

**ANOTHER PIECE OF BAGGAGE:
A LITERATURE REVIEW AND DATA ANALYSIS ON THE NEEDS OF YOUNG,
HOMELESS CHILDREN IN EMERGENCY SHELTER PROGRAMS**

by

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ABSTRACT

Young children residing in homeless shelters with their primary caregiver are at an increased risk for negative mental and medical health outcomes, including asthma and depression, as well as an increased likelihood to fail a grade and higher rates of emergency room utilization. The Adverse Childhood Experiences (ACES) study suggests that the more traumatic experiences a child has, the higher the likelihood that he will have poor health as an adult. A literature review of interventions through PubMed and the National Registry of Evidence-Based Programs and Practices in December 2013 and January 2014 showed a need for evidence-based interventions that specifically target homeless children. Qualitative interviews conducted by the University of Pittsburgh's Office of Child Development provided insight into the needs of staff and mothers involved with two shelters in Allegheny County, Pennsylvania. Staff expressed a need for more funding, and mothers wished that the shelters provided more child-centered services for their convenience. In order to increase programming for homeless children, it is necessary to increase funding at the local, state, and federal level. Providing more mental health services in shelter would help children adjust to the transition and decrease the risk of negative public health outcomes in adulthood.

TABLE OF CONTENTS

PREFACE.....	VIII
1.0 INTRODUCTION.....	1
1.1 UNIVERSITY OF PITTSBURGH OFFICE OF CHILD DEVELOPMENT	3
2.0 TOPICS RELATING TO AMERICA’S HOMELESS CHILDREN.....	5
2.1 HOMELESS WOMEN WITH CHILDREN IN AMERICA.....	6
2.2 HOMELESS YOUNG CHILDREN IN AMERICA	7
2.2.1 Adverse Childhood Experiences Study.....	8
2.2.2 Mental health of America’s homeless children.....	9
2.2.3 Physical health of America’s homeless children.....	10
3.0 METHODS	14
4.0 RESULTS	19
4.1 WHAT PROGRAMS WORK – AND WHY.....	19
4.2 OFFICE OF CHILD DEVELOPMENT INTERVIEWS	22
4.2.1 OCD staff interviews	23
5.0 DISCUSSION	30
6.0 CONCLUSION.....	33
6.1 LIMITATIONS.....	34
6.2 FUTURE DIRECTIONS.....	35

6.3	CLOSING	38
	APPENDIX A : STAFF IINTERVIEW FORM	39
	APPENDIX B : PARENT INTERVIEW FORM	43
	BIBLIOGRAPHY	45

LIST OF FIGURES

Figure 1. Homeless children experience many stressors, which begins from a young age	5
Figure 2. Burdens of homeless mothers include both past trauma and current stressors	7
Figure 3. Maslow's hierarchy of needs highlights how a homeless family often struggles to fill the lowest rung.....	11

PREFACE

My parents deserve the first acknowledgement. After Bill Needle and Mary Ward, I would like to thank my thesis committee: Mark Friedman, Martha Terry, Rachel Fusco and Joan Eichner. While I have appreciated all of their contributions to this thesis, I would like to single out Mark Friedman, who has been an amazing cheerleader on this three-year marathon to a joint degree. I would also like to acknowledge the University of Pittsburgh Office of Child Development, which collected the interview data and was gracious enough to let me use it for my thesis. Finally, I acknowledge the staff at the Pittsburgh Mercy Family Health Center, where I completed my concentration field placement this year. To my supervisor, Sue Puhala, and medical director Dr. Todd Wahrenberger: thank you for taking on your first MSW intern – truly, I am forever grateful.

This thesis is dedicated to my uncle Michael, who lost his leg to peripheral vascular disease and found his humanity along the way. If he can keep fighting after that experience, I can finish my thesis. Also dedicated to T.M.R., who changed my life with a freckle faced smile. I'm still rooting for you.

1.0 INTRODUCTION

Early childhood is stressful. From learning to effectively communicate wants and needs, to negotiating toilet training, and discovering preferences on everything from food to music, there are many changes that take place from birth to age six. It is paramount that a child has a stable, nurturing environment to begin and successfully sustain the growth process. Although environment and biology are factors in determining some circumstances in childhood, such as learning disabilities and mental health, a consistent childhood during which the parent(s) are adequately employed and able to provide supportive resources will go a long way to address developmental concerns and other problems that may arise.

Unfortunately, large numbers of children grow up without a permanent home (Fazarri, 2011). Due in large part to the Great Recession, the period of economic stagnation from late 2007 to the summer of 2009, homelessness among young children has reached nearly epidemic proportions. About 1.6 million children were homeless in 2010, which represented a 33% increase from 2007 (National Center on Family Homelessness, 2010). Major publications such as the *Washington Post*, the *Christian Science Monitor*, and the *Pittsburgh Post-Gazette* ran stories featuring homelessness among school-age children in October 2013.

There is no fixed definition of homelessness, but some governmental departments have created classifications to help manage their programs. The United States Department of Housing and Urban Development (HUD) states that a homeless person is:

An individual who lacks a fixed, regular and adequate nighttime residence; or an individual who has primary nighttime residence that is: (1) a supervised publically or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (2) an institution that provides a temporary residence for individuals intended to be institutionalized; or (3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (2012, pg. 1).

Interestingly, this definition does not include children who are living in supportive housing programs, such as the YWCA's Chrysalis Program or Sojourner House's MOMS. These programs provide transitional housing for mothers, who often have a dual diagnosis of addiction and mental illness, and allow them to live with their children while receiving supportive services to promote recovery and family cohesion. It is important to note that although some states have created their own categories for homelessness, the Commonwealth of Pennsylvania recognizes the above definition.

Given the sharp increase of homelessness among young children and their complex needs, this thesis presents a comprehensive literature review to describe Evidence Based Interventions (EBI) and uses data from the University of Pittsburgh Office of Child Development (OCD) to explore what parents living in emergency shelters with young children want from shelters and how shelter staff believe they can intervene with homeless families. The purpose of this thesis is to identify literature that has already been published on young homeless children in shelters and also identify programs that have been effective for serving homeless children to make recommendations for OCD and its partner shelters for more effective interventions. The thesis introduces OCD and identifies the difficulties that homeless children and their mothers face, including mental health stressors and physical health problems, both in childhood and adulthood. The methods used to collect the literature and EBIs is discussed, along with what programs work and why, and an explanation of Evidence-Based Interventions. There is also an

analysis of the qualitative interviews done with OCD staff and parents, a discussion on findings, and the limitations of the research. There are also suggestions for both future research and for future practice, and a closing that sums up the thesis.

1.1 UNIVERSITY OF PITTSBURGH OFFICE OF CHILD DEVELOPMENT

Before discussing some of the problems that homeless children face, it is important to give an introduction to one of the main agencies working to address their needs. OCD offers a wealth of information for the Pittsburgh community looking for resources around the well being of young children. Its website states that OCD is a "...University-community partnership whose mission is to improve the lives of children, youth and families at risk.... with collaborations across practice, program evaluation, and policy" (OCD, 2013). OCD seeks to address the trauma that young children experience while homeless by partnering with the Education Law Center. In January 2012, the partnership received two-year grants from The Heinz Endowments and the Allegheny County Department of Human Services to expand programming for young children and their families pertaining to infant mental health and housing stability. OCD also provides consultation services for families in emergency shelter programs; improves access to quality early childhood services such as Nurse Family Partnerships and Head Start; partners with family housing programs to educate parents about strengthening the parent-child bond, and tries to implement policy to address the needs of young children.

OCD implemented an Early Childhood Mental Health Consultation (ECMH) model in housing programs in Allegheny County, which is a parent-centered collaboration between a mental health professional and a parent who was experiencing homelessness. The ECMH

acknowledged that the parent is the expert on her child, performed an Ages and Stages Questionnaire (ASQ), an assessment tool for children under age six, and developed an intervention plan. The program involved a specialized referral to a mental health professional or intervention from the OCD employee if the parent's concern could be resolved in five visits. Through talking with mothers in these programs, the OCD professionals found that the top three reasons for a child referred for this service are aggression, behavior and developmental delay, and this is not uncommon among homeless, young children.

Unfortunately, because OCD only had pilot funding, the program has been discontinued. However, as a result of OCD findings, Joan Eichner, Director at the Division of Applied Research and Evaluation, presented at the Institute for Children, Poverty and Homelessness Conference in January 2014. Her lecture focused on how advocates for homeless children can apply research to the field, and how early intervention is necessary to reduce stress in young children in crisis. OCD still has a strong dedication to advocating for homeless children, even when funding is unavailable.

2.0 TOPICS RELATING TO AMERICA'S HOMELESS CHILDREN

When discussing homeless children in America, literature can be separated into articles addressing mental health outcomes and those addressing medical health outcomes. Homeless children have numerous stressors at critical periods of development (Figure 1), which can contribute to the mental and physical health problems in childhood and beyond. In this section, some of the consequences of housing insecurity in childhood are discussed to provide a more comprehensive view of how important it is to provide effective early intervention programs for these families. If these children continue to fall through the cracks, the current and future public health repercussions will be severe.



Figure 1. Homeless children experience many stressors, which begins from a young age

Source: OCD PowerPoint presentation

2.1 HOMELESS WOMEN WITH CHILDREN IN AMERICA

As noted above, several media outlets have written about the plight of the homeless American family. Who is this homeless family showing up in newsprint, on the Internet, and on the televisions of those who are fortunate enough to be housed?

A family experiencing homelessness is typically a mother in her late twenties with two children (Burt et al., 1999). Because a young mother is more likely to be the head of a homeless family, her children are more likely to be younger. Many studies have found that about half of all homeless children are under the age of six, and about 80% of families experiencing homelessness are female-headed (Office of Community Planning and Development, 2007).

Over 92% of homeless mothers have experienced severe physical and/or sexual abuse in their lifetime, and an intimate partner was the perpetrator in about two-thirds of the cases (Melnick & Bassuk, 1998). About 50% of these mothers had experienced a major depressive episode since becoming homeless, had three times the rate of Post Traumatic Stress Disorder (PTSD), and had twice the rate of drug and alcohol dependence than their matched housed peers (Goodman et al., 1999). As a result, one-fifth of homeless children are separated from their primary caregiver and placed in either foster care or kinship care, which is foster care where the placement is with a family member (The National Center on Family Homelessness, 2010).

Frequently, mothers of children in homeless shelters have experienced a lifetime of instability. When they enter a shelter, they walk in with their possessions, but also the “baggage” that comes from years of chaos and trauma (Figure 2). It is likely that these mothers spent time in foster care as children, and that they grew up in a home with substance abuse (Bassuk et al, 1996). Metaphorically, it is difficult to successfully run a race when these women are not even starting on the same track as women who are in stable homes.



Figure 2. Burdens of homeless mothers include both past trauma and current stressors

Source: OCD PowerPoint presentation

2.2 HOMELESS YOUNG CHILDREN IN AMERICA

As was previously discussed, there are 1.6 million homeless children in America, which is about one in 45 children experiencing homelessness every day of every year. They are at increased risk for a host of mental and medical health problems, such as asthma and anxiety (National Child Traumatic Stress Network, 2005). Eighty-five percent of homeless children attend grade school, but they are significantly underrepresented in preschool programs (Office of Elementary and Secondary Education, 2006). This is problematic, because the same report states that 42% of homeless children are under the age of five. Quality education is a protective factor against stress, and public health experts realize that there is some correlation between childhood trauma

and negative health outcomes as an adult. Due to the circumstances that cause children to move into shelters, homeless children can experience several types of trauma on a daily basis.

2.2.1 Adverse Childhood Experiences Study

The Centers for Disease Control and Prevention (CDC) and collaborators have implemented a public health study that asks adults what negative events they experienced as children and about their current health status. This groundbreaking research is called the Adverse Childhood Experience (ACE) study, and it has provided valuable information for both the investigators and health professionals. Each of the ACEs have demonstrated associations with a child's likelihood to experience negative experiences as an adult; the 10 ACEs are emotional, physical, or sexual abuse; emotional or physical neglect; and growing up "in a seriously dysfunctional household" as evidenced by witnessing domestic violence, alcohol or other substance abuse in the home, mentally ill/suicidal household members, parental marital discord, and crime in the household, which is measured by having a household member incarcerated (Anda et al., 2006). Although homelessness is not one of the 10 ACEs, several studies include homelessness in young childhood as an adverse childhood experience because many research participants mention an experience with homelessness in childhood (Montgomery et al., 2013).

Individuals were shown to have greater risk for more problems if they had more difficulties in childhood, as compared to those who had fewer ACEs. Examples of negative health outcomes are heart disease, chronic lung disease, liver disease, and HIV/STDs (Anda & Felitti, 2006). All of these health problems have roots in substance abuse and risky sexual behavior (Hillis et al., 2000). Substance abuse and sexually transmitted infections (STIs) are

discussed as a public health crisis, but we are less likely to discuss substance abuse as a coping mechanism, or risky sexual behavior (including sexual activity without adequate protection or prostitution) as a means of survival (Hillis et al., 2000). Homeless children are at risk for all of these experiences, and even though homelessness is not one of the 10 ACEs that researchers asked about on the survey, a homeless child is at a high risk for experiencing problems with illicit substances because of the likelihood that his parent abused substances when the child was growing up (Stein, Leslie & Nyamathi, 2002). It is important to note that the investigators on the ACEs study found that all of the experiences are highly interrelated, and it is unlikely that a child will experience just one of the ACEs. Social problems are deeply intertwined, and homeless children are right in the middle.

2.2.2 Mental health of America's homeless children

A child who moves into a homeless shelter has left his home for a strange place with a different bed and many new caregivers. As a result, many homeless children struggle with mental health problems from a young age. Homeless children have three times the rate of emotional and behavioral problems compared to non-homeless children (National Child Traumatic Stress Network, 2005). Homeless children experience loss of sleep, frequent illness and hunger, which contribute to medical health problems but can also manifest themselves emotionally through obstinate, cranky or “out-of-control” behaviors (The Institute for Children and Poverty, 1999). Many children are likely to be labeled as “difficult” or “wild,” due in part to the lack of stability of a permanent residence, and that label will persist through school, employment, and institutions that the child might encounter (National Child Traumatic Stress Network, 2005). It is important to recognize the impact that a label like attention-deficit hyperactivity disorder (ADHD) can

have on a child who has problems listening in class, frequently disrupts the teacher, or cannot focus on one task at a time. Diagnosing a child with ADHD while he is experiencing homelessness or another traumatic time labels him as being an unruly “problem” that needs to be dealt with, instead of a child whose family is going through a difficult time. Unmet mental health needs in childhood can lead to adults who are poorly prepared for integrating into society without engaging in “deviant” behaviors like illicit drug use and illegal activity (Edwards et al., 2003).

The young children coming into shelter settings often do not understand why they are there. They communicate their fear and anxiety through “acting out” behaviors, which place more burdens on their mothers. Young children learn behaviors through modeling the behavior of the adults around them, and oftentimes, the young mothers in their lives are suffering from PTSD or other mental health problems (Buckner et al., 1999). In this way, even if the mother thinks that her child will not remember the trauma of homelessness or domestic violence, PTSD is still passed down through the generations. It can be as cyclical as poverty itself.

2.2.3 Physical health of America’s homeless children

It is understandable how a mother experiencing homelessness could forget her child’s immunization schedule, yearly physical, or dental appointment. When her primary focus is survival, these preventative measures are a luxury. To illustrate this point, consider Maslow’s hierarchy of needs (Figure 3).



Figure 3. Maslow's hierarchy of needs highlights how a homeless family often struggles to fill the lowest rung

Source: Simplypsychology.org

Maslow's hierarchy of needs theorizes that it is impossible to move onto the next stage of development without accomplishing the basic tenets of survival (Maslow, 1943). Therefore, it is difficult to satisfy the higher levels of the pyramid when the basic needs, such as shelter and security, are frequently disrupted in a shelter setting. Safety is a constant struggle, and self-actualization is difficult to achieve.

A New York City-based study from the late 1980s performed retrospective chart reviews on 265 homeless children who were younger than age five and received care from St. Luke's-Roosevelt Hospital Pediatric Primary and Ambulatory Care Clinic. The control group was a group of children who were roughly the same age, attending the same clinic, but who had a home of their own. The proportions of homeless children with elevated lead levels, rates of reports of child abuse and neglect, and hospital admissions were higher than those in the comparison

groups; difference in immunization delay was substantial (Alperstein, Rappaport & Flanigan, 1988).

Homeless children use the emergency room at a rate that is two to three times higher than the general United States pediatric population, are twice as likely not to be properly immunized for their age, and are twice as likely never to have been tested for tuberculosis, which is relevant because tuberculosis is most prevalent in crowded living conditions, like homeless shelters (Anda & Felitti, 2006). One study based in Washington state found that nearly half of the 158 children in 82 homeless families had a "...wide variety of reported acute and chronic health problems" (Miller & Lin, 1998, pg. 670) and were four times more likely to report only "fair" to "poor" health than the general pediatric population. Thirty-five percent had no health insurance, and 59 percent had no identified primary care provider (Miller & Lin, 1988).

Admittedly, these study findings are more than 25 years old. But what do we do when these numbers have not improved? Mothers of homeless children are still more likely to report that their children are in fair or poor health compared to housed children, even if the housed children are in a comparable socioeconomic status (SES). Homeless children have more acute sicknesses, such as fevers, ear infections, and diarrhea, even after controlling for potential explanatory factors (Weinreb, Goldberg, Bassuk & Perloff, 1998).

Homeless children get sicker more frequently than their housed peers. Homeless children are held back a grade more frequently than their housed peers (National Center on Family Homelessness, 2010). They go on to live in society, and the cost of ignoring their mental and physical health is staggering. These children have had adverse developmental experiences as a result of trauma, will be more impulsive and more likely to show symptoms that appear to be ADHD or oppositional defiant disorder (Perry & Pollard, 1998). This increased impulsivity can

lead to higher incarceration rates, increased rates of substance abuse, and increased rates of abusing their own children (Goodman et al., 1999). Ignoring the problems of homeless children will have an increased cost later on. It pays to care about these kids.

3.0 METHODS

There are hundreds of articles on health problems, educational difficulties and developmental delays in homeless children, but there were only a handful of articles that discussed interventions that targeted these families. This chapter describes the process for finding effective behavioral interventions (EBIs) for families in homeless shelters, or at least programs that address parental trauma and the impact on the mental health of young children. Specifically, “An Evidence-Based Intervention is a prevention service (program, policy or practice) that has been proven to positively change the program being targeted. In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation” (Beaudry, 2013, pg. 1). To achieve this, evidence needs to be collected through an evaluation process when a targeted intervention is implemented to determine whether or not this intervention has positively impacted the original problem. There are three types of EBIs, as described by the Strategic Prevention Framework (SPF):

1. Included in the federal registries of evidence-based interventions; 2. Reported (with positive effects on the primary target outcome) in peer-reviewed journals; or 3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts. (Beaudry, 2013, pg. 1).

Information about EBIs came from accessing the National Registry of Evidence-Based Programs and Practices in December 2013 and January 2014. The search terms used were “children,” “families,” and “homeless.” Searching for “families” returned 86 results; searching for

“children” returned 133 results, and searching for “homeless” returned 18 results. These programs to be reviewed were not designed for use in shelter settings, although some of them have been adapted for use in that situation.

3.1 LITERATURE SEARCH

PubMed proved to be the most valuable resource for finding peer-reviewed research. Search terms included “assessment OR questionnaires OR evaluation OR outcomes,” “child OR children OR preschool OR “elementary school,” “adolescen* OR youth OR teen* OR runaway OR ‘foster care,’” “search within results for ‘homeless,’” “ limit to United States,” and then adding homeless* or shelter* to identify articles. Some articles were excluded because although the study’s researchers were American, the study was not based in America. Also, articles were excluded if the children in the study were older than first grade. It has been discussed how the majority of homeless children are under age six, and many studies discussed children who were in kindergarten or first grade. If the children were any older, they would not be appropriate for this review. There were many studies that came up about nutrition for young children in homeless shelters, which were excluded, and it was difficult to avoid articles about foster care, which were also excluded. The search yielded 25 results.

Out of these 25 results, there were many studies on foster care that took place with homeless children, which were not relevant for this thesis. There were also several interventions that did not address the mental health needs, such as programs that seek to address language delays and nutritional needs among children in emergency shelters. The only relevant

intervention is a domestic violence-related intervention developed for use in shelter-based clinics. The program has not yet been implemented, but the nurse care manager would use motivational interviewing to empower women to make informed decisions about the health and well being of themselves and their children (D’Amico & Nelson, 2008). There were no mentions about when this program would be rolled out or where the shelter was located.

3.2 DATA COLLECTION

The second part of the thesis is a presentation of data that Pitt’s Office of Child Development collected. In 2013, OCD staff members conducted eight interviews with mothers and six interviews with staff on-site at two homeless shelters in Allegheny County. Two different interview forms were used (see Appendices A and B). The mothers were asked about the programs provided, what programs mothers would like to see, and how the available programming in the shelter helps their children. They asked the mothers what their experiences had been like in the shelter, what had been hardest about being in shelter, and if there were anything that the shelter could have done to better serve both the mother and her child or children. Sample questions included, “Please think about how you were parented as a child: How has this impacted the way you parent?” “What worries you most about being a parent?” and “Please think about the physical space and center’s rules and routines. How family and child friendly is the space? What would make it better?” Interviewers asked the staff about what

supports they provide for the mothers, what they provide for the children, and what they wish they could provide.

Two Pitt OCD staff members conducted the interviews: Janell Smith-Jones, PhD, and Andrea Rudek, MSW, who worked for Pitt OCD's Division of Applied Research and Evaluation when they were conducting the interviews. Both had interview experience with many different populations throughout their careers. Both of the interviewers had input on creating the interview guide, as did Joan Eichner, Children's Policy Director for OCD. The team was looking for specific themes to be discussed when they created the interview guide, rather than creating open-ended questions for the mothers to discuss whatever they wished. For example, the interview guide asked mothers specific questions about their experiences as children and what services with which they had been connected since coming to the shelter, instead of asking the mothers to discuss their experiences in shelter without direction.

The interviewers documented the responses on the interview forms as they interviewed participants. Originally, the interview guides had adequate space for taking notes, but these have been deleted for this thesis. The interviewers reviewed their notes after the conclusion of the session to clarify statements. Next, one undergraduate and one graduate student electronically transcribed and reviewed the interview notes. Finally, the evaluator reviewed the transcriptions for clarity and accuracy, removed all identifiers (names, program locations) and assigned identifying codes for the interviewees, program sites and interviewers.

OCD assigned codes to the shelter programs and did not release the names of the interviewers or interviewees, not even staff members. The reasoning behind protecting confidentiality is obvious when talking about the mothers in the programs, but not as much for staff – what is the harm in using names to talk about what the staff had to say? There are a

couple reasons. First, staff members were more comfortable with sharing their opinions when they were guaranteed anonymity. Also, the shelter programs served women fleeing domestic violence situations. These shelters usually guard the names of their staff, just like they do not disclose the location of their shelter; both could be targets for jilted partners seeking revenge.

4.0 RESULTS

Searching for “homeless children” on the EBI database yielded only five results, and none of the programs had been developed expressly for young children living in homeless shelters. The programs that came up through PubMed were sparse, and included programs for better nutrition, better language development and implementing a nurse care manager for families in the shelter. There was nothing about programs to increase a child’s self-esteem, to address a mother’s coping skills, or to address the bond between mother and child, which could have been disrupted from addiction, IPV, mental illness, or all of the above.

4.1 WHAT PROGRAMS WORK – AND WHY

For a young child, family had the most impact on development. When talking about children who are as young as those in family homeless shelters, it is impossible to intervene with a child without also intervening with the mother (Maguin et al., 2007). These young children are completely dependent on their mother to have their needs met; parents are a child’s first exposure to interpersonal relationships. Therefore, those programs that provided services for both the parent and child were best at addressing the complex, interwoven needs of mothers and their young children.

As was previously discussed, these mothers experience increased levels of depression, anxiety, substance abuse and IPV. The literature suggests that the mothers likely have been in treatment at some point in their lives, but that it was disrupted because of foster care placement, change of residence, or transportation difficulties (Bassuk et al, 1996). To decrease stress in the young child, it is important to address the mother's coping skills and communication patterns, which lead to better interpersonal communication and less need for harsh discipline from the parent (Kumpfer et al., 2007).

4.1.1 Evidence-based programs

The Curriculum-Based Support Group (CBSG) Program originated in Texas in the 1980s and was first used in community-based settings before being introduced to school settings. It has since been adapted for use in family emergency or transitional homeless shelters (Hedl, 2009). Some of the children who participate in this program are older than the target age group of this thesis; the youngest participants are four years old and the oldest are 17 years old, while this thesis focuses on children from birth to seven years old. If there were an intervention that included the target age group, it would have been included, but there is no such program. The CBSG follows a support group model that is based on cognitive-behavior and competence-enhancement models of prevention. The group aims to teach life skills and social support to increase resiliency and reduce risky behaviors in these children and adolescents who are identified by school counselors or teachers as being at a high risk for early substance use, future incarceration and violence.

The participating children live in adverse family situations, show noticeable problems with social and coping skills, or display some early indicators of antisocial tendencies. In 10 to 12 weekly, one-hour support groups, the curriculum covers issues from substance abuse in the family, healthy choices, peer pressure and anger, to goal setting for the future. Groups have six to 10 participants within two years of age of each other and are facilitated by a trained adult leader and a few other assistants. The pre- and post-tests showed marked decreases in antisocial attitudes, self-reported rebellious behavior, and substance use (Hedl, 2009).

The Strengthening Families Program (SFP) aims to increase resilience and reduce risk factors for behavioral and social problems in children. The children in this intervention are between the ages of three and 16, and the program is made up of three life-skills courses delivered in 14 weekly two-hour sessions. The parents participate in separate sessions to try to encourage positive behavior in their children through rewards, positive attention, clear communication, limit setting and problem solving (Maguin et al., 2007). The children participate in their own session that focuses on understanding feelings, resisting peer pressure, improving social and problem-solving skills, and following authority figures' rules. There is also a session for parents with their children, which addresses communication skills, effective discipline and positive behavior reinforcement that both the parent and child learn separately and then put into practice together.

This intervention was originally for children and parents who struggled with addiction, and a curriculum around family fitness is being tested in Colorado and Utah for obesity and diabetes prevention. It has not been tested in homeless shelters and is better suited for children who are able to verbalize their feelings and perform problem-solving tasks.

The most relevant EBI is a school-based prevention program called Al's Pals: Kids Making Healthy Choices. The intervention works with children ages three to eight to develop social-emotional skills like self-control and healthy decision-making. The 46-session intervention uses tools that are relevant for young children, such as music and puppets, to teach conflict resolution, the dangers of drugs and alcohol, and coping skills. In addition to targeting the children, Al's Pals also includes communicating with parents through letters home from the teacher and suggestions for ways to reinforce the program at home. Although the program frequently works with preschool and early elementary-aged children, the program is designed for children ages birth to 12 and has been implemented in schools, childcare centers, faith-based organizations, and afterschool programs. Since the pilot was tested in 1993, over 24,500 children have been involved with Al's Pals. Studies have shown that the intervention group shows statistically significant improvements in problem behaviors (antisocial/aggressive behavior, withdrawn behavior, anxiety/somatic disorders) compared to the control group, as measured by pre- and post-intervention assessments that a teacher completed (Lynch, Geller & Schmidt, 2004).

4.2 OFFICE OF CHILD DEVELOPMENT INTERVIEWS

Although it can be important to know what the literature says about the problems homeless children face, it is also necessary to get the perspective of those who are out in the field. What literature from Boston, or New York City, or Los Angeles says about homeless children can be different from what OCD staff find in Pittsburgh. Interviewers from OCD found that the women

who reside in emergency shelters are frequently fleeing abusive situations. Several spoke of growing up in foster care or not being in touch with family, and they appreciated the services that the shelter provided them while they were in crisis. Shelter staff seemed cognizant of the effects of stress and trauma on the women in shelter, even if they did not have formal training in social services. They also recognized the effects of trauma on the children who came into the shelter, which manifested itself through name-calling, hitting, and other acting out behaviors. Trauma was a major topic in conversation, both with shelter staff and with mothers in shelter, and its presence was noticeable in the interviews, even if it was not always directly stated.

4.2.1 OCD staff interviews

The staff in emergency shelter programs can heavily influence a family's stay in shelter, and interactions between an employee and a mother can determine whether or not she will have a positive experience in that environment. It is natural that some personalities will clash, but it is important that the shelter employs empathetic individuals who will use a sensitive approach with the shelter mothers and their children. In interviews with staff, they describe women who are compassionate and committed to the population they serve. The Coordinator of Shelter at Shelter B states what she believes is the most important service that the program provides to mothers:

Support and staffing to ensure they are provided with 24 hour supportive care. To the extent possible we support skill development and when more intense supports are needed we make referrals. We directly support as much as possible facilitating day-to-day things; parenting, healthy eating, healthy family schedules (bedtime, eating time, etc.). We make referrals, particularly around areas mom presents as a crisis. We operate on the empowerment model, so referrals are driven for the most part from what mom wants or states.

The Child and Family Advocate at Shelter B stated that most of the children in Shelter B are between three and seven years old. She believes that the staff is comfortable interacting with the adults in the program. The same is not true for providing for children. This staff member thinks it would be advantageous to provide trainings and resources to help staff at all levels know how to comfort children and gain more confidence in interacting with children. She says, "This is probably an overestimation, but the percentage of staff/client interactions is about 75% interactions with adults and 25% interactions with children." The staff believes that if they meet the needs of the mothers, then that will trickle down to the children and the family will be healed.

A shelter advocate at Shelter B admits that she has seen mothers "smack" their children while living in the shelter. She discussed how they seem to lash out at a random staff person, and from the interview, it seemed like this staff member, who had 11 years experience at this shelter, understood the manifestations of PTSD and stress in parenting. This staff member said, "Remember, hitting doesn't help. Remember how you felt when you were physically abused." She goes on to say: "A lot of our moms come from histories of foster care and group home placement. Sometimes they have a baby but don't have good role models on which to base their parenting." The Medical and Volunteer coordinator echoed this, saying, "If moms didn't receive or have good roles models as a child, it can impact how they are as mothers."

The Shelter Advocate noticed that some of the children take on the role of the abuser, although this is an extreme case, but the children sometimes call their mom names, scream, and act aggressively. In her words, "Aggressive behavior, like hitting, is not uncommon in our little ones." Some of the children are unable to express feeling; she says that they sit and "just look." They have no idea how to allow themselves to process the trauma that they have been through. The Child and Family Advocate states that the shelter gets involved with a referral only if it

appears that the mother's depression has become so overwhelming that she has completely withdrawn, and so has her child. Usually, referrals are parent-driven, which is guided by the empowerment model. The interview did not clarify if shelter staff has cobbled together this model over the years, or if it is an intervention from the Substance Abuse and Mental Health Service Administration (SAMHSA), the Trauma Recovery and Empowerment Model (TREM). SAMHSA's model uses group-based meetings to facilitate trauma recovery among women who have experienced physical or sexual abuse, which significantly reduced symptoms of psychological problems one year after the intervention (Toussaint et al., 2007). Based on interview transcripts and discussions with OCD staff, it is likely that the shelter adopted aspects of this intervention to inform its practices.

The Medical and Volunteer Coordinator at Shelter A, who helps make sure the families have medical coverage and sees that medical/dental needs are met, also noticed aggressive behavior. She could tell that all of the children show depression and anxiety, even the infants. Like her colleague, she says that, "A lot of young boys assumes the role of the male authority – call moms 'bitches' – and act like abuser." The staff could benefit from drug and alcohol training. The Child and Family Advocate, who is one of the staff people who spends the most time with the families, acknowledges a lot of acting-out behaviors early on. The mothers can also struggle with processing their emotions without having the words to do so. A lot of the mothers do not realize that the stress they are under impacts their functioning as both a person and as a parent, and the staff seeks to gently help the mothers in shelter realize that their stress affects all aspects of their life. Also, the stress does not end when they get out of the negative experience. If anything, it could be just beginning anew, because of adjusting to the different routine while in shelter. Fear of the unknown can exponentially increase stress.

The Child and Family Advocate discusses what she wishes the shelter could provide:

Have someone come in on monthly, bimonthly basis and talk with moms about screening, and developing service plans that support children and their emotional needs. This would help moms become more educated about screening, their rights, the negative connotation sometimes associated with screening. Parents are sometimes fearful to call for evaluation referrals, fearful that their child will be labeled. Our approach is to see what mom says she needs and then build off of what mom says and help moms ask for what they need. For example – this is happening with my child, this is what I need.

When asked about the impact of trauma on the young children in shelter, the veteran Shelter Advocate states: “As they grow, I think the impact of trauma will be that they’ll be skeptical and not as trusting. They’ll think that human nature is not good.”

4.2.2. OCD parent interviews

The mothers who were interviewed express overwhelming gratitude to shelters A and B for the support they provide to them. Several say that they have never been in an emergency shelter before but have positive reports about the staff. Most find that the staff works hard to accommodate their needs, and several have positive opinions of the other mothers in the program. There were not as many responses in the parent interviews as in the staff interviews, but common themes emerged: Fear for the future; fear that daughters would grow up to be abused or that sons would grow up to be abusers. There is a thread of uncertainty that comes out in the mothers’ interviews as they talk about their past, their future, and how they hope the shelter will be able to help them and their children.

One mother notes that it would be beneficial for shelter B to have more supports for her six-year-old and three-year-old. Although she recognizes that the staff have provided important services to her to help increase her children’s self-esteem, she says that, “Most of the program’s

focus is on rebuilding moms' self-esteem and moving forward with goals and next steps." In her interview, she notes that the school her six-year-old attends wanted to put the child in special education classes. Shelter B helped the mother advocate for her child and convince the school that he needed time to adjust to the turmoil that was going on at home. She wishes that there could be more of the counseling-type programs that already exist for the moms. When asked what the program needs, she said, "Something more focused on helping children wrap their minds around the changes [with the family, relocation, etc.], what's going on, what they are feeling, and having someone to vent to." She acknowledges that her children do not need to know all of the details pertaining to their father and why they had to leave their house, but as a mother, she has seen the effects of the domestic instability on her children and would like professional help with addressing her children's adjustment.

Based on this sample, some of the children have positive experiences in the shelter, while others do not. A mother in shelter B, who is in a program that is five and a half hours away from her hometown, says that her children are having difficulties in the shelter setting. She notices that:

My kids do not feel comfortable here. Some women keep their kids away from my kids. My kids think it's their fault. Moms in this situation tend to be rude and some kids are aggressive. Some moms feel it is OK to allow kids to hit each other because it's only kids hitting kids, but that is not true. The program has a no violence policy; staff talk with the moms about it."

On the other hand, another mother in shelter B says that, "My children love it. They would rather be here. They call it a hotel. They have made friends. They play with kids between the apartments [transitional housing units]." This mother also talks about how childcare is only available while the mothers are in group therapy; at other times, the mothers must make their own arrangements. Sometimes mothers trade off babysitting duties. Other times, they will take

the bus to appointments together so that one mother can attend a doctor's appointment or therapy session with her child while the other mother watches the rest of the children. Transportation is a stressor, because offices can require taking two buses across town. However, the mothers know that not following through with appointments can result in involvement from Children, Youth & Families (CYF).

A mother staying in shelter A grew up in foster care and refuses to allow her children to enter the system. As a result, she keeps her children close to her and rejects intervention from shelter staff or other mothers in the program. In her interview, she repeatedly referred to herself as a "loner" and does not believe that the mandatory counseling sessions are beneficial. She told the interviewer that she is not going to form any lasting friendships with the women in the program; in her own words: "I do not associate with them [other residents]. I am not going to get involved with them. I don't do other people. I ride solo. I am not here to make friends. I am here to move on to my own destination. You get too much drama when you make friends."

Education is important to the mothers in the shelter programs. They see a good education as a way to safeguard against poverty and abuse, and there is some guilt about not providing a stable life that, the mothers believe, will make that easier to achieve. One mother, who stays in Shelter B, works two jobs and has to wake up at two in the morning so that she can make it to work. She takes her two children to a daycare that stays open 24 hours a day, and she is aware of the impact that it has on her children's ability to be alert and awake in school. She hopes that this arrangement will be for only a little while.

Most of the moms have good things to say about the shelter staff. One mother at Shelter B said, "This program is so helpful, because they make sure you have everything that you need.

If they do not know about something, they will research it to find the answers. Their help was amazing.” On the other hand, the mother who was in foster care growing up said:

Some routines are ridiculous. We have mandatory meetings that include group once a month and one-on-one meetings twice a month; twice a month is too much. I am not here to meet people and make friends. I recommend that we have group meetings every other month and one-on-one domestic violence counseling once a month.

In the staff interviews, a staff member said that she thinks some of the staff members are uncomfortable with the children. One of the mothers in the shelter notices this, too: “One-on-ones are one hour appointments; these appointments do not involve kids. Some staff do not have patience: If something arises with a child, they yell at kids or close the door because they want to focus on the one-on-one topic only.” She wishes that the staff would be more accommodating to her children, more flexible toward the needs of children experiencing trauma, and more willing to accept that one-on-one meetings cannot always stay that way when children get involved. It is possible that the staff is frustrated with not having enough support; as one mother says, “...sometimes there can be only two staff with three to sixteen kids in room while we are in group. It would be helpful for staff to have more support when there are higher numbers of kids for them to watch.”

One mother sums up the mothers’ interviews by saying, “I do not want my kids to live the life I had. I never want them to have my experiences. I also don’t want them to think I didn’t try to give them the life they deserve.”

5.0 DISCUSSION

The families in homeless shelters are at the most vulnerable point in their lives. The women who flee the streets, or IPV situations, or both, are in serious crisis situations. This stay represents a captive audience where a number of much-needed interventions could be performed. The literature suggests that although there are some excellent EBIs across the country, nothing has been specifically adapted for use in homeless shelters. The staff is aware that they could be doing more, and yet they are not. When the staff has an opportunity to create positive change, why not take it? When these women and their children enter the shelters, why are they not receiving more?

There is no easy answer to this question. Perhaps, the women in these shelter programs crave the first-time independence that being in a shelter brings. They might have spent time in foster care; they might have been abused in childhood or in their relationships. Living in the shelter is a new beginning, and they might see intervention from shelter staff as proof that they cannot do it on their own. The mother who spent time in foster care is a good example of this mindset: Perhaps she feared that the shelter staff would take her children or tell her that she is an inadequate parent, so she avoided everyone and created an insular family unit.

The interviews with shelter staff mention some of the mothers' unwillingness to get help for their children, which can be perceived as "noncompliance." However, when a mother has fled her home, her relationship, and everything else she knows, can she really be blamed for not

being able to address a potential “problem” with her child? Further, several mothers expressed a desire for more services for their children. The intense feelings of stress and exhaustion are ever present, and internalizing a developmental delay or behavioral problem in her child (believing that this is her fault, or thinking that staying in the home would have helped) is understandable. Instead of referring mothers to outside mental health services, which could create strains on transportation and care for other children, having a mental health clinician come to the shelter a few times a week could increase compliance and decrease stress.

Those who work in social services know that funding is limited. The Allegheny County Department of Human Services (DHS) Integrated Children’s Service Plan operated on a \$177,760 budget for the fiscal year 2012-2013. This plan works with CYF to get children who have been put in foster care back in their homes, which is called reunification. Also, the plan is “...working with school districts, AIU and the Homeless Children’s Education Fund to raise awareness and improve education outcomes for children experiencing homelessness” (Allegheny County DHS, 2011, pg. 5). The staff at these shelters is willing to provide more programming. The money is not there.

The staff comes across as competent and caring in their interviews. They know that these women could use more, even if “more” is something simple: A Medical and Volunteer Coordinator said that she wished they could have a quiet space for the mothers that has a rocking chair in it, so that the mothers could have a safe place to be with their young child. A few studies have addressed the benefits of touch on the maternal-infant bond. Although more research is needed, early research suggests that skin-to-skin contact can decrease the levels of cortisol (stress hormone) in an infant’s saliva (Gitau, Modi & Gianakoulopoulos, 2002). On the

other hand, for some mothers, the shelter is enough; the mother who had spent time in foster care said that the program is, "...a place to rest [her] head."

In Pittsburgh, domestic violence shelters are typically more likely to provide programming for children than other emergency shelters. Based on the interviews with parents and staff, Shelter B has an emergency shelter and a transitional shelter, and transitional housing programs have not been as heavily addressed in this thesis because they have more built-in programming for mothers with children fleeing traumatic situations.

Among mothers in shelter, there is no insight into why certain families thrive in the setting and why others do not. It is possible that these mothers and children possess high levels of family resilience and retains high levels of family cohesion, family support, and rituals or patterns that can provide support and stability during times of intense adversity (Richman & Fraser, 2001). The vast majority of mothers in these situations want the best for their children, but the stress and trauma that they have gone through in their lives make it difficult for them to exist on anything more than basic survival. It is difficult to accept that they are truly "safe" in the shelter, because they have been tricked before. It is advantageous to remain hyper vigilant, and as a result, their brains are wired to run under constant crisis. Many of these women grew up in violent, neglectful homes. Consequently, their brainstem activity has been increased at the expense of their limbic system and prefrontal cortex, which makes impulsivity high, judgment low, and the ability to plan and think ahead difficult (Perry & Pollard, 1998). The mother tries to parent a child when her brain is missing some of the essential capabilities to teach reasoning, consequences and limits. The most effective program will recognize this and provide appropriate services for both the mother and her child or children.

6.0 CONCLUSION

By ignoring the complex needs of young children living in homeless shelters with their mothers, we are perpetuating the cycle of trauma. These children have enormous medical and mental health needs, which do not improve by inattention. These children are young and vulnerable, and their problems will become more extreme as they age.

The women who reside in homeless shelters with their young children are grateful that they have found a place of respite. They appreciate the services that exist to serve them but realize that their children have suffered. They would like to see their children receive formal mental health intervention in the shelter, as opposed to receiving a referral for the child to be involved with mental health services elsewhere. Although a mother would do anything necessary for her child to receive the care he needs, the interviewed mothers cite transportation as a constant stressor, as well as finding adequate childcare. Taking a child to see a therapist involves buses, possibly bringing along other children, and a time investment. Having mental health services for children in the shelters would simplify the process and make it more likely that the child would receive the care that she needs.

6.1 LIMITATIONS

It seems that some of the OCD interviewees were staying in transitional housing programs, which was not meant to be the focus of this thesis. This skewed the responses in a more positive light, because these women and their children received more services in a transitional housing program than an emergency shelter. Because most women and children in emergency shelters have time limits on their stays, it is a high-pressure situation that is not ideal for linking to services. However, this is when children are the most fearful and confused, and they need the most intervention in those few crucial hours when they first arrive at the emergency shelter.

This researcher did not collect the data. They are excellent data, but it is unfamiliar. The researcher is not used to the interviewers' shorthand and relied on Pitt OCD staff to clarify any questions. It would have been beneficial to have participated in collecting the data to allow for more familiarity. Having seen and spoken to the women, rather than reading over their interviews, might have given the thesis more depth.

Also, these data were collected in two shelters in Allegheny County. When compared to other locations, Pittsburgh is not a large city, and opinions and experiences of women here cannot be considered representative of all homeless women with young children. That is a limitation of qualitative data: It is more comprehensive, but it is not feasible to conduct 500 interviews, which could be achieved through creating and distributing a survey. It seems that it would be difficult to replicate this survey because larger cities have more shelters, and therefore more study participants. It is unfair to assume that there is more domestic violence in rural areas, although it might appear that way because there is a larger group of women who stay in situations because there are not shelters to accommodate them.

6.2 FUTURE DIRECTIONS

Due to the population's complex needs, there are many opportunities for the future of homeless children. It is important to note that more practical interventions need to be implemented, rather than conducting more research. On any given night, every one child out of 45 spends the night without a home (National Center on Family Homelessness, 2010). They are at risk for negative health outcomes as children, and they experience greater levels of depression, substance abuse and incarceration as adults (Edwards et al., 2003).

6.2.1. Implications for future research

There is a need for EBIs that have been researched for use with homeless children, as well as children who are deemed "housing insecure." Housing insecurity is, "...difficulty paying rent, spending more than 50% of household income on housing, having frequent moves, living in overcrowded conditions, or doubling up with friends and relatives" (Kushel, Gupta, Gee, & Haas, 2006, pg. 71). This is a delicate population that was not addressed in this thesis but would benefit from similar interventions, especially children who are doubling up. There are varying definitions of housing instability and the data on its prevalence is difficult to ascertain, due to a reluctance to admit doubling up for a variety of reasons, which can include fear of landlords or fear of child protective services. These children are at risk for future homelessness and more research needs to be done to address their unique needs.

Homeless children do not need more research on the adversity they face, both in childhood and in later life. There need to be needs-based assessments and interventions so that these problems can be addressed in childhood to prevent them from occurring in later life.

Researchers are confident that homeless children have bleak outcomes, but there is a lack of research on how to address this specific population, which, as was mentioned in the “Introduction” section, continues to grow each year.

6.2.2. Implications for future practice

There are no interventions for homeless children that target the youngest age group, which is startling because about half of all homeless children are under the age of six (Office of Community Planning and Development, 2007). Employing a part-time mental health professional to come to the shelter two or three days a week would decrease these “problem” behaviors, help to educate the mothers about the stressors their children face, and help cut down on issues of “noncompliance” because of transportation problems. The professional could address issues such as PTSD, infant mental health, and social-emotional learning. Social-emotional learning is particularly important, and it can get overlooked when there is chaos in childhood. Social emotional learning is “...attitudes and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions” (Collaborative for Academic, Social, and Emotional Learning, 2013, pg. 1).

Interventions that target one aspect of the child’s life are ineffective, because a child is dependent on other people and institutions for care. A young child is, likely, still involved with a parent, and interventions that target both the parent and child are proven to be most effective (Kumpfer et al., 2007). This is consistent with the ecological perspective, which “...emphasizes

the interaction between, and interdependence of, factors within and across all levels of a health problem” (Croyle, 2005, pg. 10).

When designing programs for human participants, the most successful interventions target as many of these factors as possible. For example, Croyle (2005) outlines the different levels of functioning that could influence a professional were designing a program for a four-year-old who lives with his mother in a homeless shelter: The program should target the child (individual); the child’s relationship with his mother (interpersonal); the intake process at the shelter (institutional); the perceptions of domestic violence in Allegheny County (community), and Pennsylvania’s policies for funding emergency homeless shelters for families (public policy). These types of programs are difficult to coordinate and expensive to implement. It is more realistic to implement a program that functions at the individual level, but these programs are more expensive and time-consuming.

It could be more beneficial and cost-effective to use the Theory of Planned Behavior (Croyle, 2005). In this theory, individuals will be more likely to change their behavior if they feel that they have control over a situation (Croyle, 2005). The Theory of Planned Behavior (TPB) says that successful modification of a health behavior depends on both motivation and behavioral control, or the ability to change behavior (Boston University School of Public Health, 2013). The mother would need to be motivated to enroll the child in services and to believe that that the interventions would be successful. The TPB has been used to calculate adherence to a wide range of health behaviors and interventions, such as smoking, health care utilization, and breastfeeding (Boston University School of Public Health, 2013). For an intervention with homeless children, the program would not target the child, but would address the mother’s belief that she is able to adequately address her child’s needs, what her attitude is toward her child’s

“acting out” behaviors, beliefs about what other people think of the behavior, and if the mother believes that she can control her child’s behavior through effective parenting skills (Croyle, 2005). By empowering the mother to believe she can create change, the child’s “problem” behaviors would decrease.

6.3 CLOSING

Children who experience homelessness in young childhood are a vulnerable population who need more services than are currently available. The negative effects of homelessness and other ACEs have been well documented, but so far, researchers have not developed effective EBIs to create programming for these children’s needs. There are measurable impacts on public health outcomes by ignoring this crisis, which also affects psychology, sociology, medicine, social work, and education. It would be beneficial for these disciplines to collaborate to address this problem through effective early education programs, more child-centered assessment during the shelter intake process, and programs that address the mother’s stress and the child’s reaction to the changing environments. It is vital that more funding is available for the programs that do exist, so that cuts, like those that happened to Pitt OCD, do not continue to happen. By adequately addressing a child’s mental and physical health as the problems arise, the potential for future damage can be minimized.

APPENDIX A: STAFF IINTERVIEW FORM

STAFF INTERVIEW FORM		
Interviewee:	Interview Date:	
Program <input type="checkbox"/> <input type="checkbox"/>	Staff Position:	
Interviewer: <input type="checkbox"/> A. Rudek	<input type="checkbox"/> J. Smith-Jones	<input type="checkbox"/> Other
TP: <input type="checkbox"/> Pre	<input type="checkbox"/> Post	
YOUR BACKGROUND & SUPPORT NEEDS		
1. How long have you worked here?		
<ul style="list-style-type: none">• In what capacity?• How would you describe your role here?		
2. What is the most important thing you provide to children (probe SE aspect)?		
<ul style="list-style-type: none">• What is the most important thing you provide to mothers?		
3. What is your educational background and training?		

4. Do you have early childhood experience or training?
5. What types of training, professional development, or support would help you better complete your job here? (Probes: P/C relationships, development, awareness & access to community services and resources, transition planning)
<ul style="list-style-type: none"> • How do you learn best? (Probes: mentoring, ongoing supervision, in-person training, videos, handouts, a combination of these, etc.)
WOMEN: SUPPORTS & NEEDS
6. What is your approach to supporting these women as mothers?
<ul style="list-style-type: none"> • How do you gain their trust?
<ul style="list-style-type: none"> • How do you help them examine and reflect on things such as their roles and needs as parents & and opportunities for growth & learning as parents?
<ul style="list-style-type: none"> • Do you try to teach or model parenting behaviors? (If yes ask for examples) <ul style="list-style-type: none"> ○ How has this worked? ○ What has been challenging?
<ul style="list-style-type: none"> • Do you feel mothers have to learn for themselves? <ul style="list-style-type: none"> ○ How well does this work? ○ What has been challenging?
7. What impacts mothers' ability to utilize supports offered by you and/or the center?
<ul style="list-style-type: none"> • What strategies help mothers address these challenges? • How often are you able to use them
8. What do you think are the three most important needs of mothers?
<ul style="list-style-type: none"> • Probe about what mothers do for childcare and access to childcare.

<ul style="list-style-type: none"> • Probe about the types of mentoring, support and/or instruction mothers need (generally, around parenting, and for transition from the program)
<p>CHILDREN: SUPPORTS & NEEDS</p>
<p>9. Tell me about your direct work with young children?</p> <ul style="list-style-type: none"> • What do you do with them?
<p>10. How would you describe the behavior of these young kids?....</p> <ul style="list-style-type: none"> • Development of these young kids? • Emotional skills of these young kids? • Mental health of these young kids?
<p>11. In what ways does trauma impact the young children you see?</p>
<p>12. What do you think the number one need for the children (stress 0-5)?</p>
<p>13. Does service planning include specific goals around how mothers will support the transitions their children experience (e.g., changes in relationships, living circumstances, child care centers, family dynamics, cherished items, etc.)?</p>
<p>REFERRALS & SERVICE CONNECTIONS</p>
<p>14. How do you (or your organization) know when to make referrals to early childhood programs such as HS/EHS, EI, child MH services, etc.?</p> <ul style="list-style-type: none"> • How do you approach Mom about services for her child? • What challenges do you face in engaging moms in such services? • What are some barriers that you think prevent Moms from using services for young children? • How do you work through these challenges?
<p>15. What other barriers prevent you from making referrals for young children?</p>
<p>16. How do you recognize quality in a service for a child?</p>

<p>17. Do you make referrals to services to help mom build her parenting skills or you bring parenting groups to the program? If so, to whom?</p> <ul style="list-style-type: none"> • How do you approach mom about utilizing those services? • What has been your experiences so far making those referrals? • What do you think are the main barriers for moms using these services? • How do you work through these challenges with moms?
PROGRAM STRUCTURE & CULTURE
<p>18. Questions about program culture:</p> <ul style="list-style-type: none"> • What is your program's philosophy/theory on working with families
<p>19. What is your personal theory or approach to working with families impacted by interpersonal violence and homelessness?</p> <ul style="list-style-type: none"> • What causes homelessness? • In what ways do you feel mothers' experiences (childhood and adult) impact their parenting?
<p>20. What program rules or policies do you think are important in helping families establish family routines and interactions?</p> <ul style="list-style-type: none"> • Probe: rules/policies that support healthy child experiences, impede health family routines and interactions, impede children's healthy development
<p>21. How were the program's rules around family scheduled, participation in activities, etc. developed?</p> <ul style="list-style-type: none"> • Probe: who and/or what is involved (e.g. administration, all personnel, parents, state/fed. Regulations)
DESIRED RESOURCES
<p>22. What would you like to be able to provide to the children that you are not able to provide now?</p>
<p>23. What would you like to be able to provide to the mothers that you are not able to provide now?</p>

APPENDIX B: PARENT INTERVIEW FORM

PARENT INTERVIEW FORM			
Interviewee:		Interview Date:	
Center <input type="checkbox"/> <input type="checkbox"/>	WP #1:	wp#2:	
Interviewer: <input type="checkbox"/> A. Rudek	<input type="checkbox"/> J. Smith-Jones	<input type="checkbox"/> Other	
TP: <input type="checkbox"/> Pre <input type="checkbox"/> Post			
BACKGROUND			
1. Tell me about yourself and your child(ren). <ul style="list-style-type: none"> • Try to get the ages of each child and determine if each child lives with mom or elsewhere (with extended family, in foster care, etc.) 			
2. Is this your 1 st time at the center? What has your experience been like? <ul style="list-style-type: none"> • Please think about the supports you have received so far. What has been most helpful about living here (probes: as a parent, meeting child's needs, educ., etc.)? 			
3. What has been most challenging about living here?			
4. What's it like living with other residents?			
5. Please think about the physical space and center's rules and routines. How family and child friendly is the space? <ul style="list-style-type: none"> • What would make it better? 			
6. Are there house rules (prompts: meal times, bedtime routines, curfews, rules about guests)? If so, how do you feel about them? <ul style="list-style-type: none"> • Ask for examples so we can have some feedback on making existing rules more family friendly. 			
ROLE AS A PARENT & SUPPORT NEEDS			
7. Let's talk about your role as a parent. <ul style="list-style-type: none"> • What do you find most rewarding? • What is the most challenging about being a parent? • What worries you most about being a parent? 			
8. Please think about how you were parented as a child? <ul style="list-style-type: none"> • How has this impacted the way you parent? 			
9. In general, do you feel the staff here is supportive? Please tell me how. <ul style="list-style-type: none"> • Have there been times where you felt staff was not supportive of you? <ul style="list-style-type: none"> ○ What were these times like (Probes: were staff respectful, sensitive to needs, did staff talk down to the mother)? ○ What would make this experience better for your family? 			

<p>10. Do you feel the staff here are able to support you as a parent? Please tell me how.</p> <ul style="list-style-type: none"> • What would help you feel more supported and equipped in your role as a parent? (Probes: information, education, mentoring, modeling) • What can staff here provide? • What can others (service providers, other parents) provide?
<p>11. What might you need after leaving this center?</p> <ul style="list-style-type: none"> • Do you have a support system outside of the shelter/this center (e.g. family, friends)?
<p>USE OF SERVICES</p>
<p>12. Before coming to this center:</p> <ul style="list-style-type: none"> • Did you participate in any services (e.g. child care, employment, education, support centers, counseling)? <ul style="list-style-type: none"> ○ What were they?
<p>13. Do you still use any of these services?</p> <ul style="list-style-type: none"> ▪ If “no” what things have gotten in the way of utilizing these services? ▪ Do you plan to use any of these services or other services when you leave here? ▪ What barriers may get in the way?
<p>14. What supports will be important to have in place for</p> <ul style="list-style-type: none"> • your child (i.e. from staff, other service providers or parents)? • yourself as a parent (i.e., from staff, other service providers or parents)?
<p>15. Since coming to the center:</p> <ul style="list-style-type: none"> • Have you been connected to any new services or programs outside of this center? If so, what are they?
<p>16. Have you participated in any groups or 1:1 meetings offered here (probes: assistance with finding employment, housing, medical services, or child care; counseling; other)?</p> <ul style="list-style-type: none"> ○ If so, what have they been? ○ Was this optional or mandatory? ○ On a scale of 1-5 (share visual), how helpful were they? <ul style="list-style-type: none"> • What made them helpful or not helpful (probes: staff style or personality; relevance of area being taught/discussed; setting/timing; participation by other members)? ○ If not, what classes or centers would you find helpful and why?
<p>17. Is there anyone in particular here (staff or peer) who is especially caring and supportive?</p> <ul style="list-style-type: none"> • What is it about this person or experience that helped you feel supported? (Probes: use engagement strategies identified in staff interviews)
<p>CHILD’S EXPERIENCE IN CENTER</p>
<p>18. What has your child’s experience been like in this center?</p> <ul style="list-style-type: none"> • How do you know (i.e. by their behavior, did they tell you? etc.)
<p>19. What has been challenging for your child about being here? (Probes in areas such as 1:1 time, space or schedule issues, other adults or children)</p>
<p>20. What has been helpful for your child about being here?</p>
<p>21. What are your fears or worries for your child? (probes: safety, mood, behavior, development)</p> <ul style="list-style-type: none"> • What kind of support do you need for him/her? • How are these needs supported by [center]? <ul style="list-style-type: none"> • How might this [center] better support these needs?
<p>22. How would you describe staff’s interactions with your child(ren)?</p>
<p>23. Has staff provided information on services (e.g. EHS/HS, AFIT, DART, Home Visiting) to support your child’s readiness for school?</p> <ul style="list-style-type: none"> • How do you feel about using such services, and why? • How do you feel about using such services, and why?
<p>Recommendations</p>
<p>24. In closing, what do you think is important for the staff here to know or consider when working with families?</p> <ul style="list-style-type: none"> • How can staff show they respect you and your children? • What does it take for staff to earn your trust?

BIBLIOGRAPHY

- Alperstein, G., Rappaport, C., & Flanigan, J.M. (1988). Health problems of homeless children in New York City. *American Journal of Public Health*, 78(9), 1232-1233.
- Anda R.F., Felitti V.J., Walker J., Whitfield, C.L., Bremner J.D., Perry B.D., Dube S.R., Giles W.H. The enduring effects of abuse and related averse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neurosciences*, 2006; 256(3):174-86
- Anda, R.F., Felitti, V.J., Brown, D.W., Chapman, D., Dong, M., Dube., S.R., Edwards, V.J., Giles, W.H. (2006) Insights Into Intimate Partner Violence From the Adverse Childhood Experiences (ACE) Study. In PR Salber and E Taliaferro, eds. *The Physician's Guide to Intimate Partner Violence and Abuse*, Volcano, CA: Volcano Press; 2006.
- Anda R.F., Croft J.B., Felitti V.J., Nordenberg D., Giles W.H., Williamson D.F., Giovino G.A. Adverse childhood experiences and smoking during adolescence and adulthood. *Journal of the American Medical Association*, 1999;82:1652-1658.
- Congressional Briefing. Anda, R.F. and Felitti, V.J. Adverse Childhood Experiences as a National Public Health Problem. Sponsored by the American Academy of Pediatrics and The Family Violence Prevention Fund. Capitol Hill, Washington, DC. April 18, 2006.
- Bassuk, E.L., & Friedman, S.M. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). *Facts on trauma and homeless children*. Los Angeles, CA: National Child Traumatic Stress Network.
- Boston University School of Public Health. *The theory of planned behavior*. (2013, January 13). Retrieved from <http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/SB721-Models3.html>
- Buckner, J., et al. (2004) Exposure to Violence and Low-Income Children's Mental Health: Direct, Moderated, and Mediated Relations. *American Journal of Orthopsychiatry*. 74: 413-423.
- Buckner J.C., et al., "Homelessness and its relation to the mental health and behavior of low-income school-age children, [Worcester, Massachusetts]," *Dev Psychol*, 35(1): 246-57, January 1999.

- Burt, M., et al. (1999) Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients: Technical report prepared for the Interagency Council on the Homeless. Washington, DC: The Council.
- Croyle, R.T. U.S. Department of Health and Human Services, National Institutes of Health. (2005). *Theory at a glance: A guide for health promotion practice* (05-3896). Retrieved from website: <http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf>
- D'Amico, J., & Nelson, J. (2008). Nursing care management at a shelter-based clinic: an innovative model for care. *Professional Case Management*, 13, 26-36.
- Dietz P.M., Spitz A.M., Anda R.F., Williamson D.F., McMahon P.M., Santelli J.S., Nordenberg D.F., Felitti V.J., Kendrick J.S. Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood. *Journal of the American Medical Association*. 1999;82:1359-1364.
- Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S. The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*. 1998;14:245-258.
- Gitau, R., Modi, N., & Gianakoulopoulos, X. (2002). Acute effects of maternal skin-to-skin contact and massage on saliva cortisol in preterm babies. *Journal of Reproductive and Infant Psychology*, 20(2),
- Goodman, L., et al. (1999) Homelessness as Psychological Trauma. *American Psychologist*. 46: 1219-1225.
- Hedl, J.J., Jr. (2009, December). Reducing interrelated risks for substance abuse, delinquency and violence: Effects of the Rainbow Days' Curriculum-Based Support Group Program. Nonequivalent control group study--Study conducted in 2003; analysis conducted in 2007. Final report: January, 2008 (Rev. ed.).
- Kumpfer, K.L., Greene, J.A., Bates, R.F., Cofrin, K., & Whiteside, H. (2007). State of New Jersey DHS Division of Addiction Services Strengthening Families Program Substance Abuse Prevention Initiative: Year Three Evaluation Report (Reporting period: July 1, 2004-June 30, 2007). Salt Lake City, UT: LutraGroup.
- Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine*, 21(1), 71-77.
- Lynch, K.B., Geller, S.R., & Schmidt, M.G. (2004). Multi-year evaluation of the effectiveness of a resilience-based prevention program for young children. *Journal of Primary Prevention*, 24(3), 335-353.

- Maguin, E., Nochajski, T., DeWit, D., Macdonald, S., Safyer, A., & Kumpfer, K. (2007). The Strengthening Families Program and children of alcoholic's families: Effects on parenting and child externalizing behavior. Manuscript submitted for publication.
- McLeod, S.A. (2010). Behavioral Therapy. Retrieved from <http://www.simplypsychology.org/behavioral-therapy.html>
- Miller, D.S., & Lin, E.H. (1988). Children in sheltered homeless families: Reported health status and use of health services. *Pediatrics*, *81*(5), 668-673.
- Melnick, S., and Bassuk, E. (1998) Identifying and responding to violence among poor and homeless women. Newton, MA: National Center on Family Homelessness.
- Bassuk, E. et al. (1996) The characteristics and needs of sheltered homeless and low income housed mothers. *Journal of the American Medical Association*. 276: 640-646.
- Dong M., Anda R.F., Felitti V.J., Williamson D.F., Dube S.R., Brown D.W., Giles W.H. Impact of residential mobility during childhood on health in adults: The hidden role of Adverse Childhood Experiences. *Archives of Pediatrics and Adolescent Medicine*. 2005;159:1104-1110.
- Edwards V.J., Anda R.F., Dube S.R., Dong M., Chapman D.F., Felitti V.J. The wide-ranging health consequences of adverse childhood experiences. In: K Kendall-Tackett and S Giacomoni, eds. *Child Victimization: Maltreatment, Bullying, and Dating Violence Prevention and Intervention*, Kingston, NJ:Civic Research Institute;2005:8-1-8-12.
- Edwards, V.J., Holden, G. W., Anda, R. F., & Felitti, V. J. Experiencing multiple forms of childhood maltreatment and adult mental health: Results from the adverse childhood experiences (ACE) study. *American Journal of Psychiatry*. 2003;160(8):1453-60.
- Edwards V.J., Anda R.F., Felitti V.J., Dube S.R. Adverse childhood experiences and health-related quality of life as an adult. In: K Kendall-Tackett, ed. *Health Consequences of Abuse in the Family: A Clinical Guide for Evidence-Based Practice*. Washington, DC:American Psychological Association; 2003:81-94.
- Hillis S.D., Anda R.F., Felitti V.J., Marchbanks P.A. Adverse childhood experiences and sexual risk behaviors in women: A retrospective cohort study. *Family Planning Perspectives*. 2001;33:206-211.
- Hillis, S.D., Anda, R. F., Felitti, V. J., Nordenberg, D., & Marchbanks, P. A. (2000). Adverse childhood experiences and sexually transmitted diseases in men and women: A retrospective study. *Pediatrics*, *106*(1).
- Perry, B.D., & Pollard, R. Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America*. 1998. 7: 33-51,viii.

- Richman, J.W., & Fraser, M.W. (2001). Resilience in childhood: The role of risk and protection. In J. Richman & M. Fraser (Eds.), *The Context of Youth Violence: Resilience, Risk, and Protection*. Westport, CT: Praeger Publishers.
- Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: Mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect*, 26(10), 1011-1027.
- The National Center on Family Homelessness. (1999). *Homeless Children: America's New Outcasts*. Newton, MA.
- Toussaint, D.W., VanDeMark, N.R., Bornemann, A., & Graeber, C.J. (2007). Modifications to the Trauma Recovery and Empowerment Model (TREM) for substance-abusing women with histories of violence: Outcomes and lessons learned at a Colorado substance abuse treatment center. *Journal of Community Psychology*, 35(7), 879-894.
- U.S. Department of Housing and Urban Development, (2012). *The homeless definition and eligibility for SHP, SPC, and ESG*. Washington, D.C.
- Weinreb, L., Goldberg, E., Bassuk, E., & Perloff, J. (1988). Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics*, 102(3), 554-562.
- What Is SEL? (2013, January 1). CASEL. Retrieved from <http://www.casel.org/social-and-emotional-learning/>