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# Programming That Targets the Needs of Children Experiencing Homeless: A Systematic Review

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Programming That Targets the Needs of Children Experiencing Homeless:  
A Systematic Review

by

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MSW Clinical Research Paper

Presented to the Faculty of the  
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### Abstract

This research set out to examine intervention programs and services targeting homeless children to identify if they were addressing the developmental needs of these children. This research used a systematic review of articles retrieved from scholarly databases. Sixteen articles were identified as meeting inclusion criteria and analyzed based on predetermined targeted intervention categories. The five categories of intervention that were focused on were basic needs, physical health, mental health, educational, and independent living skills. Additionally, this research looked at if the intervention was focused solely on the child or was a family focused intervention. This research found that many of the programs did focus on developmental needs over basic needs. However, the findings did reveal the areas of physical health and independent living skills were focused on less often than mental health and education. It was also identified that families were often part of child focused interventions. Future research on programming for children experiencing homelessness should focus on the effectiveness and long term outcomes of participation in these programs.

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## **Targeting the Needs of Homeless Children**

### **Introduction**

In the United States, homelessness is a complex and often misunderstood social problem. The National Low Income Housing Coalition reports there may be as many as 800,000 homeless people in the country on any given night and as many as 3.5 million Americans spend some amount of time each year experiencing homelessness. The U.S. Department of Housing and Urban Development (HUD) reported 610,042 individuals were homeless on a single night in January 2013; this number only includes those that were counted as there may be more who are unaccounted for. This report showed that of the total number of people who were reported as homeless, 61,541 were between the ages of 18 and 24, while 138,149 were under the age of 18 (HUD, 2014). Although not all these children will suffer long term consequences of these homeless experiences, all are at risk of developmental problems that may be linked to these experiences. Often times, these children suffer from emotional and behavioral problems, poor physical health, and missed educational opportunities (Hart-Shegos, 1999; Nabors, Proescher, & DeSilva, 2001; National Center on Family Homelessness, 2011; Whitman, Accardo, Boyert, & Kendagor, 1990; Zima, Wells, & Freeman, 1994).

The experience of being homeless has shown to have a significant impact on the physical development as well as the overall physical health of a child. Children who have experienced homelessness consistently exhibit more health problems than children who are securely housed (Harts-Shegos, 1999; McCoy-Roth, Makintosh, & Murphey, 2012; National Center on Family Homelessness, 2011; National Coalition for the Homeless,

2009b; Zima et al., 1994). Children who experience homelessness also may experience poor nutrition which can lead to stunted growth or anemia (Hart-Shegos, 1999; National Coalition for the Homeless, 2009b; Ringwalt, Greene, Robertson, & McPheters, 1998).

In addition to physical health, the experience of being homeless also has a significant impact on the emotional development and well-being of children. The constant stressors that a child experiences when they are homeless play a significant role in how they develop emotionally (Brinamen et al., 2012; Hicks-Coolick et al., 2003; Nabors et al., 2001; National Center on Family Homelessness, 2011). When a person is in a constant state of worry it is referred to as experiencing chronic stress. Chronic stress in children has shown to result in greater mental health concerns (Hart-Shegos, 1999; Nabors et al., 2001; National Center on Family Homelessness, 2011). Nearly half of children who are experiencing homelessness show symptoms of depression and anxiety, with one-third meeting the criteria for a diagnosis of clinical depression (Hicks-Coolick, 2003; Nabors et al., 2001).

Educational success is one of the areas most significantly impacted when a child experiences homelessness. The academic performance of children who are experiencing homelessness is hampered by poor cognitive development and by their often constant mobility (Groton, Teasley, & Canfield, 2013; National Center on Family Homelessness, 2011; National Coalition for the Homeless, 2009a). Nearly half of children experiencing homelessness experience at least one developmental delay and many have difficulty with language skills, fine or gross motor coordination, and social and personal development (Hicks-Coolick, 2003; National Coalition for the Homeless, 2009a; U.S Department of Education, 2004). Many of these children are often at risk, or on the border of poor

academic performances before homelessness. The experience of homelessness further perpetuates these academic difficulties (McCoy-Roth et al., 2012; U.S. Department of Education, 2004).

Research has indicated there are a variety of things that can be beneficial to children experiencing homelessness in order for them to overcome delays that may be related to this period of time (Nabors et al, 2001; National Coalition for the Homeless, 2009b; Thompson & Haskins, 2014; Zima, Bussing, Forness, & Benjamin, 1997). For physical and health limitations that accompany episodes of homelessness, it is important that these children get adequate health screenings as well as connection to primary care physicians (National Coalition for the Homeless, 2009b; Thompson & Haskins, 2014; Zima et al., 1994). With the transient nature of homelessness it can be easy for these families to be inconsistent with their health care providers (National Coalition for the Homeless, 2009b; Thompson & Haskins, 2014; Zima et al., 1994).

The social and emotional needs of children experiencing homelessness are another developmental area of concern. A major factor for children in overcoming the emotional impact that this chronically stressful situation can have on them is increasing the number of supportive adult relationships in their lives (Nabors et al, 1999; Thompson & Haskins, 2014). In addition to enhancing the supportive relationship with adults within the family, relational support from adults outside the family can also reduce the children's stress and improve their emotional well-being (Nabors et al., 1994; Thompson & Haskins, 2014).



Educational deficits that have been the result of a child's experience with homelessness can be overcome in a variety of ways. With younger children, the greatest asset for their educational needs is early intervention programs (Berliner, 2002; McCoy-Roth et al., 2012; Wang, 2009). The safety and nurturing environment provided by these early intervention programs enhances a child's ability to learn and grow (McCoy-Roth et al., 2012; Wang, 2009). Research states that school-age children are also in need of services to support their ability to learn. Programming that provides remediation and tutoring, supportive services such as counseling and after school and summer programming are beneficial for these school-age children (Berliner, 2002; Donlon, Lake, Pope, Shaw, & Hasket, 2014; Grant, Gracey, Goldsmith, Shapiro, & Redliner, 2013; Hicks-Coolick et al., 2003).

In addition to children in families, there are also older unaccompanied youth who are in need of services as well. Unaccompanied youth are defined by the McKinney-Vento Homeless Assistance Act as, "A youth not in the physical custody of a parent or guardian". These older youth have many of the same physical, social-emotional, and educational needs as younger children; however, they also have developmental needs related to living independently that need to be addressed as well (Aviles & Helfrich, 2004; Heinze, Hernandez-Jozefowicz, & Toro, 2010). It has been identified by unaccompanied youth that services focused on life skills such as meal preparation, clothing care, cleaning, household maintenance, money management, accessing transportation, time management, social interaction, and community safety are of great importance in preparing them as they age into adulthood (Aviles & Helfrich, 2004; Heinze et al., 2010).

This research aims to examine current programming which targets youth experiencing homelessness to discover whether or not the services and interventions provided are addressing the developmental needs that research has shown these children have.

Although it is known by the researcher that it is best practice to use person first language when referring to children experiencing homelessness, for the purposes of this study the term homeless children or homeless youth will be used interchangeably with the phrase children or youth experiencing homelessness in order to enhance the flow for the reader.

## **Literature Review**

### **What is Homelessness**

In 2012, the U.S. Department of Housing and Urban Development (HUD) adjusted the definition of homelessness which now includes four broad categories of homelessness. The definition as stated on the website [www.endhomelessness.org](http://www.endhomelessness.org) is:

(1) People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. (2) People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing. (3) Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. (4) People who are fleeing or attempting to flee domestic violence,

have no other residence, and lack the resources or support networks to obtain other permanent housing.

The definition of homelessness may vary depending on the entity that is attempting to define it; however, homelessness can broadly be defined as a condition in which a person lacks a regular place to stay or dwell. People who are homeless are most often unable to acquire or maintain regular, safe, secure, and adequate housing, or lack “fixed”, regular and adequate night-time residence (National Center on Family Homelessness, 2011; HUD, 2014; National Coalition for the Homeless, 2009c).

There are often many causes which contribute to a person or household experiencing homelessness. One main reason people find themselves homeless is the inability of individuals or families to find housing due to the scarcity of affordable housing across the nation (National Coalition for the Homeless, 2009c; Wang, 2009; Wilder Research Institute, 2014 ). A second factor that contributes to homelessness is poverty. Those who are already living with limited resources are often forced to choose what they will pay for when they are unable to pay for all of their expenses (National Coalition for the Homeless, 2009c; Wang, 2009; Wilder Research Institute, 2014). Housing accounts for a large majority of a person or family’s income and this is often what gets sacrificed when choices need to be made regarding expenses (National Coalition for the Homeless, 2009c; Wilder Research Institute, 2014). Although these are the two most prevalent factors contributing to homelessness, other factors consist of: lack of affordable health care, domestic violence, mental illness, and addiction (National Center on Family Homelessness, 2011; National Coalition for the Homeless, 2009c; Wang, 2009; Wilder Research Institute, 2014).

## **Number of People Impacted**

It is often difficult to get an accurate picture of the number of people impacted by homelessness due to the transient nature of homelessness and difficulty accessing the shelter system. (Link et al., 1999; National Alliance to End Homelessness, 2014; Wilder Research Institute, 2014). Those who are experiencing homelessness that most often get missed are referred to as the “hidden homeless”. These are the people who may sleep outside, in abandoned homes, or may reside with family and friends; a practice commonly referred to as “couch-surfing”. These hidden homeless are often missed because surveying takes place within locations that house homeless or agencies that provide services to those who are homeless; therefore, missing those who may not utilize either of these (HUD, 2014; Link et al., 1994; Wilder Research Institute, 2014). Another difficulty in identifying the exact number of people who are experiencing homelessness is, for many people, episodes of homelessness may be brief or relatively short. Therefore the hidden homeless may miss the times and dates in which homeless counts are taking place (HUD, 2014; Link et al., 1994; National Center on Family Homelessness, 2011). According to the research, the best attempt at capturing an accurate picture of the number of people impacted by homelessness comes from point-in-time (PIT) counts. The 2013 Annual Homeless Assessment Report to Congress defines the PIT counts as a snapshot of homeless, both sheltered and unsheltered, populations on a single night. The counts are conducted each year in January and the statistics are reported to the U.S. Department of Housing and Urban Development (HUD). Although the sheltered homeless population is counted every year, the unsheltered population is only counted every other year; however, the PIT counts are the only count that captures both the sheltered and

unsheltered population (HUD, 2014) The reports compiled from these counts are intended to provide an overall picture of the prevalence of homelessness as well as to chronical changes in overall homelessness and individual homeless subpopulations. The latest reports were published in 2014 and reflect the PIT counts having been completed in January of 2013 (HUD, 2014; National Alliance to End Homelessness, 2014).

Communities are required by HUD to submit this data every other year in order to qualify for federal homeless assistance funds; however, many communities attempt to conduct counts more frequently in order to gain a better understanding of the number of people impacted by homelessness (National Alliance to End Homelessness, 2014).

### **Overall Prevalence**

The January 2013 PIT count reported 610,042 people experiencing homelessness on a given night across the country. Of this total number, 394,698 of those individuals were in sheltered locations while 215,344 were in unsheltered locations. Single adults accounted for 387,845 of the total population; however, approximately one third of this population was homeless families. There were 222,197 homeless people in families reported in the latest PIT count (HUD, 2014; National Alliance to End Homelessness, 2014).

A study conducted by Link, Susser, Stueve, Phalen, Moore, and Strueing (1994) tried to gain a better understanding of the difficulties in gathering an accurate account of the number of people who have experienced homelessness. Their study surveyed a number of individuals to find out if they had ever experienced homelessness within the last five years, as well as if they had ever experienced homelessness within their lifetime.

Link et al. (1994) then used those responses to generalize the statistics to the overall population using the 1990 census. The 1990 census showed slightly more than 185 million adults 18 years and older living in the United States; therefore, using the prevalence rates from their study they estimated approximately 13.5 million (7.4%) adult residents of the United States had been homeless at some point during their lives. Using their five year prevalence rates, they also estimated that 5.7 million of those had been homeless within the last five years (Link et al., 1994). The study concluded that if you were to take in to account the number of individuals living in doubled-up situations, the numbers would increase to 26 million adults who have experienced homelessness in their lifetime and 8.5 million who have experienced homelessness within the last five years (Link et al., 1994).

For many adults who are experiencing homelessness, their first experience with homelessness was as a child. Nearly one third of homeless parents had their first experience with homelessness when they were under the age of 18 (National Center on Family Homelessness, 2011; Wilder Research Institute, 2014).

### **Children in Families**

On a single night in January 2013, it was reported that there were 222,197 homeless individuals in 70,960 families. Of the total number of homeless individuals in families, 58% were under the age of 18 (HUD, 2014). HUD defines families with children as households comprised of at least one adult and one child under the age of 18.

The January 2013 PIT counts were the first time in which three different age categories were identified to get a more accurate picture of youth homelessness. The

three age categories were 0-17, 18-24, and 25 and older (HUD, 2014). It was identified in this 2013 PIT count that of the 610,042 overall number of homeless individuals, 10% or 61,541 were 18-24 while 23% or 138,149 were under the age of 18 (HUD, 2014).

There are other reports that also attempt to identify the number of children who are experiencing homelessness. The National Center on Family Homelessness reported more than 1.6 million children will experience homelessness throughout the course of the year. This same report estimated that 40% of homeless children, or approximately 640,000 over that timeframe, were children under the age of six. The U.S. Department of Education also tracks the number of homeless students in schools throughout the year. The statistics for the 2012-2013 school year reported there were 1,258,182 homeless students enrolled throughout the year. This number is an increase from the numbers reported in 2010-2011 (1,065,794) and 2011-2012 (1,168,354).

According to HUD, the number of homeless families increased by 20% between 2007 and 2010. HUD has also identified a 39% increase in families entering the shelter system between 2007 and 2010 (National Alliance to End Homelessness, 2014). The trend showing the number of families experiencing homelessness increasing in recent years is not new. In a study by Zima et al. (1994), the number of families with children was the fastest growing population of homeless, making up as much as 40% of the total number of people experiencing homelessness.

### **Unaccompanied Youth**

Attempting to get an accurate count of the number of homeless youth may be even more difficult than getting an accurate count of the overall population of homeless.

Many children are included in statistics of families experiencing homelessness; however, there is also a large number of unaccompanied youth who for a variety of reasons, have left their current housing situation and are experiencing homelessness on their own. The federal definition of an unaccompanied youth is defined in the McKinney-Vento Homeless Assistance Act. The Act defines an unaccompanied youth as, “a youth not in the physical custody of a parent or guardian”. For the purposes of this paper a youth who is homeless on their own and not with a family unit will be considered an unaccompanied youth. The point-in-time counts conducted in January of 2013 were the first time in which the subpopulation of unaccompanied children and youth were counted separately. This subpopulation identifies individuals experiencing homelessness, who are unattached to a family household and are under the age of 25 (HUD, 2014; National Alliance to End Homelessness, 2014).

Of the number of homeless children and youth counted in the January PIT count, 77% or 152,766 were part of homeless families. The remaining 46,924 children and youth experiencing homelessness were unaccompanied (HUD, 2014; Wilder Research Institute, 2014). This total number of unaccompanied children and youth was also broken down by age. There were 40,727 youth ages 18-24 that accounted for 87% and 6,197 youth ages 0-17 that accounted for 13% of the unaccompanied children and youth (HUD, 2014). About two-thirds of people ages 18-24 experiencing homelessness were unaccompanied (HUD, 2014; National Alliance to End Homelessness, 2014).



## **Effects of Homelessness**

### **Negative Outcomes of Homelessness**

The growing number of people impacted by homelessness is of significant concern for social work professionals and communities alike. Regardless of the length of time homeless, any episode can have deleterious effects on an individual. Research shows a link between high levels of stress and decreased success in areas such as school, work, and relationships (National Center of Family Homelessness, 2011; National Coalition for the Homeless, 2009c; Wilder Research Institute, 2014). Those who experience homelessness are impacted by the accumulation of many chronic stresses such as concern for safety, inadequate sleep, inadequate nutrition, and disrupted relationships (Heinze et al., 2010; Wilder Research Institute, 2014). This chronic stress also causes damage to the body and brain which results in a reduction of overall health (National Center on Family Homelessness, 2011; National Coalition for the Homeless, 2009b; Thompson & Haskins, 2014). In 2009, The National Coalition for the Homeless reported that homeless people are three to six times more likely to become ill than those in housing. They also reported that common diseases among the homeless population include heart disease, cancer, liver disease, kidney disease, skin infections, HIV/AIDS, pneumonia, and tuberculosis (National Coalition for the Homeless, 2009c; Wilder Research Institute, 2014).

A large scale survey of homeless adults conducted in 1997 provided information regarding the characteristics, needs, and effects of homelessness on the physical health of an individual. Bines (1997) conducted a study which revealed that the health of the homeless respondents, compared with the general population, experienced considerably

worsened health. In addition to showing the homeless population to be more likely to have health problems, the study also identified they were more likely to have more than one health problem; more than half of the respondents who identified as homeless reported more than one health problem compared to a quarter of the general population (Bines, 1997).

Statistics similar to these were found in a more recent study conducted in Minnesota through the Wilder Research Institute (2014). The Wilder study was conducted in October of 2012 and aimed to document the needs and characteristics of parents who were experiencing homelessness. Wilder identified 1,747 families as being homeless in Minnesota on the night the study was conducted. 48% of the parents in the study reported having at least one serious, chronic physical health problem such as asthma, high blood pressure, or diabetes. In addition, nearly half (45%) of the parents reported being told by a mental health professional that they had a serious or persistent mental health disorder. Of those identified as having a mental health disorder the most common diagnosis reported was major depression, 37%, followed by post-traumatic stress disorder, 23%, and bipolar disorder, 16% (Wilder Research Institute, 2014). Twenty nine percent of these parents surveyed reported suffering from both a chronic health condition as well as a serious mental illness. In comparison, there were only 29% of homeless parents in the survey who did not identify as having a chronic physical health problem or mental health problem (Wilder Research Institute, 2014).

In addition to the physical health issues that were identified, Bines study also showed a large disparity in mental health concerns among those experiencing homelessness compared to the general population. The mental health problems were

reported at eight to ten times higher in the homeless population than in the general population (1997). At the time the Bines study was conducted, 1997, it was reported that in the general population the incidence of mental health increased with age and therefore, older individuals were identified as being more likely to have mental health concerns. However, among the people experiencing homelessness that were surveyed it was identified those between the ages of 25 and 59 were more likely to report mental health problems (Bines, 1997).

Many of the reported statistics and studies focus their attention on the adults who are experiencing homelessness. However, with the increase in families experiencing homelessness there is an increase in children who are experiencing homelessness as well. Many of the same negative outcomes identified by adults who have experienced homelessness are also seen in homeless children (Hatton, Kleffel, Bennet, & Gaffrey, 2001; Whitman et al., 1990).

### **Negative Outcomes of Homelessness in Youth**

As previously identified, living without permanent housing creates a large number of stressors on an individual that can negatively affect the health of an individual (Heinze et al., 2010; National Center on Family Homelessness, 2011; Thompson & Haskins, 2014). However, being homeless can be particularly detrimental to children as it not only impacts their current physical and mental health but also can impact the future healthy development of a child (Hart-Shegos, 1999; McCoy-Roth et al., 2012; Nabors et al., 2001; National Center on Family Homelessness, 2011). The effects of homelessness on children may last significantly longer than simply for the length of time that a child is

homeless and can affect every facet of a child's life including the physical, emotional, cognitive, social and behavioral development (Hart-Shegos, 1999; McCoy-Roth et al., 2012; National Center on Family Homelessness, 2011; Zima et al., 1997).

**Physical.** The experience of being homeless has been shown to have a significant impact on the physical development as well as the overall physical health of a child. Homeless children consistently exhibit more health problems than securely housed children. The National Center on Family Homelessness reports that homeless children are sick four times more often than other children (2011). Additionally, it was reported these children have four times as many respiratory infections, twice as many ear infections, and five times more gastrointestinal problems (National Center on Family Homelessness, 2011).

Physical delays that a child may experience can begin at birth. Children born into homelessness are more likely than children who are securely housed to have low birth weights (Hart-Shegos, 1999; Thompson & Haskins, 2014). Homelessness can also expose infants to environmental factors that can endanger their health. The overcrowded conditions that an infant may be subjected to while living in a shelter or other living situation may expose the infant to disease and illness, lack of sanitation, lack of refrigeration and sterilization for formula, and lack of routine (Hart-Shegos, 1999; Hatton et al., 2001; Wilder Research Institute, 2014). All of these factors have been shown through research to have an impact on the physical health and well-being of a child's development (Hart-Shegos, 1999; Hatton et al., 2001; Zima et al., 1994).

Once these children reach school-age they are still at a greater risk of poorer health and more physical delays than their housed peers. A report by Hart-Shegos (1999) showed 16% of homeless children have one or more chronic health problems such as cardiac disease, peripheral vascular disease, endocrine dysfunction, or neurological disorders compared to 9% of their housed peers. Other health issues that homeless children are at a greater risk of experiencing include respiratory infections, exposure to tuberculosis, diarrheal infections, asthma, and lead poisoning (Hart-Shegos, 1999; Hatton et al., 2001; National Center on Family Homelessness, 2011). In addition to these significant health concerns, children experiencing homelessness often have limited access to healthy and nutritious foods which leads to poor nutrition within this population. Poor nutrition may lead to stunted growth at a rate that is six times that of other children as well as an increased likelihood of experiencing iron deficiencies resulting in potential anemia (Hart-Shegos, 1999; McCoy-Roth et al., 2012; National Center on Family Homelessness, 2011).

Despite the large number of health concerns exhibited within this population they lack access to consistent health care; which increases the severity of the illnesses they may experience (Hart-Shegos, 1999; Hatton et al., 2001; National Center on Family Homelessness, 2011). With the increased mobility of homeless families, it becomes increasingly difficult to receive routine medical care. As a result, this population often ends up accessing emergency room treatment as opposed to preventative and consistent care (Hart-Shegos, 1999; Hatton et al., 2001; National Coalition for the Homeless, 2009b).

**Social and emotional.** Another area of concern among homeless children is the effect it has on a child's social and emotional development. A child who is homeless often spends much of their time worrying about things such as where they will sleep, loss of their current sleeping accommodations, separation from friends or family, leaving belongings behind, making friends at a new school, being seen as different among their peers, physical safety in their living situation, and concern for family members (Thompson & Haskins, 2014; Zima et al., 1994). The constant worry and transition that is often experienced during episodes of homelessness creates chronic stress which results in higher incidences of mental health concerns (Hart-Shegos, 1999; Nabors et al., 2001; National Center on Family Homelessness, 2011; Zima et al., 1997). The social-emotional dysregulation of these children often appear in a school setting as a behavior problem (McCoy et al., 2012; Nabors et al., 2001; National Center on Family Homelessness, 2011; Zima et al., 1997).

Homeless children as young as 18 months old begin to show signs and reactions to the stress of the experience. They may become insecure, tearful, irritable, and may regress in development. In preschoolers age three to six it has been shown that 38% of homeless children exhibit emotional and behavioral problems (Hart-Shegos, 1999; National Center on Family Homelessness, 2011). It has been identified that one in five homeless children demonstrate extreme emotional distress leading to professional intervention (Hart-Shegos, 1999; National Center on Family Homelessness, 2011).

Homeless children ages 6-17 continue to have a higher rate of mental health diagnosis compared to their housed peers (Hart-Shegos, 1999; Heinze et al., 2010; Zima et al., 1994). One out of six homeless children has emotional disturbances which is twice

the rate of other children (National Center on Family Homelessness, 2011). One-third of homeless children have at least one major mental disorder that interferes with daily activity (Hart-Shegos, 1999; Zima et al., 1994). Almost half of these children (47%) have problems with anxiety, depressions or withdrawal compared to 18% of other school age children. (Hart-Shegos, 1999; National Center on Family Homelessness, 2011; Zima et al., 1997). Homeless children also exhibit more delinquent and aggressive behaviors than their housed peers. The National Center on Family Homelessness (2011) reported the numbers to be 36% of homeless children showing delinquent and aggressive behaviors compared to 17% of other school age children.

Impairment in social and emotional development among homeless children often shows itself in the form of their external behaviors. According to McCoy-Roth, Mackintosh, and Murphey (2012) boys will exhibit aggressive behaviors while girls will exhibit depression and withdrawn behaviors. Due to these symptoms presenting as behavioral, interventions for these children often focus on the behavior and not the underlying mental health issue that caused the behavior (Hart-Shegos, 1999; McCoy-Roth et al., 2012; National Center on Family Homelessness, 2011). Unfortunately, as the severity of the mental illness increases, children experiencing homelessness are less likely to receive the adequate mental health care that they are desperately in need of (Hart-Shegos, 1999; McCoy-Roth et al., 2012; National Center on Family Homelessness, 2011).

**Education.** One of the largest areas of impact on a child experiencing homelessness is their educational advancement; they are four times more likely to show delayed development and twice as likely to have a learning disability as their housed

peers (National Center on Family Homeless, 2011). Homeless children face barriers to school enrollment such as residency requirements, guardianship requirements, delays in transferring of school records, and lack of transportation (National Coalition for the Homeless, 2009a; U.S. Department of Education, 2004). Homeless children enrolled in school experience notable struggles with regular attendance. The National Coalition for the Homeless (2009a) reports that while 87% of homeless youth are enrolled in school, only 77% are able to attend school regularly.

A 2011 report from The National Center on Family Homelessness showed that children without stable homes are more than twice as likely as others to repeat a school grade, be expelled or suspended, or drop out of school. The academic areas in which homeless children appear to struggle the most are math, reading, and spelling. Nationally 75% of homeless children perform below grade level in reading, 72% perform below grade level in spelling, and 54% perform below grade level in math (Hart-Shegos, 1999; National Center on Family Homelessness, 2011; U.S. Department of Education, 2004). Many of these children are often at risk or on the border of poor academic performances before homelessness and the experience of homelessness further perpetuates the problem (McCoy-Roth et al., 2012; U.S. Department of Education, 2004 ).

Although academic achievement among lower income children has shown to be below average regardless of homelessness, a large study of urban elementary school students (grades two to five) who were homeless scored lower on reading and math achievement test compared to low-income students with housing (McCoy-Roth et al., 2012). Studies such as these identify the significant impact that homelessness adds beyond poverty that can affect academic achievement. One of these risk factors is a



higher rate of school mobility which increases the likelihood of repeating a grade (McCoy-Roth et al., 2012; National Coalition for the Homeless, 2009a; U.S. Department of Education, 2004). Another study identified by McCoy-Roth, Mackintosh, and Murphey (2012) showed that formerly homeless children had attended 4.2 schools since kindergarten compared to 3.1 schools attended by their peers who had never experienced homelessness. The study identified that both groups of children demonstrated poor academic achievement but half of the formerly homeless children had repeated at least one grade with 21.7% having repeated two grades in that time period in comparison with only 8% of those who had never experienced homelessness having to repeat at least one grade (McCoy-Roth et al., 2012).

These statistics reported by McCoy-Roth et al. (2012) are similar to a study done 26 years ago by Whitman, Accardo, Boyert and Kendagor. This study of children staying in a shelter program in St. Louis, MO showed serious delays in the child's capacity to produce and use language. It also suggested that homeless children were at a greater risk for developmental and language delays when compared to their counterparts in the general population (Whitman et al., 1990).

Although these statistics reveal the high needs of homeless students, this does not always lead to greater access to specialized services. A report by Hart-Shegos (1999) showed that 38% of homeless children with learning disabilities received treatment for their disabilities compared to 75% of their housed peers with similar identified disabilities and 9% of those children are in special education classes compared to 24% of their housed peers. Another study by Zima et al. (1997) reported similar statistics. This study reported that almost half of school age sheltered homeless children in their study

merited a special education evaluation. However, less than one quarter of those with any disability had ever received special education testing or been in special education classes (Zima et al., 1997).

### **Targeted Needs of Children Experiencing Homelessness**

When faced with chaos and unpredictability, children experience stresses (Berliner, 2002; National Center on Family Homelessness, 2011). These stressors, as explained above, are what lead to many of the developmental deficits that are reported in homeless children (Berliner, 2002; National Center on Family Homelessness, 2011). However, there have been a number of services and interventions identified that can improve the chances for these children to develop and function at an age appropriate level as well as reduce the long-term problems associated with the early life stress they experience (Berliner, 2002; Thompson & Haskins, 2014; Zima et al., 1997).

#### **Physical**

Two major target areas that can improve physical health in homeless children are health screenings and connection to primary care physicians (Hatton et al., 2001; Thompson & Haskins, 2014; Zima et al., 1994). With the transient nature of families experiencing homelessness it is easy to forgo a consistent connection to a primary care physician or clinic. However, establishing a primary source of care, or medical home, can create the consistency in health care that benefits children and increases their overall physical health (Hatton et al., 2001; Thompson & Haskins, 2014; Zima et al., 1994).

In addition to promoting and maintaining the consistency in primary care providers among homeless families, increased health screenings may identify problems

earlier and connect children with needed medical care as soon as possible. A study done by Hatton, Kleffel, Bennet, and Nancy Gaffrey (2001) of staff in homeless shelters identified the need for thorough health screenings for residents in order to provide more specialized treatment that shelter staff are not equipped to handle. Some beneficial screenings include screenings for nutrition, vision, and hearing problems (Hatton et al., 2001).

### **Social and Emotional**

A report by Thompson and Haskins (2014) focused on identifying initiatives that can help children facing chronic adversity. Two different studies looking at children in foster care were cited in reference to their design model which chose to focus on relational support for the children, reducing stress for adults, and addressing the children's specific needs (Thompson & Haskins, 2014). Other research supports the use of this particular model in showing that supportive relationships with adults can help children better cope with adverse circumstances (Nabors et al., 2001; Wang, 2009). In addition to enhancing the supportive relationship with adults within the family, relational support from adults outside the family can also reduce children's stress and is often a component of programs for children who have been abused (Thompson & Haskins, 2014; Wang, 2009). Although the studies cited did not directly address children experiencing homelessness the article identified homelessness as another situation in which a child would face chronic adversity and the initiatives referenced would also apply to children experiencing homelessness (Thompson & Haskins, 2014).

As previously stated, physical screenings, connection with primary caregivers, the formation of natural supports and mentoring linkages are all noted to have significant positive impacts on children experiencing homelessness. Along with these interventions, programs incorporating mental health and education together can be beneficial to school age children (Wang, 2009). A report by Wang (2009) showed that one of the most effective models of intervention to improve a child's healthy development is a community-based model that uses a mix of teacher-led and child-initiated activities to promote not only academics but also problem-solving, self-regulation and other social-emotional skills.

### **Education**

In terms of educational deficits for children who have experienced homelessness, it is well known that early educational opportunities offer the greatest benefit to children with the greatest disadvantages that have the farthest to go to catch up (Berliner, 2002; Thompson & Haskins, 2014; Wang, 2009). One benefit of early intervention educational programs is these young children who are experiencing chronic stress are in an environment which is warm, responsive, safe, predictable, and child-centered (McCoy-Roth et al., 2012; Wang, 2009). These early intervention programs can be educationally based or more child care focused; the important aspect of these programs in terms of educational value is the consistency and structure provided (McCoy-Roth et al., 2012; Wang, 2009). Additionally, many of these high-quality programs are likely to devote more attention to these children's other needs, such as self-regulatory issues, and be better educated in the needs of children coming from chronically stressful environments (McCoy-Roth et al., 2012; Wang, 2009).

Along with children participating in early intervention programs, there are also programs that are beneficial to school age children to ensure that they keep up academically with their housed peers or catch up if they are behind. Multiple studies have identified key components to programming that will assist in the educational needs of homeless children (Berliner, 2002; Donlon et al., 2014; Grant et al., 2013). Key components in these programs include remediation and tutoring, supportive services such as counseling, and after school and summer programming (Donlon et al., 2014; Grant et al., 2013). Consistency and stability in providing services such as these have been shown to reduce the developmental delays in children, as well as reduce disruptive classroom behavior in homeless children (Donlon et al., 2014; Grant et al., 2013). As stated above, Wang (2009) reported that the most effective way to implement these interventions is in a center based design that uses a mixture of teacher-led and child-initiated activities focusing on the development of language, problem-solving, self-regulation, and other social emotional skills are most effective in improving a child's healthy development. This suggested model of intervention focuses on both education and social-emotional needs to improve the overall healthy development of a child.

A report by Berliner (2002) identified changes that a school can make to assist students experiencing homelessness. One suggestion is to increase communication between schools, shelter staff, families and other service providers working with the family. Increasing communication assists in increasing attendance rates and raising awareness of current crisis that the student and family may be experiencing (Berliner, 2002).

## **Older Youth**

While the interventions for younger youth have been explored, adolescent homelessness offers different challenges. Adolescence is a period of conflict, stress, and impressionability; a period of time in which physical, mental, and emotional changes occur (Heinze et al., 2010). Unaccompanied youth have many of the same needs as younger children, however; they also have developmental needs that need to be addressed (Heinze et al., 2010). Of particular note during adolescence is the desire to develop independent living skills. During this stage of development adolescence are expected to master an area of work, develop a stable set of values, and establish their own identity. In order to develop these skills consistent support from adults is needed (Aviles & Helfrich, 2004).

Typical development during this time often comes with the support and foundation of a youth's family, school, peer groups, neighborhood, and other interests. However, if a youth is experiencing homelessness they rarely have access to these supports and resources (Aviles & Helfrich, 2004). Poor support and instability affect a youth's ability to deal with new situations and develop life skills.

Therefore, older homeless youth have a complex array of needs that require a variety of services. Service providers have identified some areas in which youth need assistance in being connected to these services. These areas include assistance in obtaining housing, maintenance of their education, health care, mental health care services, vocational services, and possible connections to substance abuse services

(Aviles & Helfrich, 2004). Unaccompanied youth have also identified a need for assistance in planning, advice, support and encouragement.

Some skills these youth have identified as particularly important include but are not limited to, activities of daily living such as meal preparation, clothing care, cleaning, household maintenance, money management and community management skills such as accessing transportation, time management, social interaction and community safety (Aviles & Helfrich, 2004). To better assist unaccompanied youth, providers should recognize the services that these youth identify as important and helpful to them and maintain the programming that provide these services. Also, these services need to be readily accessible to these unaccompanied youth.

### **Current Programing for Homelessness**

With the increasing number of homeless youth, it is imperative that social work professionals look at the current programming that targets those experiencing homelessness to determine if the true needs of these individuals are being met. The first line of defense for these children and families is the emergency shelter. However, in these settings the needs of the children often become secondary to the needs of their homeless parent. When faced with a situation where basic necessities to survival are unmet, it is easy to focus on that as the priority and forgo the other developmental needs the children may have. The second main line of defense currently is the implementation of the McKinney-Vento Homeless Assistance Act designed to protect children's academic needs within the school system.

### **Emergency Shelters**

The most common place for a family experiencing homelessness to be connected to services is through a family shelter. However, within a family shelter setting it appears that the primary goal is to assist the family in obtaining housing and thus the children in those families may be excluded from being connected to needed services. Donlon et al. (2014) reported that children in families experiencing homelessness who are utilizing a shelter are often seen as invisible as the result of the staff members' primary focus being on the immediate safety and housing needs of the family. In addition to the primary goals of shelter staff being safety and housing it was also identified by Donlon et al (2014) that most agencies serving homeless families lack the screening and assessment protocols necessary for referring children to appropriate mental health providers and lack sufficient resources to serve these children appropriately.

### **McKinney-Vento Act**

Along with the shelter component as a form of intervention, the McKinney-Vento Act is another intervention that has focused on addressing youth homelessness. Considerable protection for the educational needs of homeless children and youth was addressed with the passing of the McKinney Homeless Assistance Act in 1987 and the amendments to the act in 1990 and 1994. This act addresses and attempts to rectify many of the policies, practices, laws, and regulations that often act as barriers to enrollment, attendance, and school success to homeless students (Jozefwicz-Simbeni & Isreal, 2006; Rafferty, 2006; U.S. Department of Education, 2004). State Educational Agencies must ensure each homeless child and youth have equal access to the same free appropriate



public education, including preschool, as other children and youth (Berliner, 2002; U.S. Department of Education, 2004).

The first barrier to education is often enrollment itself. The most frequent hurdles to overcome regarding enrollment are transportation, immunization requirements, residency requirements, producing birth certificates, and legal guardianship requirements (Rafferty, 2006; U.S. Department of Education, 2004). The McKinney-Vento Act seeks to eliminate these barriers by enacting immediate enrollment requirements, placement in schools based on best interest of the child, and requirements for the transportation to and from the school of origin (National Center for Homeless Education, 2014; U.S. Department of Education, 2004).

Once enrolled in school, the McKinney-Vento Act also attempts to address some of the needs for additional services for these children. The Act allows for additional funding to provide services on top of what already exists (Jozefowicz-Simbeni & Isreal, 2006; National Center for Homeless Education, 2014; Rafferty, 2006; U.S. Department of Education, 2004). According to the U.S Department of Education (2004) these funds may support tutoring, supplemental instruction and other educational services. They can also be used to develop before and after school programming or summer school programming (U.S. Department of Education, 2004). Beyond educational support services the McKinney-Vento funding can also be used for referrals to meet medical, dental, mental health, and any other health needs (Rafferty, 2006; U.S. Department of Education, 2004). Although significant progress has been made in recent years to remove barriers to education for homeless youth, obstacles still exist that prevent them from maintaining regular school attendance and academic success (Jozefowicz-Simbeni &

Isreal, 2006; Rafferty, 2006). Many of the children experiencing homelessness do not receive the additional educational services that were mandated with the McKinney Homeless Assistance Act.

### **Summary**

Children and youth who are experiencing homelessness have erratic and challenging lifestyles characterized by housing instability that leave them cut off from traditional programming that targets youth. Many of the current services for families experiencing homelessness identify the parent or head of household as the primary recipient of services and the children become secondary to the overall needs of the family. The consequences of not having the developmental needs of the children in these households met through current programming further compounds the negative impact that the experience of being homeless has on these children. Therefore, there is a strong case to be made for programming that identifies homeless children as the target population. In addition to programming focused on homeless children, it is necessary for these programs to go beyond meeting the fundamental materialistic needs of these children and address the physical, social-emotional, and educational deficits that occur as the result of having experienced homelessness. This research study sets out to investigate this issue by systematically reviewing intervention programs aimed at homeless children and families. Specifically, it seeks to look at current programming which targets youth experiencing homelessness to discover whether or not the services and interventions they provide are addressing the developmental needs that research has shown these children have.

## **Methodology**

### **Research Design**

A systematic review was chosen as the design method for this study. The Agency for Healthcare Research and Quality through the U.S. Department of Health and Human Services defines a systematic review as a critical assessment and evaluation of all research studies that address a particular issue; it is an organized method of locating, assembling, and evaluating a body of literature on a particular topic using a set of specific criteria. To conduct this systematic review, a variety of databases were used to search for relevant articles related to homelessness. Specific, predetermined terms were used as key word searches in the databases in order to gather the articles. Once articles were gathered, specific criteria were used to narrow down the number of articles to include ones that specifically focus on an intervention strategy or service that has been used to assist in meeting the needs of homeless youth.

This study reviewed articles published in English and met predetermined search criteria. This review was limited to peer-reviewed articles that were published and available in electronic databases.

All articles that were gathered in the initial database search were reviewed and duplicates were removed. Articles were also removed in the initial review if they were published prior to the year 2000. Once duplicates and articles prior to the year 2000 were removed, the titles of the remaining articles were studied for key words to determine if they would be included or excluded from the study. Next, the abstracts of the remaining articles were read. At this stage, the articles were kept if the abstract identified that they

targeted children and youth experiencing homelessness and articles that focused on adults experiencing homelessness were removed. Studies were removed from this review if they focused only on substance abuse, chemical dependency, or youth sexual activity.

### **Selection Criteria & Search Strategy**

The studies that remained after reading the abstracts were reviewed and included in this review if they met the pre-determined inclusion criteria. The first inclusion criterion for all studies in this review was that they contained an intervention or service model designed to target children and youth experiencing homelessness. For the purpose of this study the terms children and youth included persons under the age of 24 who qualified for services through a homeless youth program. This review did not specify the type of homeless situation the sample population in the study must be experiencing. Acceptable types of homeless situations included, but were not limited to, shelter, living on the streets, couch hopping, living with another family in a doubled-up situation, or any other environment not meant for human habitation. There were no requirements as to where the study needed to take place and accepted studies took place both inside and outside of the United States. The setting in which the intervention or service took place was also not limited to specific settings. The main inclusion criteria in regards to this review were that the study included an intervention or service. The studies did not have to have a certain number of participants and did not have to contain a control and experiment group as the overall outcome of the study was not the main focus of this review; the researcher was focused on what need the intervention was attempting to address, rather than the outcome. The interventions could offer a variety of models of service delivery and could include multiple services or interventions. Studies were

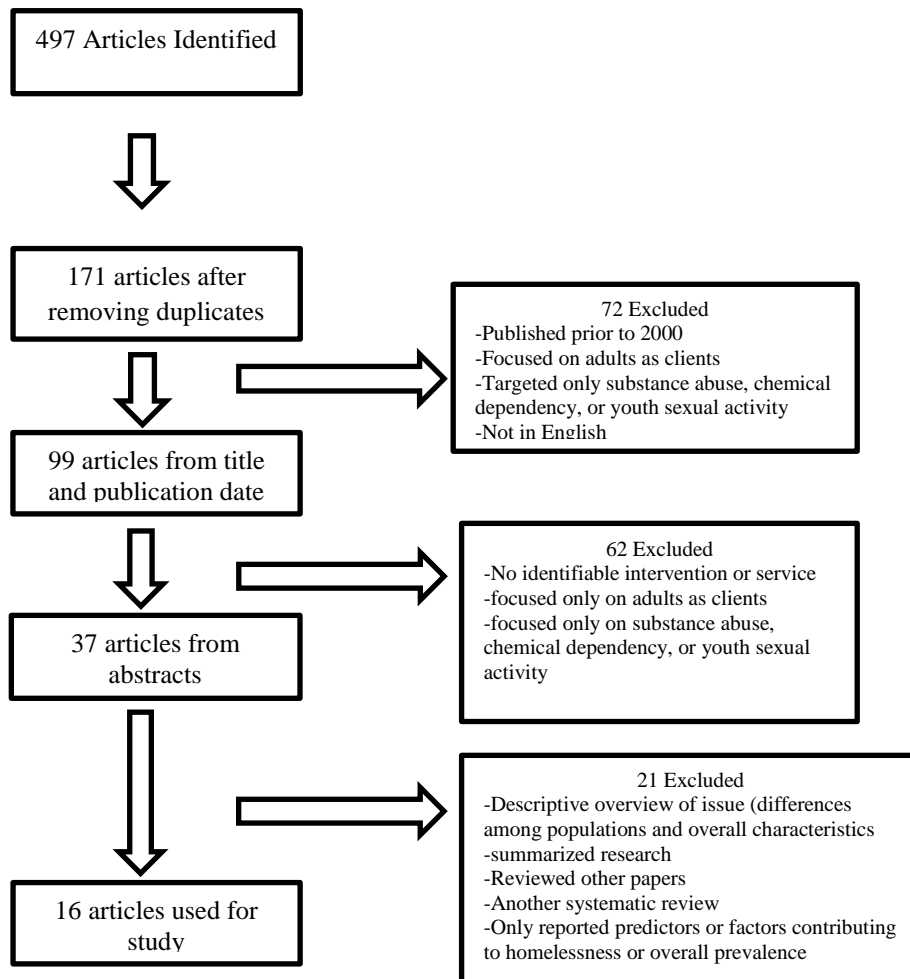
excluded if they were conducted prior to the year 2000 as well as if they focused only on substance abuse, chemical dependency, or youth sexual activity. Additionally, studies were excluded if they focused only on the parents with no connection or incorporation of the children or if no intervention was present at all.

The following scholarly databases were used to conduct the systematic literature review: SocIndex, PsychInfo, ERIC, Child Development and Adolescent Studies, and Family Studies Abstracts. Three word phrases were searched in each database. The following three word phrases were used: homeless families and (programs, services, prevention, strategies, and interventions), homeless youth and (programs, services, prevention, strategies, and interventions), homeless adolescents and (programs, services, prevention, strategies, and interventions), and runaway youth and (programs, services, prevention, strategies, and interventions). Example phrases that were used when searching the databases would be “homeless families and programs” or “homeless youth and services”.

Using this method, 479 peer reviewed articles were identified through the electronic database search. The number of articles remaining was brought down to 171 after removing duplicate articles. The titles and publication dates were reviewed to further narrow down the number of articles. Articles were removed if publication dates were prior to the year 2000. Reading the titles was used to remove articles that were not in English. Based on the title, if it was identified as focusing on adults as the client, substance abuse, chemical dependency, or youth sexual activity it was excluded from the study. Based on the review of titles, 99 articles remained. The abstracts of those 99 articles were read and analyzed. Many of the same inclusion and exclusion criteria used

for analyzing the titles was again applied when analyzing the abstracts. If the abstract identified children or youth experiencing homelessness as the main focus of the study, it was included. The article could address a variety of needs but articles were excluded if they focused solely on substance abuse, chemical dependency, or youth sexual activity. Additionally, abstracts were excluded if there was no identifiable intervention or service. After reading the abstracts, the number of articles was narrowed down to 37. These 37 articles were reviewed more thoroughly to ensure they met the predetermined criteria for inclusion into the study. In reviewing the remaining 37 articles, they were included if they not only were published after the year 2000 but if the study actually took place after the year 2000. At this stage of analysis, articles were removed if they discussed differences among population and reported on overall characteristics. Articles were also removed if they discussed predictors or factors that contribute to homelessness as well as investigated the prevalence. A final exclusion criterion was articles that summarized research, reviewed other papers, or was another systematic review. Sixteen articles remained that were a study of an intervention or service attempting to meet a need of a child or youth experiencing homelessness that did not include substance abuse, chemical dependency, or youth sexual activity.

**Figure 1: Exclusion Criteria**



Once the 16 articles were identified, the following four demographic variables were coded: geographical location of the study, number of participants in the study, design of the program and whether it was administered within an individual or group format.

In order to explore the primary research question of identifying if the programs and interventions implemented for homeless youth are addressing their developmental needs, the intervention was coded according to five pre-determined categories central to

youth well-being that emerged from the literature review: meeting basic needs, health and physical well-being, social and emotional needs, educational needs, independent living skills. It was also identified whether the intervention targeted the youth specifically or the youth via the parent or family system. The interventions were then reviewed further to determine any common themes among the various interventions and programs. For the purpose of this study, the researcher developed criteria for each of the five categories in order to systematically capture whether or not a particular program or intervention targeted each need. Please see Table 1 below for the review criteria. It is important to also note that a program or intervention could be coded in more than one category, if appropriate. For example the type of intervention may target basic needs as well as educational needs.

**Table 1:** Targeted Intervention Categories

1. Meeting basic needs	Intervention provided a tangible or material good to that participant in the study. Tangible or material goods were identified as housing, clothing, food, household items, financial assistance
2. Health and Physical Well-being	Intervention targeted the physical health of the participant such as meeting with a Doctor, administering medication, physical fitness, and health assessments
3. Education	Intervention provided a service to improve the academic performance of the participant or was focused on learning of some sort. These included tutoring, summer programming, remedial assistance at school, or classes being offered.
4. Mental Health	Intervention targeted the social and emotional development of the participant. These interventions included direct services to participants such as therapy, support groups, emotional regulation skill training and was also included in this



	category if the service included an assessment and referral to outside mental health services
5. Independent Living Skills	Intervention focused on skills youth need to learn to complete everyday life tasks such as cooking, cleaning, time management, budgeting, accessing resources and transportation, etc.

### Findings

The articles were analyzed to identify similarities, differences, and common themes among them. The findings examined both demographic variables as well as the targeted interventions of the 16 articles.

First, basic demographic information for each of the articles was listed and placed into a table. The demographic variables that were looked at included location of study, age of children in study, number of children in study, and method of intervention used. For the purposes of this research, the method of intervention variable refers to whether the intervention was implemented in a group, individually, or utilized a combination of both.

When analyzing the targeted interventions utilized in the articles, the interventions were placed into one of five pre-determined categories. The targeted intervention categories were created based on what was identified in the literature as major areas of developmental need. These categories included physical health, education, and social-emotional health. Hence, these areas were each made into a targeted intervention category. The research also indicated older unaccompanied youth identified building independent living skills as something important to their personal development

and therefore was included in a category as well. Finally, research indicated the majority of services for homeless families is often focused on the parents and assisting them in ensuring the basic needs of the family are being met and thus was included as a category. Therefore, based on the literature the five categories used to categorize the targeted interventions were: meeting basic needs, health and physical well-being, education, mental health, and independent living skills.

### **Demographics Variables**

The 16 identified articles encompassed a wide range of settings, ages, interventions, and methods. Twelve of the articles identified programs that were administered within the United States while four articles looked at programs outside of the United States. Additionally, 11 articles revealed specific locations while five articles were unclear about location. The locations within the United States that were specifically identified included: Boston, New York, California, Baltimore City, and Florida. Two studies were conducted each in Baltimore City, New York, and California. Four of the articles that identified having been located within the United States did not identify specific locations. Of the studies that took place outside of the United States, two of them were in the United Kingdom, one was in Canada, and one was in Australia.

For the purpose of this section the researcher placed the studies into groups based on ages. The three categories the researcher identified were; prior to school age, school age, and older youth. Prior to school age studies were those that targeted children under the age of six, school age studies targeted children between ages six and 14, and older youth studies targeted youth ages 14 and older. Of the 16 studies, two had a broad age

range, four targeted children prior to school age, five targeted school-age, and four targeted older youth. More specifically, two of the studies used broad age ranges (3-16 and 2-17) and didn't focus on a specific developmental stage. Four of the studies targeted a younger age group (0-6), presumed by the researcher to be those children not yet in school. One of these studies categorized by the researcher as prior to school-age did not list specific ages but identified the target population as preschool age which is why it was placed in that category.

Of the remaining ten articles, five targeted school-age children, four targeted older youth, and one study could be placed in either category based on the age range. One of the five school-age studies did not specify an age range and only identified the children as school-age. Of the four that did specify ages, the range was 5-14 years of age. The age range for the study which could be identified as both school-age and older youth was 12-17.

The number of children that participated in each study varied greatly. The range of participants in the 16 studies was 1-171, with one study having an unknown sample size. Of the 15 studies in which a sample size was reported, the average number of participants was 49. Many of these studies incorporated family interventions as well and although many referenced the families or number of families, for the purposes of this research only the number of children participating was reported.

The final demographic variable addressed in this research was the method of intervention utilized by each study. It was discovered that five studies used only a group method, four studies used only individual client interventions, and the majority of the

studies (7) used a combination of both a group and individual format. Table 2 below shows the breakdown of the demographic variables in relation to one another.

**Table 2:** Demographics of Study

	<b>Location of Study</b>	<b>Age of Children</b>	<b>Number of Children</b>	<b>Method of Intervention</b>
<b>Article 1</b>	Boston	5 and under	16	Group
<b>Article 2</b>	Ontario, Canada	Preschool	13	Group
<b>Article 3</b>	Southwestern US	5-12	12	Both
<b>Article 4</b>	Southern California	12-17	68	Individual
<b>Article 5</b>	Long Island, NY	16-21	Unknown	Both
<b>Article 6</b>	Southern US	School age	62	Group
<b>Article 7</b>	United Kingdom	3-16	27	Both
<b>Article 8</b>	Baltimore City	0-3	99	Both
<b>Article 9</b>	Florida	6-11	24	Group
<b>Article 10</b>	United States	14-24	172	Individual
<b>Article 11</b>	New York City	9-14	81	Both
<b>Article 12</b>	Los Angeles	18-24	12	Group
<b>Article 13</b>	United States	2-6	60	Individual
<b>Article 14</b>	Sydney, Australia	16-21	1	Both
<b>Article 15</b>	Leicester, UK	2-17	49	Individual
<b>Article 16</b>	Baltimore City	5-11	53	Both

### **Targeted Interventions**

The purpose of this systematic review was to identify whether the programs and interventions targeting homeless children and youth were addressing their developmental needs and thus the focus of the article analysis was on the targeted intervention described and not on the outcomes of the interventions. Based on the previous research, in regards to deficits and need of homeless children, it was determined the interventions would fall into five categories: basic needs, education, mental health, physical health, and independent living skills. Due to the comprehensive nature of many programs it was possible for one study to address multiple needs and thus could fall into multiple categories. Based on this knowledge, for the purposes of this study, articles could be placed in more than one intervention category. Categorizing articles in more than one category allowed for a more complete picture of all the needs that were being addressed by each study.

The interventions and services implemented in each of these 16 articles was vastly different from one another and all the studies, even if they only focused on one intervention category, had multiple components to their program.

Analysis of the target interventions revealed that eight studies focused on only one category while the other eight studies focused on multiple categories. Table 3 below shows the 16 articles as well as the five targeted intervention categories. The table displays the number of categories each article addressed as well as the specific intervention categories each addressed.

**Table 3:** Category of Interventions

	<b>Basic Needs</b>	<b>Education</b>	<b>Mental Health</b>	<b>Physical Health</b>	<b>Living Skills</b>
<b>Article 1</b>		<b>X</b>			
<b>Article 2</b>		<b>X</b>			
<b>Article 3</b>		<b>X</b>			
<b>Article 4</b>			<b>X</b>		
<b>Article 5</b>	<b>X</b>		<b>X</b>		<b>X</b>
<b>Article 6</b>			<b>X</b>		
<b>Article 7</b>			<b>X</b>		
<b>Article 8</b>		<b>X</b>	<b>X</b>		
<b>Article 9</b>			<b>X</b>		
<b>Article 10</b>	<b>X</b>		<b>X</b>	<b>X</b>	
<b>Article 11</b>		<b>X</b>	<b>X</b>	<b>X</b>	
<b>Article 12</b>		<b>X</b>	<b>X</b>		<b>X</b>
<b>Article 13</b>	<b>X</b>		<b>X</b>		
<b>Article 14</b>			<b>X</b>		
<b>Article 15</b>		<b>X</b>	<b>X</b>	<b>X</b>	
<b>Article 16</b>		<b>X</b>	<b>X</b>		

Of the 16 articles analyzed, eight only addressed one targeted intervention category while eight addressed multiple categories. Within the ones in which only one

targeted intervention category was addressed three articles addressed only education while five addressed only mental health. Of the articles that addressed multiple categories, four articles addressed two categories while the other four addressed three categories. No articles addressed more than three of the targeted intervention categories.

As stated previously, articles could address multiple intervention categories and therefore when looking at the number of articles addressing each category the number will total more than 16. Three of the articles addressed the issue of basic needs, eight addressed education, thirteen addressed mental health, two addressed physical health, and two addressed independent living skills.

Two studies which were identified as meeting the basic needs of children and youth were both placed in this category because they provided housing. They were the only two studies in which housing beyond that of a homeless shelter was provided. Both of these programs utilized a case management service model to assist the clients in ensuring other basic needs were met; however, no other specific basic needs were identified as being the focus of the services. One of these programs targeted homeless families while the other one focused on unaccompanied youth. Both of these programs which were identifying meeting basic needs also focused on other targeted intervention categories as well. A third study was categorized as meeting basic needs because it provided food, clothing, hygiene items, and other tangible items for the unaccompanied youth it served. This program was implemented at a drop-in center and focused on other targeted intervention categories as well. None of studies categorized as basic needs focused only on meeting the basic needs of the children and youth.

There were eight studies that addressed education in some way within their service or intervention. One study was a case management service model in which the staff member worked with the parents but provided assessment and referrals for the children in those families. This article was categorized under education because it specifically identified academic screenings as well as referral and advocacy in the area of education. Three of the studies targeted children younger than school age and identified literacy and language development as the primary focus of the program. All three of these programs also took the parent as teacher approach to their service. Within these programs the staff worked directly with the children to improve their language development but also identified the importance of teaching the parents how to work with their children to improve development in these areas as it was the parents who have the most interaction with their children. Three studies targeted the educational needs of school age children. One program provided individual tutoring to children as well as group learning activities; this study focused only on educational needs. The other two studies that provided services to school age children used a summer program approach. Children in these programs attended daily, all day long for approximately six weeks. The programs described in these articles were similar to a school structure in which they provided group learning activities but they also incorporated mental health into their programming. The last study identified as addressing educational needs was for older youth. This program provided a four month course in software programming followed by a three month course in business to help prepare the youth for potential job opportunities. This program incorporated mental health throughout as well.



Thirteen of the sixteen studies stressed the importance of and addressed mental health needs of the children and youth. The ways in which mental health was addressed was vastly different from program to program and even within the same program. All of the programs provided mental health assessment and suggestions for treatment or referrals. Four of the studies addressed mental health with a case management model. They provided the assessment but did not directly provide the mental health services for the clients, instead assisting them in connecting with another agency for that. The remaining nine studies incorporated mental health services into their programming in a variety of ways and often provided multiple ways of addressing mental health. Some of the interventions included individual therapy, group therapy, support groups, stress reduction skills, family therapy, and family communication skill building.

Physical health and well-being and independent living skills were the least addressed interventions among the articles each only having two studies that addressed these needs. In regards to physical health, in one study the importance of being physically active was incorporated into the summer educationally programming while the other study addressed physical health by providing limited health care within a drop in center. Neither of these studies placed a high priority on the physical health aspect of services but did identify its importance in the overall healthy development of children and youth.

Independent living skills was only addressed in two of the programs providing services to older youth. One program was categorized here because it provided vocational training and emphasized skill building in the area of employment. The other study that addressed living skills was the housing program for older youth. This program regularly

provided classes and individual coaching to improve youth's ability to cook, clean, manage a budget, and becoming aware of how to access their resources.

The studies were also analyzed to determine if the interventions targeted only the youth experiencing homelessness or if the parents or family were also a part of the services. It was determined that in six of the studies the intervention targeted only the youth while ten of the studies incorporated the parent or family as part of the intervention. Of the interventions that focused only on the youth, three of them were services specifically for older youth ages 14-24. Also, three of the studies that utilized parents as part of the intervention were focused primarily on case management or assessment and referral as the intervention.

Although this study set out to capture the predetermined types of interventions, two other themes emerged during this review. First, in 6 out of 16 studies, program participants who resided in shelters reported feeling the shelter staff were often not adequately trained to properly assess their needs. Many who participated in these programs appreciated the extra training given to the staff who worked within these programs. Being able to recognize other needs of the family outside of housing was important to the parents.

Another theme that emerged, that was not originally a focus of the study, from the researchers was that despite the success of many of the programs there was not funding or the support to sustain and continue the program. The programs that were offered as a one-time service were often not repeated. Also, the amount of staff and training required

to make these programs successful was difficult to sustain over the long term for many of these programs.

### **Discussion**

The purpose of this study was to identify if programming that targets children and youth experiencing homelessness is addressing their developmental needs. As outlined in the literature review, living without permanent housing can negatively impact not only current development but also future healthy development of a child (Hart-Shegos, 1999; McCoy-Roth et al., 2012; Nabors et al., 2001; National Center on Family Homelessness, 2011). The experience of homelessness can affect every facet of a child's life including the physical, emotional, cognitive, social, and behavioral development (Hart-Shegos, 1999; McCoy-Roth et al., 2012; National Center on Family Homelessness, 2011; Zima et al., 1997). With these effects well documented and researched, the body of literature suggests the importance of programming that directly and specifically serves homeless children and youth. The findings above reveal that services targeting homeless children and youth are addressing many of their developmental needs. The programs addressed these needs using a wide range of methods and services focusing on homeless children. The studies that were analyzed provided very different perspectives on ways to address the developmental needs of homeless youth.

Throughout the review of the literature there is strong support for needed mental health services as evidenced by the higher incidences of mental health diagnosis among the homeless population. The constant worry and transition that often accompanies

episodes of homelessness creates chronic stress, which results in higher incidences of mental health concerns (Hart-Shegos, 1999; Nabors et al., 2001; National Center on Family Homelessness, 2011; Zima et al., 1997). It has been identified that one in five homeless children demonstrate extreme emotional distress leading to professional intervention (Hart-Shegos, 1999; National Center on Family Homelessness, 2011; Zima et al., 1997). The research also showed that almost half of these children (47%) have problems with anxiety, depression or withdrawal compared to 18% of their school-age counterparts (Hart-Shegos, 1999; National Center on Family Homelessness, 2011; Zima et al., 1997). The significant impact of a child's mental health on their overall well-being and the important role mental health plays in a child's development was reflected in the number of studies that placed an importance on addressing this need. Thirteen of the 16 studies incorporate mental health services into their program in some way.

Although the research in the literature review revealed mental health needs of children and youth experiencing homelessness should be of concern to the social work field, there was not much research to identify the most effective strategy in meeting this developmental need. It was evident in this research study there are multiple ways in which the social and emotional needs of children and youth can be addressed. The findings revealed a variety of models were used to address mental health needs in homeless children.

Another area in which research has shown that homelessness significantly impacts a child's development is in education. The National Center on Family Homelessness (2011) reports homeless students are four times more likely to show delayed development and twice as likely to have a learning disability as their housed peers. The academic areas

in which homeless children appear to struggle the most are math, reading, and spelling. Nationally 75% of homeless children perform below grade level in reading, 72% perform below grade level in spelling, and 54% perform below grade level in math (Hart-Shegos, 1999; National Center on Family Homelessness, 2011; U.S. Department of Education, 2004). Many of these children are often at risk or on the border of poor academic performances before homelessness and the experience of homelessness further perpetuates the problem (McCoy-Roth et al., 2012; U.S. Department of Education, 2004).

The significant need for services addressing the educational needs of homeless children is reflected in the findings of this study. Half of the programs in this study did address the education piece of a child's development. The ways in which education services were provided in these studies also reflected the educational needs of homeless youth in the literature review. The research revealed targeted interventions for children not yet in school as well as school-age children. It is well known that early educational opportunities offer the greatest benefit to children with the greatest disadvantages that have the farthest to go to catch up (Berliner, 2002; Thompson & Haskins, 2014; Wang, 2009). These early intervention programs can be educationally based or more child care focused; the important aspect of these programs in terms of educational value is the consistency and structure provided (McCoy-Roth et al., 2012; Wang, 2009). Three of the studies in this research specifically targeted preschool age children and focused on improving the literacy and language skills with these children as well as with their parents. The finding of the study in regards to the types of interventions that target homeless youth was also consistent with what was developed from the research. Multiple studies identified key components to programming that will assist in the educational

needs of homeless children (Berliner, 2002; Donlon et al., 2014; Grant et al., 2013). Key components in these programs include remediation and tutoring, supportive services such as counseling, and after school and summer programming (Donlon et al., 2014; Grant et al., 2013). These components made up the structures of the identified studies that focused on education needs.

However, programs that addressed educational needs of children did not always address some of the major barriers identified in the literature review to a child's academic success. Two of the biggest barriers to academic success among homeless children are school stability and attendance rate (National Coalition for the Homeless, 2009a; U.S. Department of Education, 2004). Due to the transient nature of homelessness, research shows that homeless students struggle to keep pace with their housed peers because they transfer schools more frequently (McCoy-Roth et al., 2012, U.S Department of Education, 2004). Additionally, the requirements to enrolling in a new school also prove to be barriers for homeless students and their families who may not always have the required paperwork easily accessible (National Coalition for the Homeless, 2009a; U.S Department of Education, 2004). The research also showed that even the homeless students who have been stably enrolled in a school throughout their time spent homeless struggle to attend school on a regular basis (McCoy-Roth et al., 2012; National Coalition for the Homeless, 2009a; U.S. Department of Education, 2004).. The passing of the McKinney-Vento Homeless Assistance Act was identified as a major factor in attempting to lessen the barriers homeless students have in attending school; however, none of the studies that addressed the educational needs of homeless children mentioned this piece of policy or working with schools on accessing services for the children in their studies in

relation to this piece of policy. Only one of the studies that used the case management model to assess and provide support in meeting educational needs identified working with the students' school to assist in improving the child's academics.

Throughout the review of the literature there is strong evidence that more programming targeting physical health and well-being of homeless children is needed. However, the results of this study show that addressing health concerns was a low or non-priority for many of the programs. Homeless children consistently exhibit more health problems than securely housed children. The National Center on Family Homelessness reports that homeless children are sick four times more often than other children (2011). Additionally, it was reported these children have four times as many respiratory infections, twice as many ear infections, and five times more gastrointestinal problems (National Center on Family Homelessness, 2011). A report by Hart-Shegos (1999) showed 16% of homeless children have one or more chronic health problems such as cardiac disease, peripheral vascular disease, endocrine dysfunction, or neurological disorders compared to 9% of their housed peers.

Another factor identified in the research as contributing to the physical health of children experiencing homelessness is their limited access to consistent healthcare. Despite the large number of health concerns exhibited within this population they lack access to consistent health care; which increases the severity of the illnesses they may experience (Hart-Shegos, 1999; Hatton et al., 2001; National Center on Family Homelessness, 2011). With the increased mobility of homeless families, it becomes increasingly difficult to receive routine medical care. Addressing these health care concerns was discussed in the research as a way to combat the effects homelessness has

on the physical development of a child. Two major target areas that can improve physical health in homeless children are health screenings and connection to primary care physicians (Hatton et al., 2001; Thompson & Haskins, 2014; Zima et al., 1994). With the transient nature of families experiencing homelessness it is easy to forgo a consistent connection to a primary care physician or clinic. However, establishing a primary source of care, or medical home, can create the consistency in health care that benefits children and increases their overall physical health (Hatton et al., 2001; Thompson & Haskins, 2014; Zima et al., 1994). Despite the significance of this research, only one of the programs in this study addressed the need for direct medical care for homeless youth.

The other targeted intervention categories or areas that were focused on less often in the articles were basic needs and independent living skills. A category that seemed to be missed more often was increasing the independent living skills of homeless youth. Older unaccompanied youth identified this as a part of services they feel is lacking and that they are in need of. These youth are navigating homelessness independently, often without the assistance of family or friends. In order for these youth to be successful and thrive, they identified the need for assistance strengthening their independent living skills. The idea of independent living skills is a broad concept and thus the researcher allowed for this category to encompass a variety of things. However, of the 16 studies, five of the studies focused on older youth as part of their participant group but only two of them incorporated independent living skills into their intervention. Additionally, only one of those programs that did address independent living skills offered participants the opportunity to learn more about a variety of skills.



The category of basic needs was included in this study to identify whether or not interventions were focused on tangible goods. The research in the literature review identified that although homeless children have a large number of needs they are often categorized as being a part of a family unit and not often the focus of services. In situations where a family is experiencing homelessness, services are often focused on working with the parents in the family to meet the basic needs of the family and thus improving the family's situation. Donlon et al. (2014) reported that children in families experiencing homelessness who are utilizing a shelter are often seen as invisible as the result of the staff members' primary focus being on the immediate safety and housing needs of the family. This method of service in addressing homelessness does not address the impact the experience has on the child. Despite the research indicating that many services targeting homeless families focus on basic needs this review found that of the programs focusing more specifically on the children and youth in those families or living on their own, basic needs was rarely the focus of the intervention. Only three of the programs even provided anything categorized as basic needs and two of those programs provided housing but did not identify other basic needs being met.

This study revealed that current programming is addressing the developmental needs of homeless youth as evidenced by the large number of studies that focused on educational and mental health needs. However, the area of physical health and well-being is still often not a part of programming that addresses the needs of children and youth experiencing homelessness. Additionally, although unaccompanied youth identified their need for assistance in developing independent living skills many programs are not incorporating that piece into their services.

## **Limitations**

While this research was able to contribute to research showing the importance of programming targeting the developmental needs of children and youth experiencing homelessness there were limitations within this study including sources used to identify articles, subjectivity of the researcher, and the large scope of intervention styles and target areas addressed. The articles used for this study were limited to studies on programs that were published and publicly available. It is highly likely there are many more programs that provide services to youth experiencing homelessness but have not been studied or written about. Additionally, this research was limited to the databases used to search for articles. More articles and studies would have been identified if more databases had been used.

Another limitation was the subjectivity of the researcher in defining the variables used. The definition for the variables was defined through the lens of the researcher and thus another researcher may have defined the variables differently. Also, due to the subjectivity of the researcher in coding and analyzing the data, another researcher may have interpreted the data differently resulting in different findings.

Finally, a third limitation encountered by the researcher was the limited number of studies which contained a wide variety of services offered and needs being addressed. With the large variation in style of programming it became difficult to thoroughly compare and contrast the programs. General themes and similarities were identified and discussed; however, more in depth comparisons among programs was difficult.

### **Implications for Social Work**

This research provided a brief look at homeless youth programming and the developmental needs that are being addressed. For further implications it is suggested that similar studies be conducted identifying larger numbers of programs. Additionally, it is recommended that research look at programming specific to each area of development: physical, education, and social and emotional. Further research is also needed to determine the effectiveness and long term outcomes of these programs. At this point research on the effectiveness of homeless youth programming is very limited thus providing the opportunity to further this research study.

This research also revealed information useful for direct social work practice as well as social work at the macro level. Practice implications that arose from this research include the importance of adequate training of staff within programs that offer services to the homeless population and the importance of client advocacy in getting their needs met. Macro level implications within this research include continuous emphasis on implementing comprehensive programming designed to meet the various needs of the homeless population.

It was revealed in six of the studies that parents felt staff members in the homeless shelters were not adequately trained to assess and address the complex needs of their families and children. Families themselves are able to recognize their complex needs and feel better about receiving services from staff members who are also fully trained in the complex needs these families present with. As social workers we must work to educate ourselves on not only challenges faced by homeless families, but ways we can best help

them in meeting their needs. Additionally, as social workers we must learn to work with our children and families to advocate for their needs. Often times a parent may not know about things such as the McKinney-Vento Act that can assist their child in succeeding academically. Therefore, we must be able to work with our client's to get them access to the services they need and want.

On a macro level this research indicated there is a need for more programming as the needs of the homeless population continue to grow. At this point in time, the shelter system is the best resource homeless families have in gaining access to services and this is simply not enough. The research reveals that homeless children have a wide range of developmental needs that need to be addressed in order for them to succeed. With this in mind we must respond accordingly and provide the services that address these developmental needs in a comprehensive way. With the continued number of people entering homelessness each year more programming is needed to both assist those clients with immediate needs as well as attempt to break the cycle of homelessness.

## **Conclusion**

Children who are experiencing homelessness often suffer from emotional and behavioral problems, poor physical health and missed educational opportunities. Research has shown the significant impact homelessness has on the current and future development of a child. Despite the significant amount of research that identifies these developmental needs of children and youth experiencing homelessness there is very little research on programs that specifically target children as well as the outcomes of programs that do. The opportunities for programming for this population are huge. There

are many developmental needs of youth that are impacted by experiencing homelessness and agencies are beginning to recognize that. The research into programming for this population is beginning to happen but more research needs to be done.

Also, because of the wide variety of ways in which services can be provided to this population, programming continues to develop and change without identifying the specifics of what makes the program successful. Further research on these programs should aim to look at the success of each program and the specifics of what makes each program successful. Identifying what works and what does not can direct future development and implementation of programming.

To fully research the programs as well as long term outcomes requires a significant amount of time, energy, and money that are often not available in agencies that are targeting the homeless population. Additionally, implementing a quality program requires extensive training of staff that is working in these programs which also costs an agency money. The population in which homelessness is becoming a reality is growing and will continue to do so unless resources are allocated to support this population and remove barriers to the continued cycle of homelessness.

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