Twenty-Five Years of Child and Family Homelessness: Where Are We Now?

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Family homelessness emerged as a major social and public health problem in the United States during the 1980s.

We reviewed the literature, including journal articles, news stories, and government reports, that described conditions associated with family homelessness, the scope of the problem, and the health and mental health of homeless children and families. Much of this literature was published during the 1980s and 1990s. This raises questions about its continued applicability for the public health community.

We concluded that descriptions of the economic conditions and public policies associated with family homelessness are still relevant; however, the homeless family population has changed over time. Family homelessness has become more prevalent and pervasive among poor and low-income families. We provide public health recommendations for these homeless families. (*Am J Public Health*. 2013; 103:e1–e10. doi:10.2105/AJPH.2013.301618)

FAMILY HOMELESSNESS emerged as a major social and public health problem in the 1980s for the first time since the Great Depression.[1] The dramatic increase in child and family homelessness was accompanied by intense interest in the popular media and articles published in peer-reviewed journals. Although the number of homeless families and children has steadily increased over time, attention to the issue, as indicated by articles in peer-reviewed journals, government reports, and news stories, has diminished.

We reviewed the literature that described the conditions associated with family homelessness in the United States, the scope of the problem, and what is known about the health and mental health of homeless children and families. A preponderance of available studies describing the economic conditions that fueled the increase in family homelessness, the characteristics of homeless children and families, and the impact of homelessness on children were published during the 1980s and 1990s. This raised the questions: "Does this literature on homeless children and families still accurately reflect family homelessness 25 years later?" If not, "What changes should be noted to ensure that the public health community will have the information needed to effectively address the continuing problem of family homelessness?" We concluded this review with recommendations for the public health community.

LITERATURE SEARCH

We located articles through multiple database searches, principally of PubMed and PubMed Central (National Library of Medicine), JSTOR, PsychNET, Google Scholar, and Education Resources Information Center. Newspaper and magazine articles were located through Lexis-Nexis Academic Universe. Reports from government sources and not-for-profit agencies were located through multiple Internet and database searches. Search terms included combinations of "homeless," "homelessness," "child," "children," "families," "shelters," "health," "mental health," "child development," "outcomes," "academic success," "school performance," and "school attendance." Additional searches were done using the terms "family," "homeless," "housing," "economy," "income," and "prevalence."

No specific dates were used as inclusion criteria. All material was considered for inclusion on the condition that a full-text copy was available from the publisher's website, any of the data bases consulted, or hard copy from an academic medical center library or other source. Some of the older documents cited were only available in hard copy.

We focused this review on homeless children and families, a population that typically receives transitional housing in family shelters. Homeless and street youths unattached from families have different pathways to homelessness, and their health and mental health issues differ as well.[2] A detailed discussion of homeless and street youths was therefore outside the scope of this article. We also excluded articles and reports on homeless single adults, including veterans and unsheltered individuals.[3] The focus was exclusively on homelessness in the United States, and international studies and reports were excluded.

The literature cited reflected publication trends. Considerably more information was available from 1987 to 2000 than subsequently. A May 2013 PubMed search for "health of homeless children," for example, yielded 76 relevant articles, 62% of which were published between 1987 and 1998. A similar pattern was noted for articles and reports that described economic and housing conditions associated with family homelessness. A May 2013 PubMed search for "housing and homeless family" yielded 5 articles, all of which were published between 1989 and 1998.

RISE OF FAMILY HOOMELESSNESS

The increase in family homelessness in the United States beginning in the 1980s was accompanied by increasing rates of income inequality, child poverty, and shortages of affordable housing. By 1985, the after-tax income of the wealthiest 1% of households was almost 100% higher than it had been in 1979. There was a corresponding decline in the

income of those in the lowest wage quintile. Child poverty increased from 16% in 1979 to 22% in 1983, with an inner-city child poverty rate of 31%. Families with young children headed by a single parent were the most vulnerable; this became the typical composition of a homeless family.[4–6]

While more families fell into poverty, affordable housing became less available. Between 1981 and 1986, the federal housing (US Department of Housing and Urban Development [HUD]) budget was reduced from $33 billion to less than $10 billion.[7] This represented a dramatic disinvestment in the building and maintenance of affordable housing. Economic conditions in high-poverty neighborhoods led many private owners to abandon nonprofitable properties, further eroding the supply of affordable housing.[8] By 1986, the number of families in need of housing assistance (rental subsidies or placement in public housing) had increased from 7.1 to 8.2 million families, and affordable housing stock decreased from 5.3 to 4.2 million units.[9]

Evictions, predominantly for nonpayment of rent, rose by as much as 800% in 1982 compared with the previous year.[7] In 1986, the US Conference of Mayors Task Force on Hunger and Homelessness reported that demand for emergency shelters increased by an average of 20% from the previous year in the nation's 25 largest cities. In 72% of these cities, shelters were at capacity and unable to absorb additional demand. Low-income families needing rental assistance had to wait an average of a year and a half to receive a housing subsidy, and more than two thirds of families in need did not receive subsidized or public housing.[10] By 1990, there were 1.2 million eligible households that had not received housing subsidies, and the average wait for public housing was 21 months.[11] A 1992 report by the Office of the Inspector General, Department of Health and Human Services, found that family shelter capacity was insufficient to accommodate the number of homeless families in 7 of the 8 cities discussed.[12]

Simultaneously with the rise of family homelessness was an increase in the number of homeless and street-involved youths who lived unattached from their families or guardians. Quantifying their number has been consistently difficult. Estimates vary widely, in part because of differing age ranges used to define the population. Nonetheless, a steady increase has been notable, from an estimated 250 000 in 1983 to 500 000 in 1988 and as many as 2 million in 1990.[13–15] The Government Accountability Office (GAO) cited data from 2001 that showed an estimated 5 million "disconnected youths" in the United States.[16] More accurate estimates may be obtainable from the HUD 2013 point-in-time count of the homeless.[17]

The economic conditions that gave rise to family homelessness were as prominent in 2012 as 25 years previously. The US Census Bureau reported that income inequality (the gap between the richest and poorest households) increased since 1968 with a sharp and steady rise from 1976 through 1998.[18] Between 1979 and 2010, income for the bottom 80% of households increased no more than 45% compared with a 155% increase for top 1% of households.[19] In 2012, the average annual income for the most impoverished one fifth of American households was $20 510 compared with $164 490 for the wealthiest quintile. This represents an 8:1 income disparity.[20] The median household income fell from $51 965 in 2007 to $49 777 in 2009, and the percentage increase in poverty was the highest recorded since 1994.[21]

In 1987, the child poverty rate was 21.4%.[5] In 2011, it was 21.9%, virtually unchanged from 2010.[22] The cost of housing in 2012 was often as unsustainable for low-income families as in 1987. Based on typical fair market rental rates, a 1-bedroom apartment is unaffordable for a family headed by a full-time worker earning the federal minimum wage of $7.25 per hour.[23] A 2012 study by the Community Service Society of New York found that poor and low-income families that did not have a rental subsidy typically spent 49% of their monthly income on rent, leaving $4.40 per family member per day for food and everything else.[24]

HOMELESSNESS AND FAMILY VULNERABILITIES

Studies from the 1980s showed that often an immediate precursor to family homelessness was failure to sustain doubled up housing with friends or extended family.[25] This is an unstable housing situation in which a family that loses independent housing moves in with another family, typically a relative or friend, with no lease or other legal right to the housing unit. Doubled up housing arrangements typically become unsustainably overcrowded.[26]

Bassuk and Rosenberg[27] found that, compared with domiciled low-income mothers, mothers in homeless family shelters had less extended family and other social support and higher rates of substance abuse and psychiatric disorders. These factors reduced a family's options to double up as an alternative to the shelter system. Weinreb et al.[28] reported similar findings for 2003. Episodes of homelessness were generally preceded by lengthy periods of residential instability.[29] Residential instability is associated with higher incidence of maternal depression and other psychiatric problems affecting parents and their children.[30]

Another precursor of homelessness identified in studies during the 1980s was domestic violence.[27] The link between domestic violence and homelessness was often economic. Women typically earned less than the men with whom they lived, and a woman leaving an abusive spouse or partner would experience a loss of income and simultaneous need to establish independent housing.[31] For single women raising young children, affordable child care might be necessary but unavailable to facilitate employment. Although the proportion of US children cared for in formal child care settings increased over time, infants and toddlers and children in low-income families continued to be least likely to have child care options out of the home.[32,33] In the 1996 National Survey of Homeless Assistance Providers and Clients, nearly as many homeless single mothers with children identified interpersonal violence as one of the main reasons for leaving their last regular place to stay as those who identified the inability to afford rent.[34] In a study of homeless children at multiple New York City homeless shelter sites in 2004, 34% had been exposed to

domestic violence before becoming homeless.[35]

DEFINING AND QUANTIFYING HOMELESSNESS

The public health epidemiology task of quantifying and tracking child and family homelessness over time has been complicated by inconsistent and often unreliable data and data collection methods. One problem has been whether to count those in doubled up situations as homeless. Despite not having independent housing, families in doubled up situations were often considered "precariously housed" as opposed to "literally homeless."[36] In 1983, an estimated 2.6 million families were doubled up in the Unites States, about twice the number as in 1978.[9] The GAO estimated in 1989 that there were 3 times as many children living in doubled up housing as in homeless shelters.[37] Also in 1989, the New York City Council estimated that there were at least 100 000 families with more than 200 000 children in doubled up housing compared with 5000 families with 11 000 children in the city's homeless family shelters.[38]

The question of whether to include people in doubled up housing in counts of the homeless was addressed during the 1987 House of Representatives hearings for the Urgent Relief for the Homeless Act (later known as the McKinney-Vento Act). Testimony from New York City's then Human Resources Administration commissioner prevailed. It was decided, as explicitly stated in this testimony, not to include people in doubled up housing to lower the number of officially designated "homeless" people who would become eligible for housing assistance.[39]

This issue remains unresolved in 2013. In December 2011, HUD's final rules for the Homeless Emergency Assistance and Rapid Transition to Rehousing Act were issued, narrowly defining as "homeless" families in "emergency shelters" but not those in "transitional housing" or doubled up situations.[40] Elsewhere, however, HUD defined transitional housing as short-term housing and supportive services to assist homeless families to establish independent living.[41] An alternative federal definition from the Department of Health and Human Services includes people in doubled up situations as eligible for services from Health Care for the Homeless providers.[42] Although the McKinney-Vento Act initially excluded children and youths living in doubled up situations as homeless and eligible for education assistance, in the 2001 reauthorization, the law was amended to include those "who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason."[43–45] Counts of children eligible for assistance under McKinney-Vento are often used as a method to ascertain the number of homeless children.

Another complication arose from the different ways to count the homeless, either cumulatively for the year (annual total) or only at a specific point-in-time (e.g., an average day during the year).[46] These numbers varied widely. Using data for 1998, for example, Metraux et al.[47] reported an annual total of 2021 homeless families in Philadelphia, Pennsylvania, compared with an average daily census count of 752. Reports that documented the number of homeless children and families did not always specify the methodology and inclusion criteria used.

Notwithstanding these difficulties, it is clear that the size of the homeless family population consistently increased during the 1980s and thereafter. There were about twice as many homeless families in 1987 as there were in 1984.[48] By 1993, 43% of the nation's homeless were families with children, and 30% of all homeless people in the United States were children.[49] These new homeless families were typically a single mother and her children, about half of whom were infants and children younger than 5 years. This in part reflected the demographics of poverty; however, it also reflected family shelter policies that often did not admit men. Two-parent households were often required to break up so some family members could receive shelter.[50,51]

National data from the Fragile Families and Child Wellbeing Study, which focused on low-income children with 4 waves of data for 2631 children from 20 cities from 1998 to 2006, showed that nearly 1 in 10 children (9.8%) experienced at least 1 episode of homelessness, and nearly 1 in 4 (23.6%) experienced at least 1 episode of doubling up.[52] The recession declared in December 2007 had a powerful impact on the number of families seeking shelter. National survey data showed that in the aftermath of the recession, 44% of parents with household incomes below $30 000 reported difficulty managing family housing costs.[53] By the end of 2008, there was a 40% increase in family homeless shelter demand in New York City, a 32% increase in Massachusetts, and a 20% increase in Minneapolis.[54] US Education Department data for the 2010–2011 school year showed for the first time that more than 1 million homeless children were enrolled in US public schools, a 13% increase over the previous school year.[55] The National Center on Family Homelessness estimated the total number of homeless children in the United States during 2011 to be more than 1.6 million, or 1 child in 45.[1] Between 2011 and 2012, the number of homeless parents and children grew by 1.4%.[17]

An additional homeless population that is not typically counted as such is in emergency shelters typically open to women with children who leave their abusive partner. Domestic violence shelters may be multifamily dwellings not unlike homeless family shelters or safe-houses integrated within residential neighborhoods. Nationally, the point-in-time count of children in domestic violence emergency shelters and transitional housing in 2010 was 20 406.[56]

HUD found that on a typical night in January 2012, 37% of people in homeless shelters were parents and their children.[57] In December 2012, compared with 12 months previous, there was a 7.8% increase in the number of homeless families in Boston, Massachusetts; an 18% increase in Washington, DC; and a 22% increase in New York City. In New York City, this represented more than 21 000 children, or 1% of the city's children, sleeping in a homeless shelter.[58]

IMPACT OF HOMELESSNESS ON CHILD HEALTH AND WELL-BEING

Budget cuts aimed at deficit reduction for fiscal years

1983–1985 included a $13 billion projected savings because of changes to Medicare and Medicaid, and efforts to restructure the Medicaid program as a federal block grant.[59] The impact of reduced federal health sector spending was summarized in a 1985 *New England Journal of Medicine* column by Mundinger.[60] Funding for community health centers, a key component of the health care safety net on which the poor and uninsured relied, was reduced in 1982, resulting in the closure of 250 centers and the loss of a usual source of health care for 1 million people. By 1984, there was a 25% increase in the number of uninsured people compared with 1977. Budget cuts to supplemental nutrition programs were so severe that only one third of eligible pregnant women and young children received assistance from the Women, Infant and Child (WIC) Program. Nationwide, there were increases in late or nonreceipt of prenatal care and in incidence of anemia among pregnant women, increased rates of low birth weight deliveries, and increased incidence of preventable childhood diseases, including failure to thrive, diarrhea and dehydration, and anemia. One million children lost access to school breakfast and lunch between 1982 and 1984. In 1984, there was an increase in measles incidence, the first since the introduction of the vaccine in 1963.

This is the context in which studies of health status of children in homeless shelters were done during the 1980s. Although concerns have consistently been raised about the health status of homeless children, there have been different responses to the question as to whether their health problems are more severe than those of demographically similar but housed children or reflect health disparities that continue to disproportionately affect poor and minority children. Studies in the 1980s showed that homeless children were frequent users of hospital emergency departments (EDs), whereas contemporaneously an estimated 2 million predominantly minority children in single parent households, regardless of housing or insurance status, routinely used the ED as their usual source of pediatric care.[61]

Using retrospective medical chart review, Alperstein et al.[62] at the New York City Department of Health found that compared with housed low-income children, there were 4 times as many underimmunized homeless children. Rates of lead exposure and hospitalization were also higher among the homeless. Higher rates of immunization delay and iron deficiency anemia among homeless children were found in a 1991 study in New York City using similar methodology.[63] More than 10 years later, Weinreb et al.[64] found that although hunger and food insecurity were experienced by housed poor and low-income children, severe hunger was more prevalent among homeless children.

Researchers in Los Angeles, California,[65] found higher percentages of parents in homeless families rating their child's health as fair or poor compared with parents of housed poor children. Homeless children were also found to have higher rates of nutritional problems, as well as developmental and behavioral problems. In Seattle, Washington, Miller and Lin[66] found that homeless children sought care in hospital EDs at a rate 2 to 3 times higher than typical for the pediatric population and were less likely to receive preventive health care services, such as tuberculosis testing and measles vaccination.

In a series of studies, investigators at Children's Health Fund and Montefiore Medical Center in New York City reviewed medical charts using a consistent methodology for representative random samples of pediatric patients seen at a multisite Health Care for the Homeless program for 1988, 1998, and 2004.[35,67] Although up-to-date immunization rates were significantly lower for homeless children compared with housed children in 1988 and 1998, by 2004, the rates were similar. The 2004 asthma and obesity rates for homeless children were higher than the national rates, but these rates were consistent with those in many inner city communities. The greatest disparity between rates for homeless and housed low-income children was for behavioral health conditions, with 30% of homeless children aged 12 months to 19 years diagnosed with a developmental or psychiatric disorder, including 19% of infants and toddlers younger than 36 months. By comparison, at the time, 9% of infants and toddlers in New York City were identified as developmentally delayed and found eligible for Early Intervention Program services.

Behavioral Health

Some studies done during the 1980s had small and possibly nonrepresentative samples, and some relied on anecdotal evidence. A pattern nonetheless emerged of homeless children having disproportionately high rates of coexisting behavioral and academic problems. During the 1980s, many homeless children were unable to attend school. Lacking a permanent address, they were sometimes not permitted to enroll.[68] Aspects of the shelter experience were seen as contributing factors to the academic problems of homeless children who did attend school, including disruptions of education placement and teacher and peer group relationships, inadequate space to do homework, and transportation and other barriers to consistent attendance.[69–71]

Homelessness is an especially powerful negative life event for a child because it is generally associated with multiple stressors, including loss of property, disruption of school and community relationships, and dramatic changes in family routine.[72] Studies by Bassuk and Rubin[73] and Bassuk[74] in the Boston area showed that half of homeless school-age children met criteria for a diagnosed psychiatric disorder based on screening with a standardized instrument. Children who screened positive for symptoms of depression frequently had symptom severity exceeding that of children treated for depression at community clinics.

In studies done in Los Angeles shelters,[72,75] 78% of school-age homeless children had a psychiatric, behavioral, or academic problem. Their mean age upon becoming homeless was 7.6 years. Based on standardized measures, their academic problems were reflected in vocabulary deficits (47% scoring at or below the 10th percentile) and reading delay (39% severely delayed). Psychiatric disorders were reflected in 37% screening positive for symptoms consistent with depression. Although 45% of the children met criteria for special education

eligibility, only 22% were referred for an evaluation and special education services.

Young children were especially vulnerable to the negative developmental impact of homelessness. In a 1991 study conducted at a day care center located within a New York City shelter, 75% of 3- and 4-year-old children had delayed speech and language development and behavior characterized by hyperactivity and inattention at the time of enrollment in the center. For most of these children, functioning improved to near-typical range as they were exposed to age-appropriate materials and activities in this comprehensive full-day early education program.[76]

When investigators compared the academic and psychosocial functioning of homeless children to that of demographically similar but housed children, the results were mixed. In a study of the developmental status of homeless compared with low-income domiciled infants and toddlers, Garcia Coll et al.[77] found no differences in cognitive or motor development using the Bayley Scales of Infant Development. Toddlers older than 18 months scored lower than did infants, suggesting that the factor affecting development for these young children was poverty rather than homelessness and that impact of poverty was cumulative over time. In Los Angeles, Wood et al.[65] found a near-significant difference in percentage of children with school problem behavior compared with homeless and domiciled poor children (30% vs 18%; $P = .06$). No significant differences in rates of school problems for homeless and housed children, however, were found by Ziesemer et al.[78] in Wisconsin. These investigators also found considerable variation in the functioning of homeless children, with about one fourth achieving a level typical for age. Homelessness was viewed as a risk factor, one of many adversities experienced by children growing up in poverty.

Subsequent studies explored the role of school absenteeism and changes in enrollment on academic achievement.[79–81] When school absenteeism was similar among homeless and domiciled poor children, their scores were also similar on standardized tests. The greater risk for homeless children emerged in terms of changes in school enrollment associated with residential instability and shelter placements distant from their community of origin.

The higher rates of developmental, academic, and behavioral problems found in studies of homeless children during the 1980s might at least partly have reflected the impact of harsh shelter conditions families experienced at that time. In many homeless shelters across the country, families were not allowed to stay indoors during the day and could not return until early evening in any weather conditions.[82] Hazardous levels of lead dust were found in a New York City shelter that housed families with young children.[83] At a New York City shelter that housed 440 families with more than 1000 children on any given night, rooms were as small as 130–180 square feet and furnished with a bed, desk and dresser.[76,84]

The findings of nutrition deficits for homeless children in the 1980s and 1990s might also reflect shelter conditions. A 2000 national survey of homeless shelter administrators revealed that rooms with a kitchen were provided in only 24% of shelters.[85] Fewer than half of the shelters provided a shared kitchen. Sixty percent of shelters did not allow families to store food in their room; 20% did not allow storage of infant formula.

Improvements in shelter conditions such as abandoning the worst shelter models (e.g., congregate shelters with cots lined in rows and families alternating with homeless single adults)[5] coincided with a narrowing of the gap between homeless and other low-income children. Kerker et al.,[86] in a study of homeless children in New York City in 2001–2003, attributed their health problems not to homelessness but rather to the periods of residential instability and substandard housing that typically preceded episodes of homelessness. Some of the same supportive services implemented at homeless shelters have been recommended for vulnerable children and families in permanent housing.[87] This is consistent with the notion that many of the social and environmental stressors associated with homelessness have become integral to contemporary poverty.[52] In his 2008 literature review, Buckner[88] concluded that homeless and domiciled poor children similarly faced multiple adversities that might compromise their health and development, complicating the identification of a specific effect to be attributed to the experience of homelessness. Similarly, Shinn et al.[89] found no significant differences in cognitive functioning and school achievement between formerly homeless and never-homeless domiciled peers. Both groups scored below the norm on standardized tests.

Multiple Stressors, Cumulative Stress, and Toxic Stress

The impact of multiple stressors on children was revealed in studies of children in domestic violence shelters because they were likely to have been exposed at minimum to family violence and homelessness. In a New York City study, investigators at the Children's Health Fund and Montefiore Medical Center linked health records for children and their mothers, who were seen as patients during 2004 in a comprehensive mobile health care program serving families at New York City domestic violence shelters.[90] Twenty percent of the children were diagnosed with a developmental delay or learning disability, and 23% were diagnosed with a psychiatric disorder. More than half (54%) of the mothers were diagnosed with a psychiatric disorder, including 35% with depression. Prevalence of child developmental and psychiatric diagnoses was significantly higher among children whose mother was diagnosed with depression (60% vs 34%; $P < .01$). These findings illustrated the cumulative impact of multiple stressors and the importance of accounting for confounding factors independently associated with compromised developmental outcomes before attributing child developmental, behavioral, and academic problems to homelessness.

There are several evidence-based conceptual frameworks to explain the impact of multiple psychosocial stressors including homelessness, domestic violence exposure, and maternal depression on child development. One is that these stressors have an additive impact.[91] In this framework, homeless children are viewed as having high rates of developmental, academic, and behavioral problems because homelessness is associated with other adverse events, and together these stressors have a cumulative negative impact on the developing child.

Toxic stress is a term that has been applied to a child's experience of strong, frequent, or prolonged stressful events without the mediating intervention of a supportive adult.[92] Exposure to toxic stress is associated with a heightened risk of developmental or psychiatric disorders and with health problems, including later development of chronic conditions. Maternal depression may be associated with the child's experience of other psychosocial stressors as toxic stress because depressed parents are often less available to act as mediators to buffer the child's stress reactions and support positive coping and resilience.[93] In both formulations, homelessness is one stressor among many, and outcomes may be similar for children exposed to multiple stressors or toxic stress and who were never homeless.

FAMILY HOMELESSNESS AND PUBLIC HEALTH POLICY

This review began with the observation that the preponderance of articles and reports on family homelessness were published in 1980s and 1990s, raising the question, "Is this literature still relevant for public health planning?" We concluded that the descriptions of the economic and public policy conditions associated with the rise of family homelessness have subsequently continued and are relevant 25 years later. These economic forces—wage stagnation, housing inflation and disinvestment in affordable housing, shortage of affordable child care—have led to a situation where homelessness has become integral to contemporary child and family poverty. Especially since the recession of 2009, homelessness has more generally affected low-income families, and the number of homeless families and children has increased to a record high.

There was less current relevance for many studies of the health and mental health of homeless children and their mothers from the 1980s and 1990s. Much of this literature reflected psychosocial factors associated with homeless shelter entry and the harsh shelter conditions endured at that time by homeless families. There was also a consistent problem of health and developmental outcomes that were attributed to homelessness without controlling for confounding variables that were ubiquitous in the population, such as domestic violence and maternal depression.

Children who enter the shelter system typically come from the poorest areas and neighborhoods in their city or town.[94] This is reflected in their having health indicators similar to domiciled poor children and in studies that show little difference between the 2 populations. Although health disparities must be addressed in poverty communities, it does not follow, as has been advocated, that services to improve health care access are unnecessary for children and families in homeless shelters.[86] It is notable that the study on which that recommendation was based focused on health issues for which data were readily available to investigators at a department of health, such as mortality and tuberculosis, rather than on ambulatory care–sensitive conditions like asthma. The high prevalence of asthma among children entering the New York City shelter system underscores the need for facilitated access to health care for children in shelters.[95] Despite the narrowing of the gap for health conditions between homeless and domiciled low-income children, there continue to be higher rates of unmet health care needs and ED use among homeless compared with housed low-income families, indicating problems in access to timely health care services.[96] The American Academy of Pediatrics recommends that primary care providers address issues of access to care and psychosocial stressors, and coordinate health care with community-based services.[97]

Providing health services during times of residential instability can prevent interruptions in preventive, acute, and chronic care, improving health status and reducing hospitalizations and ED use.[98,99] This has the additional public health benefit of reducing ED overcrowding that may delay care to patients with urgent and emergent problems.[100] Facilitating access to health care services for homeless families also contributes to the prevention of population-level problems emerging from their inadequate access to preventive health care services. A 2011 measles outbreak in Minnesota, for example, was attributed to low vaccination rates in the community and exposures in a homeless shelter.[101]

The high rate of nutritional problems among homeless children in part reflects the difficulty homeless families have in preparing adequately nutritious meals. This problem may be addressed by developing linkages between shelters and supplemental nutrition programs, including food pantries, and by monitoring the nutritional content of meals and snacks provided at shelters.[102]

Although the gap between homeless and housed low-income children for medical conditions has narrowed, increased need for mental health services has not. Mental health service needs often persist well after an episode of homelessness has been resolved with community housing.[103] For homeless, formerly homeless, and other vulnerable children, mental health services should be an integral component of primary care in an enhanced medical home model; that is, primary care that is comprehensive, coordinated, continuous, and augmented by facilitated access to specialists consistent with the special needs of homeless pediatric populations.[104,105] The pediatric mental health professional workforce has fallen far short of need for decades, and it is projected that in 2020 there will only be about 66% of the needed child and adolescent psychiatrists practicing nationwide.[106] Rural and inner city poverty communities, where the need for mental health services may be greatest, are especially affected by this shortage.[107]

In studies of homeless children over time, academic problems emerged as being related more to disruptions of attendance and education placement for any reason, including residential instability rather than to homelessness, which emerged as one risk factor among many associated with lower academic achievement.[108,109] For homeless children, however, continuing advocacy is necessary to ensure school enrollment and regular attendance. Despite the protections of the McKinney-Vento Act, law suits were necessary to re-establish the rights of homeless children to attend school in 2 states in 2004 and 2007.[110]

Supportive interventions for parents in homeless and domestic violence shelters can be predicted

to help prevent or ameliorate developmental, psychiatric, and health problems among homeless children by reducing stress and providing parents with timely interventions for mental health problems. Programs should focus on interventions that improve parental self-efficacy and sense of autonomy, which may be undermined by shelter placement and loss of control over many aspects of family life and child rearing.[111] Homeless families frequently need concrete services such as re-housing assistance, referrals for health and related services, help with entitlement programs, job training and placement, and legal assistance for issues including custody, orders of protection, immigration status, etc. Case management can effectively facilitate access to these services.[112] The ubiquity of adverse events in the lives of low-income children and families indicates that many of these same steps should be taken for vulnerable but housed children and families, including routine screening for psychosocial stressors at pediatric visits.[113,114]

A potential model for homelessness prevention was implemented using federal stimulus funding as the Homeless Prevention and Rapid Rehousing Program. Vulnerable families were provided economic assistance to manage rent and utility costs while housed, and homeless families received help finding housing. Short-term rental assistance was provided with the assumption that families would become economically stabilized and able to independently sustain ongoing housing costs. The program ended September 30, 2012.[115,116]

The importance of rent subsidies has been consistently demonstrated in practice. Multiple research studies demonstrated their value in facilitating the transition from homelessness to sustainable community housing.[117–119] Ensuring that families can maintain housing is not only important to child and family well-being but also protects investments in shelter costs and supportive services.

The deleterious impact of massive cuts to federal nondefense domestic spending was clear from public health data during the 1980s. Many of the same cuts to supplemental nutrition programs and Medicaid were included in the House of Representatives Fiscal Year 2013 budget.[120] The recession illustrated the importance of maintaining the flexibility of Medicaid to accommodate children who lost commercial health insurance to maintain child health coverage and access to health care. This would be lost if Medicaid were to become a block grant with a state spending cap.[5] Specific to homeless children and families, a carve-out from Medicaid managed care is recommended because re-location to a shelter frequently disrupts established health care relationships. Issues of distance, transportation, and travel time may complicate continuity of care. Network restrictions may prohibit use of accessible health care resources and reimbursement to providers of health care for the homeless, undermining their financial stability.[121]

CONCLUSIONS

A review of the literature on child and family homelessness during the past 25 years revealed several discordant trends. Income inequality increased. Child poverty remained virtually the same. There was no change to the government disinvestment in affordable housing. Housing costs consumed an often unmanageable proportion of the income of poor and low-wage earning families, and have been steadily rising. Family homelessness has become more prevalent and has affected poor and low-income families more generally than in the 1980s, when the homeless heads of household frequently had personal vulnerabilities such as depression or other mental illness. Nonetheless, there has been less attention to the issue of child and family homelessness than in the 2 previous decades. This is reflected in fewer research studies, government reports, print, and broadcast stories and in less political attention to children and families in poverty. There is evidence that interventions such as rent subsidies can help prevent homelessness and that shelter-based services can reduce its burden for affected families. It is an important public health role to implement these programs where needed and to provide facts and evidence to policymakers to help stem the increase in child and family homelessness. ■

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R. Grant was the lead writer of the initial and final versions of this article. He contributed substantially to its conception, including posing research questions, developing inclusion criteria, and comprehensively reviewing the literature. D. Gracy contributed to the initial writing and revision of this article, including editing of the final version. She contributed substantially to the literature review, especially regarding medical and mental health issues. G. Goldsmith contributed substantially to the initial writing and revision of this article. She contributed substantially to the literature review process in locating credible sources and synthesizing often contradictory information, especially regarding public health data. A. Shapiro contributed substantially to the initial writing and revision of this article. He contributed substantially to the literature review, especially regarding the health care needs of homeless children and families and public health implications and recommendations. I. E. Redlener contributed substantially to the initial conceptualization and writing of this article, including its historical scope and development of research questions. He contributed substantially to the literature review, especially regarding the public health implications of child and family homelessness. All of the authors approved the final version of this article.

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