiliency in Homeless Children

Not all children who experience homelessness do poorly. In fact, many—perhaps, even a majority—hold their own or thrive in the face of adversity and threats to development. As Masten (2001) said, resilience is “ordinary magic.” This implies that
systems involving the child, such as family and school, are functioning well and supporting the child to competently negotiate usual developmental tasks. Children experience the world within the context of their families and the broader community. The resilience literature points to a range of protective factors, including positive parenting, healthy attachments to caregivers, and community support for families (Guarino & Bassuk, 2010; Masten & Gewirtz, 2006). There are many models for strengthening attachments and building parental skills, although only a few have been used in shelter settings (Guarino & Bassuk, 2010).

The most commonly cited correlates of successful adaptation described in the literature, include (a) an ongoing relationship with a caring, prosocial adult and (b) good intellectual, cognitive, problem-solving skills (Samuels et al., 2010). Buckner, Mezzacappa, and Beardslee (2003, 2009), among others, have also identified self-regulation—indeed, of intelligence—as an inner resource that distinguishes resilient from nonresilient low-income youth (Samuels et al., 2010). They defined self-regulation as “an integrated set of abilities or skills that draw from both executive function and emotional regulation capacities”—and are interrelated. Executive functions include: working memory, executive attention, inhibitory control, planning, and decision making (Buckner et al., 2009). They also investigated external resources and found that parental monitoring—defined as a “parent’s proclivity to pay close attention to the whereabouts of a child when away from home and with whom the child was spending time”—was also a predictor of resilience (Samuels et al., 2010, p. 25).

To further investigate resilience in homeless children, the National Center on Family Homelessness reanalyzed data from the Worcester Family Research Project—a case–control longitudinal study comparing 436 homeless and housed families and their 637 children. Using cluster analysis, the researchers measured adaptive functioning, academic achievement, and emotional and behavioral health within each child. They found that homeless children were not homogeneous: They clustered into two main subgroups with different needs and functioning levels. The higher functioning subgroup was doing well in all three domains despite their adverse circumstances. In the lower functioning group, the children were doing poorly in all three domains. In this latter group, the intensity of mental health symptoms experienced by the mother was higher, and more of these children had been exposed to physical and/or sexual violence (Huntington, Buckner, & Bassuk, 2008). This study highlighted the importance of using a person-centered analytical approach. The authors also emphasized the importance of targeting intensive and often scarce resources to those children who were lower functioning, while continuing to support higher functioning children.

**Strategies for Ending Family Homelessness**

Given this picture, where do we begin in preventing and ending family homelessness? In the last decade, federal policies focused on ending chronic homelessness among single adult individuals by promoting state and local plans to end chronic homelessness and through rapid rehousing, using Housing First approaches. Housing First strategies are based on the belief that housing is a right and that few conditions should accompany that right (e.g., low-demand, harm-reduction approach). Providers have successfully housed chronically homeless people—those who have been homeless for long periods and have various disabilities—without mandating that they meet various service requirements or are so-called housing ready (Stefancic & Tsemberis, 2007). The Corporation for Supportive Housing documented that more than 80% of supportive housing tenants maintain their housing for at least 12 months and tend to engage in services even when it is not a condition of tenancy (Barrow, Soto, & Cordova, 2004). Use of more costly services, such as emergency health care, hospitalizations, and criminal justice services decreases as well (Corporation for Supportive Housing, 2006). In the federal Collaborative Initiative to End Chronic Homelessness, participants showed improvement in housing stability, had fewer days of homelessness, used public services less, and had reduced health-care costs (Mares & Rosenheck, 2010). Despite these accomplishments, prior federal policies allocated scarce resources primarily to only one subgroup of homeless people—to the exclusion of families and children.

With the change in administration in 2009, the U.S. Interagency Council on Homelessness (ICH, 2010), representing 19 federal agencies, including the cabinet secretaries, issued *Opening Doors* “the first ever comprehensive strategic plan to prevent and end homelessness” in America. The overview to the plan states:

> This is the right time to align our collective resources toward eradicating homelessness. There is a legislative mandate from the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and bipartisan support to adopt a collaborative approach. Most importantly, we now know how to address this important issue on a large scale. Over the past five years, the public and private sectors have made remarkable progress in reducing chronic homelessness. By developing the “technology” of combining permanent housing and pipeline of support services, there has been a reduction of chronically ill, long-term homeless individuals by one-third in the last five years. (U.S. Interagency Council on Homelessness, 2010, p. 1)

By ensuring federal interagency collaboration, strengthening existing public and private partnerships at state and local levels, and aligning mainstream resources, this comprehensive plan provides a roadmap for addressing this tragic problem among all subgroups of homeless people. A key focus and goal is to prevent and end homelessness for families, youth, and children within 10 years.

Much needs to be accomplished and significant resources must be allocated to realize the ambitious goals of the new federal plan. To make Housing First and rapid rehousing, a reality for all homeless people, including families, national legislation and funding must increase the stock of affordable housing units. Federal stimulus funding allocated $1.5 billion toward rapid rehousing and prevention. Rather than supporting the continued growth of an emergency shelter system, the thrust was to reallocate resources to Housing First models using shallow rent subsidies (National Alliance to End Homelessness [NAEH], 2009). We must also capitalize the National Housing Trust Fund (NHTF). This dedicated fund was developed to provide local communities with money to build, rehabilitate, and
preserve housing for extremely poor and homeless households (The National Center on Family Homelessness, 2009; National Low Income Housing Coalition, 2009). The U.S. House of Representatives approved $1 billion for the NHTF, which will now move to the U.S. Senate for consideration (National Low Income Housing Coalition, 2009). In addition, adequate numbers of housing vouchers must be issued and targeted to extremely low-income families. Vouchers must “provide a subsidy that makes it possible for a household to afford a housing unit with a rent in about the middle of the local housing market” (Khadduri, 2008, p. 2). Research has demonstrated that vouchers are a successful strategy for addressing the shortage of affordable housing. Studies suggest that housing vouchers decrease the likelihood of shelter readmission and increase residential stability for homeless families. However, vouchers alone may not be enough to ensure long-term stability and should be used in combination with case management and others services (Bassuk & Geller, 2006).

We know that housing is essential but not sufficient for ending homelessness. Services and supports responsive to the needs of families and children must also be part of the solution. Although many innovative programs and promising practices for serving homeless families have emerged, we do not know which services (e.g., nature, intensity, duration) work best for different subgroups of homeless families and children. Currently, HUD is launching a multisite evaluation to learn more about which combinations of housing models and services work best for homeless families. This study will use an experimental research design to determine which interventions are most effective for promoting housing stability, family preservation, child and adult well-being, and self-sufficiency.

Despite limited research to date, fundamental principles of care have emerged from years of experience serving homeless families and children. These basic principles of community-based care are briefly described next (for a full listing, see http://www.familyhomelessness.org). All programs serving families and children experiencing homelessness should implement policies and practices that address the needs of every family members—including the children. At a minimum, programs should promote:

1. Rapidly Rehouse Families—Every effort should be made to rehouse families as quickly as possible, minimizing their time in shelter.
2. Respond to Immediate Needs—Programs must first work to ensure that families’ immediate needs for safety, housing, financial assistance, and pressing health, mental health, and substance use needs are addressed before engaging them in longer term care.
3. Link Housing With Services and Supports—For all families, housing is essential but not sufficient. Supports such as child care and transportation are critical. In addition, many families require specialized and sometimes intensive services at various times in their lives.
4. Assess Families and Create Individualized Housing/Service Plans—The needs of homeless families and children are heterogeneous, each with their own strengths and challenges. Programs must assess the needs of each family member and create individualized housing and service plans.
5. Support Family Unity—Families experiencing homelessness should not be separated unless the health and well-being of children are at immediate risk.
6. Deliver High-Quality Services—Services provided to families experiencing homelessness must be effective and of high quality. They should be family oriented and employ evidence-based and promising practices that are strengths based.
7. Provide Trauma-Informed Care—And ensure the physical and emotional safety of all family members. Given the high rates of interpersonal and random violence experienced by these families and children, all services must be provided through the lens of trauma.
8. Address Unique Needs of Children—The needs of homeless children are often overlooked, especially in settings with limited resources. At a minimum:
   i. Child-specific services and child-friendly settings must be provided.
   ii. Services must be developmentally appropriate.
   iii. Programs must help children access and succeed in schools.
   iv. Medical, trauma-specific, and mental health services must be available for children.
9. Ensure A Basic Standard of Care by Training the Workforce—All staff working with homeless families should receive basic training that supports the development of specific competencies. In addition, providing staff with appropriate supervision, continuing education, and career development opportunities are important.
10. Monitor Progress and Outcomes—It is important for programs to understand the needs of the families they serve and the effectiveness of the services they are providing so that they can provide high-quality care.

Given the complex needs of homeless families and children, it is essential that they receive responsive services. However, many barriers (e.g., transportation, child care, insurance, stigma) interfere with their ability to access mainstream services. To ensure family stability and well-being, these barriers must be addressed. Furthermore, the success of the goals outlined in the new federal plan partly depends on the ability of these families to connect to community-based and specialized services. With this in mind, The National Center on Family Homelessness developed Building on Strengths and Advocating for Family Empowerment (BSAFE; Bassuk, Guarino, Clervil, & Cowan, 2010), an adaptation of Critical Time Intervention (CTI). CTI is a time-limited phased treatment approach originally developed to bridge the service gap for people with serious mental illness as they moved from shelters/institutions back into the community (Herman, Conover, Felix, Nakagawa, & Mills, 2007). CTI was designated an evidence-based practice by SAMHSA’s Registry of Evidence-Based Programs and Practices (NREPP). This 9-month intervention addresses the need to build a network of supports and services that will ensure the stability and well-being of homeless people in the community. The CTI model has also been adapted for homeless mothers with mental illness.
and/or substance use disorders by Judith Samuels (Bassuk et al., 2010; also see http://www.nami.org).

BSAFE is modeled after CTI. While rapid rehousing into a safe and affordable setting is a priority, BSAFE recognizes that services and supports are also needed by many families. Developed within an ecological framework, BSAFE emphasizes the integral connection among community-based services, social networks and broader systems of care, and the housing, health, and well-being of families. This trauma-informed, family centered intervention is designed to address the needs of families and children who are homeless or formerly homeless as they transition into the community and/or stabilize in supportive housing (Bassuk et al., 2010).

BSAFE is a 12-month case management intervention divided into three phases, each of 4 months duration. This is accomplished by: identifying the needs of all family members—including children; establishing plans for each family unit and each family member; facilitating access to community supports and services; creating referral networks of culturally competent and developmentally appropriate services; and enhancing social and community connectedness. BSAFE can be implemented by paraprofessionals who are trained and have some clinical backup (Bassuk et al., 2010).

Campaign to End Child Homelessness

In addition to implementing effective interventions, eradicating homelessness will require the mobilization of political will at the national, state, and local levels as well as encouraging widespread community involvement and citizen participation (Bassuk et al., 2010). In an effort to mobilize communities to participate fully in ending family homelessness and to highlight the needs of the children, The National Center on Family Homelessness launched the Campaign to End Child Homelessness in 2009 with the publication of America’s Youngest Outcasts: State Report Card on Child Homelessness. Using national data sets, the report determined the housing, health, and educational needs of homeless children, and how our country has responded to their situation. Each state was assigned a rank based on four domains: extent of child homelessness, child well-being, structural risk factors for homelessness, and policy and planning efforts. The report focused on children in homeless families, excluding youth who are homeless and living on the streets without their families (The National Center on Family Homelessness, 2009).

Using data collected by 12,550 Local Education Agencies as mandated by the McKinney-Vento Homeless Assistance Act, we found that approximately 1.5 million children, 1 in 50, were homeless in 2005–2006. In a given year, 2% of all American children experience homelessness (The National Center on Family Homelessness, 2009). Although the lack of affordable housing and extreme poverty are the primary drivers of family homelessness, other structural factors such as household composition, housing market factors, and generosity of benefits when considered together determine the risk for child homelessness in each state (The National Center on Family Homelessness, 2009).

Across the states, the geographic distribution of homeless children is uneven, with 75% of identified children clustered in just 11 states (The National Center on Family Homelessness, 2009). The findings from America’s Youngest Outcasts indicated that most states have not yet formulated policies to respond to child homelessness. Only six states have done extensive planning. Twenty-four states have done little or no planning (The National Center on Family Homelessness, 2009).

Within this context, the Campaign to End Child Homelessness is achieving considerable momentum. Its goals are to increase public awareness; strengthen national, state, and local policies; and improve program design and service delivery. The campaign is facilitating an array of coordinated national, state, and local efforts to address these goals. We have developed a communications strategy to educate the public about the needs of homeless children as well as effective policy and program responses. Nationally, the campaign has engaged the White House and U.S. Congress in understanding and addressing child homelessness, and will continue as an active voice in Washington, D.C. to urge evidence-based action. In several states, the campaign is mobilizing local coalitions of providers, consumers, advocates, and policy makers to identify needs as well as strategies and solutions for ending family homelessness. These activities are strengthened by our provision of technical assistance to states and communities, including on-site training and consultation. Networking and information exchange is fostered through the campaign’s Web-based resources. For more on America’s Youngest Outcasts and The Campaign to End Child Homelessness, see http://www.HomelessChildrenAmerica.org.

Conclusion

Embracing the spirit of international law as stated in the 25th article of the United Nations Declaration of Human Rights (“Everyone Has The Right to Housing,” 1948), the failure to house one child for even one night in our nation represents an unacceptable societal failing (see also Convention on the Rights of the Child, 1989, art. 27). Much is known about the needs of homeless children and families, and how to provide housing, services, and other support to address and alleviate their plight. All that is required is the public will to end this national tragedy. The growing numbers of families and children on the streets should mobilize us all to take action before child homelessness becomes a permanent feature of the American landscape.

Keywords: children; homelessness; families; United States; poverty; single mother; complex trauma; depression; resiliency; affordable housing; community-based care; federal programs

References


