

Meeting the Needs of Young Families Experiencing Homelessness:
A Guide for Service Providers and Program Administrators

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STRENGTHENING
At Risk and Homeless
Young Mothers and Children

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A Guide for Service Providers and Program Administrators

An Initiative of the Conrad N. Hilton Foundation and The National Center on Family Homelessness in partnership with The National Alliance to End Homelessness and ZERO TO THREE: The National Center for Infants, Toddlers, and Families.

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INTRODUCTION

Strengthening At Risk and Homeless Young Mothers and Children (the Initiative), was a multi-year, multi-site Initiative funded by the Conrad N. Hilton Foundation from 2007-2012. The Initiative aimed to improve housing, health, and developmental outcomes of homeless and at-risk young mothers aged 18-25, and their children. Findings from the Initiative indicated that the needs of young homeless families are similar to homeless families overall, but are developmentally determined and more intense. Young mothers tend to have fewer life skills, are more at-risk, and have complex needs that require intensive services. Programs designed to respond to this subgroup must understand the impact of trauma and homelessness on young mothers' and children, strategically integrate community and in-house services, and tailor interventions.

Strong local collaborations were the hallmark of the Initiative, which was comprised of four programs across the country--in Chicago; Antelope Valley and Pomona, California; and Minneapolis. Whether located in a major city with access to resources, or in suburban areas, all programs provided integrated, interdisciplinary, services. As a result, families demonstrated significant improvement in housing stability, family functioning, family preservation, and maternal and child well-being. All children were assessed and provided with individualized early interventions. This resulted in improvement across multiple developmental domains (National Center on Family Homelessness 2009b & 2010). Through these interdisciplinary partnerships, families received coordinated services that met their complex needs. Clinically oriented services, where staff received regular supervisory support, resulted in the best outcomes.

When designing or delivering services for young families providers must know: 1) how to conduct comprehensive assessments and target services to meet the specific needs of this subgroup; 2) how to provide or ensure timely access to early intervention for children and; 3) how to build strong collaborations and strategic partnerships while also managing costs. This approach to service delivery forms the foundation of quality programming for young homeless families.

INTRODUCTION

This Guide provides service providers and program administrators a developmental model for programs working with homeless families, as well as strategies for those thinking about addressing the needs of young homeless mothers aged 18-25 and their children. While the model is appropriate for all homeless families, younger families require more intensive supports based on their developmental stage. This model is based on research conducted by The National Center on Family Homelessness that assessed the impact of collaborative, developmentally based, intensive service interventions on outcomes for young homeless families. Results of the Initiative, coupled with decades of science on child development, trauma, risk and protective factors, and best practices, form the basis of this Guide.

In the first section of the Guide, we review the developmental needs of 18-25 year olds and children under six, and the risk and protective factors that influence development. Next, essential elements of the model are reviewed including collaboration, management of costs, and key program components that are trauma-informed. After reviewing these elements, we highlight specific strategies for service delivery including the assessment process, individualized service planning, and developmentally appropriate interventions that target brain development, relationships, and social-emotional skill building. The final section discusses the importance of program evaluation and summarizes key points for administrators to consider when collecting data. This Guide will help providers and administrators adapt existing program approaches, or newly design services, to meet the needs of young homeless families.

Towards a Neurodevelopmental Understanding of the Needs of Young Families

Developmental Needs of Emerging Adults

The stage of development between the ages of 18-25 is known as post-adolescence or early adulthood, and is more recently described as “emerging adulthood” (Arnett & Tanner, 2009). This unique life-stage is typified by identity development, being self rather than other focused, behavioral patterns marked by exploration and growth, and instability and risk taking. Emerging adulthood is a stage when young adults are “in-between.” Behind them lies their positive and negative childhood experiences; ahead lays the path to mature adulthood. Depending on how stable the past has been, the road through young adulthood may be tumultuous.

Young homeless parents between the ages of 18-25 are still working through many typical adolescent issues. Developmental tasks during this period are marked by exploration and experimentation. This applies to areas such as education and career goals, identity development, peer relationships, and romantic and sexual interests (Arnett, 2009).

Neurologically, individuals in this age group are still maturing. The brain continues to develop through the mid to late twenties (Ackerman, 2007; Arnett, 2009; Shonkoff & Phillips, 2000; U.S. Department of Health and Human Services, 2009). Brain Plasticity is a term that is used to describe the ability of the brain to adapt to change and acquire new learning (Perry, 2006; U.S. Department of Health and Human Services, 2009) and “underlies our transit of all life’s major passages” (Ackerman, 2007). Brain plasticity is often referred to when working with young children since the brain grows most rapidly during the first three to five years of life (Center for the Developing Child, 2010; Siebel, 2012; Shonkoff & Phillips, 2000). However, the second greatest growth period for brain development is from adolescence through young adulthood.

The period between ages 15-25 is a sensitive phase of human development, one with distinct cognitive, emotional and behavioral features that distinguishes younger from older adults. Sensitive periods are considered windows of time in the developmental process when certain parts of the brain are most susceptible to experience. During these periods, development occurs rapidly, as seen in the first five years of life when significant milestones in motor, cognitive, and language skills are achieved. After puberty through the mid to late twenties, the young adult brain goes through a similar sensitive period. During this growth spurt the brain is not necessarily growing in size but is developing certain functions in specific regions of the brain, and developing circuits that ensure that these regions are working together (Ackerman, 2007, U.S. Department of Health and Human Services, 2009).

During young adulthood, neurological circuits that lead to mature emotional regulation, impulse control, planning, and problem solving are being refined. In young adults, the frontal lobe and limbic systems are developing further. The frontal lobe is an area responsible for “executive functioning”- impulse control, organization, reasoning, planning, and decision-making. The limbic system is the center of the brain where emotions are processed (Ackerman, 2007; U.S. Department of Health and Human Services, 2009). More mature, well developed frontal lobe and limbic systems permit better processing of information and expression of socially correct behaviors. Brain systems that are still developing are less mature, making inconsistency and impulsivity more likely, and continued support necessary (Arnett, 2009).

Young Adult Development: Overview

<i>Developmental Level and Tasks</i>	<i>Physical</i>	<i>Cognitive</i>	<i>Emotional</i>	<i>Social</i>
<p>Late Adolescence into Young Adulthood</p> <p>Tasks: Identity Development; Career, Educational, Romantic & Sexual Exploration</p> <p>Typical Features: Tests authority & rules; Experimentation; Exploring & questioning; Patterns of impulsivity; Inconsistent risk assessment skills</p> <p>Influenced by emotion & peer groups; Self vs. other focused; Seeking independence but needs structure & guidance; Interested in growth, learning, new opportunities</p>	<p>Major gross and fine motor milestones achieved</p> <p>May be improving gross and fine motor skills through practice (athletic, dance, artistic, writing)</p> <p>Late stage puberty and development possible for late adolescence</p>	<p>Growth in frontal lobe (executive functions)</p> <p>Immature executive functions leads to inconsistent behaviors (planning, problem solving, assessing risks, judgment)</p> <p>Neural networks connecting two systems develop with learning and external influences</p>	<p>Growth in functioning of limbic system (emotional processing)</p> <p>Immature limbic system and its ability to be regulated cognitively (leads to sensitivity to fear stimuli, tendency to be reactive emotionally)</p> <p>Neural networks connecting two systems develop with learning and external influences</p>	<p>Exploration of relationships with peers and partners; experimentation can lead to sexual risk taking</p> <p>Influenced by peer group; More focused on self-interests, needs, wants versus needs of others</p> <p>Mature commitments in relationships evolve towards later end of stage into middle adulthood</p>

Evidence suggests that young adults are especially sensitive to negative stimuli, especially fear, and are more likely to be emotionally reactive (Arnett, 2009; Williams et al. 2006). During young adulthood, the frontal lobe is not yet mature enough to consistently override the emotional reactivity of the limbic system. Between the ages of 18-25, the emerging adult is susceptible to making decisions based more on emotion than reason. For example, a young adult faced with a decision involving some element of risk may not be able to use their cognitive skills to accurately assess the situation and respond appropriately. This does not occur all the time. Behaviors can be inconsistent as young adults are learning to use their frontal lobes to regulate their emotions. Therefore, it is not uncommon for young people to sometimes act impulsively, take risks, and not always think through decisions or plan ahead. It is also why it is essential that providers working with young adults understand their needs and provide support, guidance, and structure to influence healthy brain development.

The young adult brain is also more susceptible to stress. Young homeless parents are faced with enormous stressors. Their living situations are unstable. They are trying to parent young children who demand their full attention and a high degree of structure and support; and they often must do so with very little support. They are entering this phase of life carrying the cumulative impact of childhoods marked by instability, family separations, disrupted attachments, exposure to violence, and mental health and/or substance use challenges (Bassuk et al., 1996, 1997; Bassuk, Perloff, & Dawson, 2001; Browne & Bassuk, 1997; Burt et al., 1999; Fowler, Toro, & Miles, 2009; Lowin et al., 2001; Medeiros & Vaulton, 2010; National Center on Family Homelessness, 2009a; Rog et al, 1995; Rog & Buckner, 2007; Shinn & Weitzman, 1996; Vaulton, 2008; Weitzman, 1989). Histories of trauma are compounded by the experience of homelessness and early parenting. It is no surprise then that accomplishing the normal developmental tasks of young adulthood can be difficult, and providing services to this high need subgroup can be challenging.

While new learning is hard when under stress, both children and young adults can make up for adverse experiences given the right circumstances due to brain plasticity (Ackerman, 2007). Resiliency is defined as the individual's capacity for adapting successfully and functioning competently despite experiencing chronic stress (Cicchetti et al., 2000). Promoting wellness involves creating environments that are safe, trauma sensitive, and protective from additional stressors; providing supports and services to minimize the impact of risk factors on developmental outcomes; and for young families, capitalizing on brain plasticity to foster resiliency.

Research indicates that services targeted towards improving developmental outcomes have positive effects on individual and family functioning, and decreased costs to society (Shonkoff & Phillips, 2000). Providing nurturing relationships, stable living conditions, and teaching new skills can aid the development of a young adult's cognitive and social-emotional competencies. Homeless service providers are in a position to capitalize on these neurodevelopmental features of young adulthood and strengthen their ability to parent and live independently.

Developmental Needs of Young Children

Children of young mothers are typically under the age of five or six--a critical stage of development. Recent research has demonstrated that early life experiences impact children's development. Significant adversity and toxic early experiences can lead a child down unhealthy developmental pathways that can persist far into adulthood (Center on the Developing Child, 2010; Felitti et al., 1998; Parlakian, 2010; Shonkoff & Phillips, 2000; Shonkoff et al., 2012a; Shonkoff et al., 2012b; U.S. Department of Health and Human Services, 2009).

Young children between birth to age six are going through major developmental transitions. During the first two years of life, young children's development is marked by significant growth in physical, motor, cognitive, and language skills. Typical physical milestones include learning to roll over, sit up, crawl, and walk. Toddlers' receptive language develops ahead of their expressive language. They understand a great deal, but only know a few words. They don't have a sense of time, their memory is not yet sequentially organized, and their emotions are primary and can be intense. Loud noises, and even new experiences can lead to feelings of fear or anxiety. Being left alone for long periods of time, or being hungry, creates an inner sense of abandonment that is relieved only by the reassuring presence of a caregiver who meets their needs. Forming secure attachments is the primary developmental task of this period, one that sets the stage for future healthy development (Greenspan & Greenspan, 2003).

Child Development Birth-Two Years: Overview

(adapted from Greenspan & Greenspan, 2003)

<i>Developmental Functioning & Tasks</i>	<i>Physical</i>	<i>Cognitive</i>	<i>Social-Emotional</i>	<i>Play</i>
<p>Child age 0-2, infancy to young toddler</p> <p>Tasks: Growth, getting basic needs met, learning how to interact with others and environment</p> <p>Typical Features: Major growth spurts, high need for supervision, repeats behaviors that are pleasurable, focused on primary caregiving relationship, fears of abandonment and not getting needs met</p>	<p>Rapid development; Main focus on gross motor skills; Risk for failure to thrive with poor nutrition and low growth</p> <p>Milestones to reach involve reaching, grasping, rolling over, sitting up, crawling, walking</p> <p>Repeats motions that are pleasurable, enjoyable, and meet needs</p>	<p>Rapid brain growth in size, cell growth, structure/ architecture, and neural pathways- requires healthy nutrition and caregiving to achieve</p> <p>No language skills, makes sounds, develops single words by end stage; Memory not sequential, no sense of time</p> <p>No object permanence or conceptual understandings of categories</p>	<p>Feelings are primitive, intense, discrete, can move between moods quickly</p> <p>Attachment to primary caregiver is major developmental task -- leads to secure vs. insecure vs. disorganized attachment</p> <p>Peers not main focus, not able to share, take turns, engage in interactive play with peers</p>	<p>Play is repetitive, physical, based on motor movements and stimulation of senses</p> <p>Learns through play that is repetitive; Enjoys repetitive mildly arousing activities that do not scare or shock</p> <p>Play is primarily with caregivers or individual</p>

As the child grows, language development takes center stage. By 18 months differences in children’s language skills can already be seen (Center on the Developing Child, 2010). Children between three and four years of age increasingly use language to express their needs, engage socially, and explore the world. The speed of motor development slows. Gross motor skill development (running, skipping, hopping) precedes fine motor skill development. Young children often display intense emotions, and moods change quickly in response to outside influences. During these years, children rely heavily on external structures and support (e.g., routines, relationships) to manage emotional states. As they reach preschool age their social worlds broaden and play becomes more interactive. Social-emotional skill building and learning how to get along with other children are major developmental tasks of this stage (Greenspan & Greenspan, 2003).

Child Development Two-Six Years: Overview

(adapted from Greenspan & Greenspan, 2003)

<i>Developmental Functioning & Tasks</i>	<i>Physical</i>	<i>Cognitive</i>	<i>Social-Emotional</i>	<i>Play</i>
<p>Child age 2-6, infancy to toddler-preschool</p> <p>Tasks: Growth, getting basic needs met, learning how to interact with others including peers, learning how to follow rules</p> <p>Typical Features: Major growth spurts, high supervision needs, begins to explore world beyond primary caregiving relationship, develops peer relationships, learns to follow rules and structures, engages the world through language, fears of punishment and loss of control</p>	<p>Main focus on gross motor skill development</p> <p>Milestones to reach include walking and running, feeding self, dressing</p> <p>Fine motor skills weak but developing (holding crayon or toy, coloring, holding utensils, feeding self)</p>	<p>Rapid brain growth in size, cell growth, brain structure, neural pathways- requires healthy nutrition and caregiving to achieve</p> <p>Language acquisition: single words; use of language to interact increases significantly; uses labels to identify objects; beginning understanding of conceptual categories; learns from experience, but cause/effect understanding limited; establishes object permanence and conservation skills</p> <p>Egocentric orientation - leads to tendency to blame self</p>	<p>Limited vocabulary for feelings; basic emotional feelings expressed- “mad, sad, happy, scared”; expresses emotional upsets behaviorally vs. with words (tantrums, hitting, biting)</p> <p>Attachment patterns established; slowly moves away from caregiver, explores world, test limits and boundaries, learning rules</p> <p>Peers and social play increasingly important; makes friends based on similar likes</p>	<p>Enjoys pretend play; ability to engage in fantasy play is high and enjoyable; uses play to manage emotions; explore issues related to safety, structure, control; build relationships, and learn about world and self; enjoys solitary play, but increasingly more social in play; learns empathy, taking turns, sharing</p> <p>Play is physical, based on motor movements and stimulation of senses; learns through play that is repetitive</p> <p>Enjoys mildly arousing activities that do not scare or shock; play is primarily with caregivers or individual</p>

Infant mental health is defined as “the growing capacity of (young) children to experience, regulate and express emotions, form close and secure interpersonal relationships and explore the environment and learn, all in the context of family, community and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development ” (Zero to Three Infant Mental Health Task Force, 2002; Siebel, 2012).

Research shows that establishment of physiological regulation occurs in the early years of life when the development of new neural pathways and brain development are at its peak (Center for the Developing Child, 2010). By the age of three, a baby’s brain has reached almost 90 percent of its adult size (Siebel, 2012). The growth in each region of the brain largely depends on receiving stimulation that spurs activity in that region and allows for learning (U.S. Department of Health and Human Services, 2009).

Children’s development starts with the health of the parent (Center on the Developing Child, 2009; Shonkoff et al., 2000). Starting prenatally, the mother’s health significantly impacts her child’s health. A developing child’s brain requires good nutrition to support prenatal brain growth. After birth, the health and mental health of the mother continues to impact the child’s developing brain and early development. Research has established that intrauterine exposure to toxic substances, poor nutrition, or high levels of maternal stress impact the developing fetus’ brain (Gilkerson & Klein, 2008; Siebel, 2012).

Caregiving relationships are the context in which a baby’s development takes place. When these relationships provide nurturing, responsive care that ensures safety, stability and security, early brain development is healthy (Siebel, 2012). This contributes to lifelong health and mental health, as well as success in relationships, school, and work. Maternal depression negatively impacts a child’s development (Center for the Developing Child, 2009). Secure, nurturing early relationships are so powerful that they can protect very young children from the impact of trauma or “toxic stress” (Shonkoff et al., 2012a). Treating maternal depression is good for the mother, but also positively impacts the child. Parents own histories of disrupted attachments may impact the security of the attachment with their child (Siebel, 2012). A mother who is emotionally available, less stressed, and healthier, is more able to meet her child’s needs. It is within the give and take between a mother and her child that children develop the capacity to better regulate their emotions and manage stress (Center for the Developing Child, 2010).

Homelessness threatens the stability of caregiving relationships and children’s development (Siebel, 2012). Compared to older mothers who are homeless, young homeless mothers (age 18-25) are more likely to have experienced disrupted attachments and separations from their own families. This can place young mothers and their infants and toddlers at increased risk of developmental and mental health disorders. Supporting brain development can lead to healthier outcomes for children’s cognitive, social-emotional, physical, and language development (Center for Disease Control, 2010). This especially true for those children who are homeless or at-risk of homelessness as they are faced with additional stressors and challenges.

Shelter providers are often the first line of response for young children experiencing homelessness. They have the opportunity to observe, assess, and refer young children to early intervention services. Though homeless service providers are often under-resourced (Mullen, 2010), when trained to understand early childhood development, identify attachment related difficulties, and provide or refer families to services, their efforts can reverse potentially negative developmental trajectories

(DeCandia, 2012a). Three recommended areas to target when working with young children include brain development, attachment, and social-emotional development (Center for the Study of Social Policy, 2011). Specific strategies in each area are highlighted below.

Risk and Protective Factors for Healthy Development

Homeless families are a high-risk population. Studies have documented that 92 percent of homeless mothers have been exposed to interpersonal and community violence including physical and/or sexual abuse, and extremely high rates of domestic violence and substance abuse (Bassuk et al., 1996, 1997; Bassuk, Perloff, & Dawson, 2001; Browne & Bassuk, 1997; Burt et al., 1999; Lowin et al., 2001; National Center on Family Homelessness, 2009a; Rog et al, 1995; Rog & Buckner, 2007; Shinn & Weitzman, 1996; Weitzman, 1989). They have higher rates of mental health problems, including major depression, anxiety disorders, and post-traumatic stress disorder (PTSD) when compared to the general female population (Bassuk, et al., 1998; Shinn & Bassuk, 2004).

The developmental periods between birth to six and ages 18-25 present certain advantages as well as unique risks for young homeless families. While young children and young adults' brain plasticity creates opportunities for growth, it is also a time of heightened susceptibility to risk. For young adults, significant trauma and lack of social support, family separation, time spent in foster care, early pregnancy and parenting, and experiences of housing instability are all risk factors for immature brain development. In addition, psychiatric disorders often emerge during this stage, and behaviors such as substance use and sexual risk-taking can intensify (Tanner et al, 2007; Arnett, 2009). The impact of these risk factors on long-term development is potentially severe. For example, the Adverse Child Experiences Study (ACE) found that adults with seven or more risk factors as children are three times more likely to experience significant health problems, including medical risks such as cardiovascular disease, as adults (Center on the Developing Child, 2010; Felitti, et. al., 1998).

For children, significant adversity during critical periods can alter the developing brain's architecture and make it difficult for the body to manage stress (Center on the Developing Child, 2010; Parlakian, 2010; Perry, 2006; Shonkoff & Phillips, 2000; Shonkoff et al., 2012a & b). Research shows that the impact of trauma on overall functioning is greatest when experienced at younger ages or when fewer social supports are available (Center on the Developing Child, 2010; Guarino, & Bassuk, 2010). Many homeless children have physical, emotional, behavioral, and cognitive issues due to exposure to trauma and high levels of stress (Rog & Buckner, 2007; Cook et al., 2005). For example, homeless children have more acute and chronic medical problems, four times the rate of developmental delays, three times the rate of anxiety, depression and behavioral difficulties, and twice the rate of learning disabilities. Fifty percent perform below grade level and thirty-three percent of homeless children under the age of five demonstrate more than one developmental delay (National Center on Family Homelessness, 2009a).

Signs of Traumatic Stress in Young Adults	
<i>Behavior Type</i>	<i>Young Adults Age 18-25</i>
<i>Cognitive</i>	
Difficulty expressing feelings in words	√
Memory problems(forgetfulness, can't recall specific age periods or certain autobiographical details, forgets details, seems disorganized)	√
Impaired executive functions (difficulties focusing, paying attention, learning; faulty judgment; disorganization and planning difficulties)	√
Dissociation (spacing out, not being present)	√
<i>Behavioral</i>	
Signs of depression, anxiety, panic	√
Difficulties with trust, relationships, lack of social supports	√
At-risk behaviors (self-harm, risky health behaviors, excessive sexual/drug risk-taking beyond experimentation)	√
Aggressive behaviors (emotionally abusive, yelling & fighting; physical abuse to children)	√
Concerns with parenting (neglectful, withholding, unresponsive, poor attachment, harsh or abusive discipline)	√
Re-experiencing traumatic event (cognitive or sensory flashbacks, engages in high-risk or self-harming behaviors)	√

Signs of Traumatic Stress in Young Children (Siebel, 2012)

<i>Behavior Type</i>	<i>Children aged 0–2</i>	<i>Children aged 3–6</i>
<i>Cognitive</i>		
Poor verbal skills	√	
Memory problems	√	
Difficulties focusing or learning in school		√
Learning disabilities		√
Limited skill development		√
<i>Behavioral</i>		
Excessive temper	√	√
Demands attention through both positive and negative behaviors	√	√
Regressive behaviors	√	√
Aggressive behaviors	√	√
Acting out in social situations		√
Imitates the abusive/traumatic event		√

Even in optimal circumstances, it takes robust supports such as responsive caregivers and stable environments that provide safety and structure to sustain healthy development. Young homeless mothers lack many of the relational and environmental supports that aid healthy development. The level of fear and unpredictability that accompanies the experience of homelessness, and the challenges of parenting infants and toddlers with limited resources, creates a barrage of stress on top of histories marked by multiple risk factors, placing young families in a high risk subgroup.

Young families experiencing homelessness need the same supports as all homeless families; however they require intensive targeted services to foster healthy development (DeCandia, 2012a). While young children's brains are especially vulnerable to exposure to toxic stress, they are also highly plastic and amenable to intervention. Similarly, the young adult brain is still developing, making its plasticity an asset and responsive to targeted interventions.

There is a window of opportunity for providers to support healthy brain development and enhance cognitive and emotional capacities in young families. Recent studies have identified five "protective factors" that can strengthen families, help prevent abuse and neglect, and promote healthy brain development- all goals of working with this subgroup. They include: supporting secure attachments, building knowledge of child development, strengthening parental resilience, building social-emotional competencies, and providing concrete supports for parents (Center for the Study of Social Policy, 2011; DeCandia, 2012a; U.S. Department of Health and Human Services, 2009). Research supports interventions targeted towards promoting these protective factors. Programs serving homeless families are in a position to capitalize on the inherent strengths of these life stages, build resiliency by enhancing protective factors, and influence the development of young families in a more adaptive direction.

A Service Delivery Model

Collaborations and Partnerships

It is well known from research and field experience that to provide high quality services to individuals and families with complex service needs, a collaborative approach works best. One organization alone cannot meet all of the needs of young parents and their families who are experiencing homelessness; formal, inter-organizational arrangements can reduce gaps and duplication in services.

Strong collaborations are essential for ensuring comprehensive service delivery. While homeless providers may be able to attend to housing and self-sufficiency goals, they may not have the staff or clinical resources to assess or treat maternal mental health, domestic violence, and substance use issues, or provide child specific services. Collaborating closely with community providers, including child development specialists, enables providers to ensure families are receiving the services they need. Integration of services and collaboration among partners makes a real difference in outcomes for homeless families. Through integrated and collaborative services a family's needs across multiple areas can be addressed.

Collaboration is not always an easy task. Providers may be unaware of the resources in their community, uncertain how to build collaborations, or struggle with “turf” issues related to competition for limited funding. Strategies for fostering collaboration include cross-training, team meetings to share knowledge and resources, regular case conferencing, co-locating staff to increase frequency of communication, creating formal means of regular communication (weekly calls to discuss a case), and inviting partners to sit on program advisory boards or attend community events to build relationships.

Trauma-Informed Care

In response to the high rates of traumatic stress among families who are experiencing homelessness, providing “trauma-informed” care is considered a best practice in the delivery of homeless services. Young families have high rates of relational violence and disrupted attachments. The sensitivity and emotional and cognitive immaturity of their developing brains place them at added risk when exposed to traumatic stress. Without understanding the potential impact on the brain and body, service providers may inadvertently re-traumatize families by responding in ways that mimic previous traumas, or create program environments that don't support growth and healing. A trauma-informed program integrates trauma concepts and trauma sensitive responses into daily practice. Key components to providing trauma-informed care in homeless settings include staff training on trauma and its impact; ongoing supervision to reinforce trauma-based concepts; assessment and screening; and providing trauma informed services for children (Hopper et. al., 2010; Guarino, 2012).

Staff training is critical for transforming a program's culture, policies, and practices so that they are trauma informed. Training should include information about the homeless service system, education about young adult and child development, risk and protective factors, the impact of traumatic stress at various stages of development, importance of relationships and social supports, and responsiveness to culture and context in assessing individual needs. Skills training for staff should address strategies

to foster housing stability, economic and educational growth, emotional health and improved executive functioning, child development, and parenting and life skill development. Homeless service agencies, early child centers, and recovery and community mental health agencies can collaborate to share knowledge about trauma-informed practices, and participate in cross-training to learn from one another. Collaboration across disciplines supports staffs' professional development and leads to improved quality of care.

Whereas training lays the foundational knowledge for program staff, supervision ensures ongoing learning and skill development. Providing intensive services to a high-risk group is challenging and demanding work. Supervision is necessary to support staff, provide ongoing training in core competency areas, and maintain a trauma-informed, developmentally sensitive program culture. Addressing topics related to self-care, vicarious trauma, and burnout in supervision ensures that staff maintain appropriate boundaries and are able to engage in the intense, emotional work of caring for homeless families.

Program Components

The goals of working with young homeless families include: 1) stabilizing families in housing; 2) reducing risk factors and; 3) building solid foundations for individual and family development (DeCandia, 2012a). To accomplish these goals, programs should target interventions around five main areas. These include: 1) housing, 2) maternal well-being, 3) child well-being, 4) family functioning and, 5) family preservation. It is well known that housing stability is associated with improved functioning of homeless families (Cohen, 2011; Lubell et al., 2007). Maternal well-being influences child well-being as well as the overall functioning of the family. Family functioning is influenced by parents' and children's success in school and work settings. Keeping families together and strengthening or creating social support networks that are meaningful to the family is protective and builds resiliency. Program design, case management strategies, and individual and group interventions should target each of these areas. Systematically addressing each through in-house and partner services ensures better outcomes for families as well as for programs.

Cost Effectiveness

Young homeless families need safe and stable housing, health and mental health assistance, and children's services. Family homeless shelters are often the primary source of assistance. These programs tend to focus on the instrumental supports that families need to transition out of homelessness (e.g. housing assistance, employment). Unfortunately, many family shelters do not have the resources or expertise to provide the additional supports that many young families need to thrive. Most family shelters have limited programs and services for children, few mental health services for families (Rog & Gutman, 1997; Bassuk & Geller, 2006), little emphasis on families' emotional and relational systems, and lack of follow-through as families' transition from shelter to permanent housing.

The costs of family homelessness are extremely high for both individuals and communities. Research indicates that sheltering a family long-term can cost between \$30,000 and \$55,000 per year (Culhane et al., 2007). In contrast, the average annual cost of serving a family enrolled in the Hilton Initiative, ranged from \$11,150 to \$26,752 (National Center on Family Homelessness, 2011). Through

collaborative interdisciplinary partnerships designed to address family's housing, employment and income, mental health and child development, and family well-being improved with significant cost savings.

No single program can meet all the needs of homeless families, but by working together in a coordinated fashion, integrated service systems can improve outcomes for families and manage costs effectively. Rapidly moving a family into permanent housing is an effective response to homelessness. However critical, housing alone does not meet the needs of many young families who require services and supports to remain housed and to progress towards full independence. Collaboration across service systems strengthens individual programs' service delivery by increasing the resources available to families. Program staff are better equipped to manage complex issues with support from knowledgeable partners in other disciplines. The result is improved outcomes for families along with substantial cost savings (National Center on Family Homelessness, 2009b, 2010, 2011, 2012).

Developmentally Appropriate Strategies and Interventions

Assessing Homeless Families

Assessment of young mothers is a critical process for identifying mother's mental health issues and readiness to live and parent independently. Not a one-time event, assessment is a process that begins at intake and continues throughout a family's stay in shelter or transitional housing. Research shows that when homeless service providers are trained to conduct assessments and ensure mothers and children's access to services, families can stabilize, maternal risk factors can be reduced, and children can make significant gains in all areas of development (National Center on Family Homelessness, 2009b & 2010).

Assessments consist of various elements. First, assessment should be developmentally focused and culturally relevant. It should include an assessment of the parent, and developmental assessments of the child(ren). Second, providers should assess risk and protective factors, and take into account the impact of prior and current experiences on current functioning. Finally, assessment must be trauma-informed, specifically assessing for trauma and its impact. Practically, this means ensuring that a family feels emotionally and physically safe. This may include meeting in a private space; being clear about the process and what to expect; explaining confidentiality and respecting boundaries; offering options about where to sit, and who is in the room; offering water and breaks; and being aware of body language that may indicate that a consumer is feeling overwhelmed (Guarino, 2012; DeCandia, 2012b). Assessments should also be "culture-fair" and free from bias. Questions and procedures should take into consideration a family's cultural and linguistic background. This may mean obtaining translation services, providing documents in a family's first language, being respectful of a family's cultural practices, and incorporating a cultural understanding of a family's current level of functioning.

Gathering information for assessment can be accomplished by observing, interviewing, and using formal measures or scales. Program staff frequently observe children and families in multiple settings. They are in a position to see first-hand how a child is developing and how a parent is functioning. While all staff are in a position to assess through observation, without a solid foundation of knowledge of young adult and childhood development, or an understanding of the impact of trauma, much valuable information is lost. However, with training, staff can learn what to look for, and how to observe systematically by looking for patterns of behavior and comparing what they see with what would be expected at a particular stage of development. This, in turn, enables staff to more clearly communicate to other providers when making referrals, obtaining consultation, and advocating for families.

All programs conduct intakes and some form of assessment. Considerable information can be gathered while interviewing families during programs' regular intake and ongoing assessment. Intake and assessment questions should explore a broad array of issues including family functioning, parental stress, maternal mental health, and child development—and not limit interviews to asking solely about housing and income.

For those with adequate resources, programs may wish to add clinical and child measures to the intake and assessment process in order to better evaluate individual outcomes. Incorporating reliable and valid measures enables case managers and clinical staff to track changes among family members. For example, use of the Ages and Stages Questionnaires (ASQ) can help homeless providers screen children for developmental delays (The National Center, 2009a & 2010). The ASQ second edition is “A Parent-Completed, Child –Monitoring System” (Bricker, D. & Squires, J., 1999). This scale is comprehensive, easy to use, and can identify the needs of infants and young children who may be struggling with developmental delays or disabilities. Use of this scale has been effective in shelter and home visitation. For example, Initiative providers working with homeless or those at-risk for homelessness screened and identified children for developmental delays, and then offered specific interventions resulting in effective treatment (The National Center on Family Homelessness, 2009b, 2010). Use of reliable, valid measures also may help with formal program evaluation.

It is important to remember that assessment is an ongoing process; families' stories tend to unfold over time in the context of trusting relationships. Young families, due to their developmental stage, may need more support and time to build trust with service providers. Homeless providers should comprehensively assess families' needs, even if it requires several meetings over a few weeks to complete the process. The better the assessment, the more targeted the services, the greater likelihood of improved outcomes for families (DeCandia, 2012b).

Individualized Service Planning

Comprehensive assessment is critical for matching services with individual needs. In the same way, understanding the neurodevelopmental issues underlying the challenging behaviors of younger homeless families may help providers respond more effectively.

“One size does not fit all.” This common adage is also true of homeless service delivery. While housing is critical for all those facing or experiencing homelessness, homeless families also need support around parenting and child development. In addition, young families often have intensive clinical needs as they may have difficulty managing stress. Understanding their needs allows providers to design individualized programs. The more programs can align services with individual needs, the greater the likelihood of improved individual and family outcomes.

Best practice indicates that services for homeless families are most effective when they are voluntary, trauma-informed and recovery-oriented; person-centered, individualized to meet specific needs; and culturally competent. For younger homeless families, services should also be developmentally sensitive and more intensive to match the higher level of need. Finally, to the extent possible, services should incorporate evidence-based practices to ensure the best outcomes for families.

Identifying and Providing Supports for Parents

All families need support. Young homeless families require more concrete supports due to their age and developmental level. Supports build protective factors that strengthen families' resiliency (Center for the Study of Social Policy, 2011). Concrete supports to meet basic needs may include acquiring food stamps, WIC, income supports and vouchers for housing, baby supplies for new mothers, vouchers for child care, and assistance with transportation. Young parents may need individualized assistance to navigate healthcare and social service systems, obtain employment, pursue educational goals, and access treatment for domestic violence, mental health, and substance use issues. Providers should assess the specific needs of each family and provide supports that match their needs, recognizing that younger families may require added instructional support so as not to become overwhelmed.

Brain Based Interventions

Depending on the degree of stress and available supports, young adult neuropsychological development can be enhanced and strengthened. Under normal circumstances, it takes time for young adult brains to mature so that emotional reactions can be mediated cognitively. Some cognitive capacities that lead to more mature social-emotional functioning include: incorporating different perspectives into one's understanding of a situation, assessing risks and consequences, planning and decision-making, and organizing and managing multiple demands.

To facilitate development of these cognitive capacities, young adults need repeated experiences that strengthen and sensitize neuronal pathways (Ackerman, 2007). Encouraging young adults to create their own goals allows them to take control of their lives and futures and helps build the brain's executive functions. For example, instead of telling a young adult what to do, or doing it for them, staff and case managers can teach young adults how to think about a situation, problem-solve, consider alternatives, and make plans based on concrete, realistic goals. Case management meetings focused on life skill development that include identifying goals, breaking them down into small actionable steps, and concretely planning a strategy to achieve each step while considering potential obstacles also strengthens executive functioning. Learning life skills is like any other type of learning. It must be frequent and consistent so that more adaptive skills can begin to take the place of old, trauma or survival driven habits (Siebel, 2012).

This strategy also applies to managing behavioral problems. In general, providers should remain flexible in their approach to rule setting. While rules related to health and safety may require strict, clear, non-negotiable limits; to decrease the frequency of disruptive behaviors, a flexible approach that incorporates teaching is preferred. For minor issues, this could involve 1:1 processing of what was done wrong and how it can be handled differently. For issues that impacted the larger community, use of community restitution projects are often helpful. This provides an opportunity for young adults to consider the impact of their behavior on others, learn alternative ways to manage their emotions, and correct their mistakes. In addition to fostering brain development, this also puts providers in the role of mentors rather than authority figures, models flexibility, and fosters trust in the relationship.

Increasing Parents' Knowledge of Child Development

Healthy child development is linked to effective parenting. When parents operate with appropriate developmental expectations of their children, there is a decreased risk for child abuse and neglect. Knowledge of child development and age appropriate parenting skills are known protective factors for developing strong families (Center for the Study of Social Policy, 2011). A recent review of the literature on parenting in the context of homelessness indicates that stressors experienced by homeless parents are associated with aggression, diminished parental confidence and in some cases, increased rates of child maltreatment (Pearlman et al., 2012). Young parents may require psycho-education to increase their knowledge of child development, parenting skills, and discipline techniques to prevent child abuse and neglect.

Parental skills training is an important component of programs serving homeless families. However few parenting programs have been adapted for this population, and even fewer are evidence based (Gewirtz, 2007; Perlman et al., 2012). Parenting Through Change model (PTC) is an evidence based parenting program that has been recently adapted for use with homeless families. This 14-week program focuses on active learning to enhance skills including problem solving, limit setting and monitoring children. Among non-homeless at-risk families, positive parenting outcomes and reduced child and maternal mental health and behavioral risks were reported. Preliminary results among homeless mothers indicate high retention rates and program satisfaction (Pearlman et al., 2012).

As with all homeless services, a “one size fits all” approach to parenting education and training does not meet the diverse needs of all homeless families. Cultural differences as well as level of functioning dictate different approaches. In addition, parents struggling with depression or severe PTSD may require a more clinically oriented or trauma sensitive parent program (Pearlman et al., 2012). Whenever possible, case managers should assess a parent’s needs and try to match them to the most appropriate parenting support or training program. Issues to consider include a parent’s own experiences of being parented, attachment history, cultural beliefs and practices regarding parenting, knowledge of basic child care and child development, quality of the parent-child relationship (for each child), type of family structures used (routines, rules), and discipline techniques.

Expected lengths of stay in shelter or access to services from transitional housing are important factors to consider when implementing a parenting program. Many parenting groups require commitments of 10, 16, even 20 weeks. This may not be realistic or feasible in the context of emergency shelter. While groups are a useful modality to deliver parent skills training, if programs are unable to provide parenting groups, staff can be trained to support positive parent-child relationships. Modeling nurturing interactions, providing positive feedback to mothers for responsive caretaking, and teaching a young parent about child development in the context of shelter meetings or during home visiting, can be effective ways to support parents.

Strengthening Parental Resilience

Parental resilience refers to a parent’s capacity to manage stress, solve problems, seek help, and build trusting relationships. Resilience is associated with a decreased risk of child abuse and neglect and cohesive family functioning. Factors contributing to the development of resiliency include the ability to problem solve, think critically, cope with setbacks, and ask for help. Providers can strengthen these qualities in young parents by teaching and supporting these skills in the context of their relationships. For example, staff can normalize failures and reframe them

as learning experiences, provide a sound basis for reality testing, and encourage young adults to ask for help before a crisis. Emotionally supportive, engaged provider-consumer relationships are the context in which many skills associated with resiliency are taught and developed.

Supporting Early Childhood Development

Young homeless children are at risk for developmental delays and future school difficulties. Supporting early childhood brain development is critical for ensuring a healthy developmental trajectory. The five R's of healthy brain development for young children include relationships, responsive interactions, respect, routines, and repetition (Siebel, 2009 & 2012).

Responsive parenting involves being emotionally engaged in the relationship with one's children and meeting their changing developmental needs. This can involve showing delight when they do something positive and having fun when playing together; using words and actions to show your understanding of a child's feelings and; trying different soothing techniques to discover what works for each individual child. Providers who regularly recognize, acknowledge, and support parents' responsive interactions with their child, reinforce parents' behavior, and indirectly support children's early brain development.

When interacting with young children, providers and parents can show their respect of a child's developmental level and likes and dislikes by having age appropriate toys, and bending down to interact with them on their level. For young children, structure and routines create a sense of safety and predictability. Young parents may have difficulty establishing and maintaining routines due to their own stage of development. Providers can assist by educating young parents about infants and toddlers needs for routine, and helping to set up developmentally appropriate bedtimes, mealtimes, and rituals that foster a child's early development.

For all people, learning takes place over time. For young children, learning needs to be repetitive to establish new neural networks. Repeating words, songs, and reading stories over and over is highly enjoyable to young children, though sometimes less so for young parents. Providers can encourage repeated activities for learning within established program structures. Establishing regular afterschool/work or after dinner activities such as "mommy and me" play groups and reading times create an environment supportive of children's development.

Nurturing Relationships and Secure Attachments

The earliest relationships shape brain development. Secure attachments with a consistent, caring adult in the early years are associated later in life with better academic grades, better mental health and behaviors, more positive peer interactions, and increased ability to cope with stress. Young mothers who have insecure familial attachments require extra support. Providers must work to build trusting relationships, be caring and consistent, and model healthy emotional boundaries with the mothers they serve (DeCandia, 2012).

Strengthening Parent-Child Relationships

Young homeless mothers often have many risk factors that can lead children and families toward unstable developmental trajectories. Early relationships are the foundation for healthy development. Attachment patterns develop over the first few years of life. Securely attached infants are less anxious and have more positive social experiences than insecurely attached children, and demonstrate better functioning as adults. The give and take between parent and child forms the basis for building secure attachments as well as healthy brain development. Lack

of consistent, reliable, responsive caregiving in the first few years of life disrupts this “serve and return” process between parent and child (Center for the Developing Child, 2010). When disrupted by severe parental stress, abuse and neglect, or other traumas, children’s development suffers.

Professionals working with young homeless families can facilitate secure parent-child attachments in the same way that they support healthy brain development. Professionals’ respectful, responsive, reliable interactions with parents act as a model for parents’ relationships with their children (Siebel, 2012). When parents have such experiences their needs are met, and they are more likely and able to create them with others, including their own children.

Building Relationships with Parents

The quality of the relationship between providers and families is the foundation upon which all other work occurs. Relational approaches are empathically driven, client focused, maintain emotional and physical boundaries, and respect privacy. To build healthy provider-family relationships, staff can use techniques such as active listening and role modeling, and provide choices so families are empowered to make decisions. Focusing on strengths and acknowledging even small gains is another important way to build relationships with parents. When parents feel good about themselves, they are more engaged in working on their goals, and more able to respond to their children’s needs.

Enhancing Social Support Networks

Young homeless mothers have more limited social support networks than other homeless or at-risk mothers. Social networks are important to all of us as a source of information and advice. Some provide emotional support and others instrumental supports. Strong social networks also create a sense of belonging and community and can provide an effective buffer against trauma and stress. The potential instrumental gains from such a network—help caring for a sick child, paying bills, or getting a ride to work—are especially significant for the economic and emotional survival of low-income families. However, many young adults who are homeless lack access to friends or family (or may have strained relationships) who can offer assistance in times of need. They may depend on friends and family members who are equally depleted and unable to sustain long-term support. Without this valuable social capital, these young families live precariously and are often unable to weather crises (Ammerman et al., 2004).

Achieving long-term self-sufficiency is challenging for all homeless and at-risk families. However, the journey may be even more precipitous for younger families. Young mothers have very limited work histories and may not make attractive tenants to landlords due to their age and lack of rental history. Furthermore, schools are often ill-equipped to meet the needs of homeless young adults (Ammerman et al., 2004), let alone those who are also parenting, further compromising their capacity to make educational progress. As a result, many young mothers do not have the tools to manage their economic situation.

Strong social support networks are protective and enhance resiliency (Center for the Study of Social Policy Studies, 2011). Providers should work with families to understand who is in their support network, the nature of the support provided (emotionally and/or instrumentally), and how they can build additional supports into their lives. For families with limited or no social supports, providers can help families identify community supports. Depending on a community’s resources, these may include, church groups, recreational centers, parent groups, or activities and places to develop healthy peer relationships.

Social-Emotional Competencies

Programming for young families should be designed to foster social-emotional skills for young children as well as young parents. “Gaining social and emotional skills enables children to learn, make friends, express thoughts and feelings, and cope with frustration” (ZERO TO THREE, 2005). Family homeless service providers can build child specific services into their regular programming to develop these skills. For young parents, building social-emotional capacity involves learning coping and stress management skills, prosocial interpersonal skills, and learning when and how to reach out and ask for help.

Developing Child-Specific Services

Most programming in shelter settings is focused on adults. While obtaining permanent housing is the main objective for all families, children’s needs may be overlooked. The impact of trauma and homelessness on child development and the parent/child relationship is profound. For children in homeless shelters, child friendly programming is essential.

In many shelters there may be inadequate space for running and playing, limited resources for toys and activity programming, and sometimes non-childproofed environments creating safety hazards. When designing services for children, programs should first assess their environment for child safety. This includes ensuring that electrical outlets are covered; windows have safety bars; play spaces have age appropriate, safe, and clean toys; cribs are free from pillows, blankets, and small objects; and locked storage areas exist for cleaning products. Families may need assistance in making their rooms or homes child safe, and younger families may need staff to help set up a home for a new baby or toddler.

Play is critical for all children’s development. The inability to play is a hallmark of trauma. Through play children develop social and emotional skills and competencies. With support from engaged adults they learn how to manage frustration, disappointment, and jealousy; develop empathy for other children’s feelings; learn to share, wait, and take turns; and discover the pleasure in accomplishing a task like painting a picture or building a castle. Having safe spaces where parents can sit quietly and read to their child, play, and have fun together is essential for healthy child development. Providers act as teachers and role models for parents to help them learn how to develop these capacities in their children. Programs that incorporate activities such as infant massage or family play time into their weekly schedules create routines that foster social-emotional skill building in children.

In addition to child friendly programming, early intervention and trauma-specific services for children may be required. This may include individual and family therapy services that focus on helping children manage traumatic stress, or therapeutic play groups that are creative and provide non-verbal activities such as art, dance, and yoga for children. All of these outlets allow children to build coping skills to identify, express, and manage feelings associated with the stressors they face (Guarino, 2012). Based on the results of a child assessment, specific services to target developmental delays may be indicated. For children under age six, typical services include early intervention to target motor skill development or speech therapy for language delays. Research indicates that language delays are first evident in traumatized children by 18 months of age, and that by three years old the vocabulary differences between children from low and middle income groups is already evident (Center for the Developing Child, 2010). Referring children early on for specialized intervention can make a significant difference in a child’s future development.

Strengthening Parents' Copings Skills

Raising young children while trying to meet educational goals, or attain and keep a job are difficult for any parent, but can be especially challenging for homeless parents as they also search for permanent housing. Many young homeless parents often feel overwhelmed by all these pressures. The youngest of this subgroup, those in late stage adolescence, may be naive about how difficult it can be to live independently and may harbor youthful, though unrealistic hopes, of quickly attaining financial and residential independence.

Young parents need assistance as they face the hard realities of homelessness and must work to fully adopt adult responsibilities. Program staff can help these mothers develop various coping skills. Programs can teach life skills such as cooking and doing laundry, responsibility for their own health and medication management, and navigating agreements with cell phone companies, creditors, student loan offices, and landlords. Financial literacy is a critical life skill necessary for self-sufficiency. Learning how to create a budget, track spending for groceries, address child care needs, and ensure transportation is essential. Guidance, coaching, and dedicated case management meetings where life skill development is focused on skill building enhances young adults' ability to cope on their own.

Social skills for young adults are as important as they are for children. Young adults are often faced with a variety of difficult situations with friends and family, as well as in the workforce. Social skills, or "soft skills" are critical to successful employment, and other than poor job performance, are often a primary reason for job loss. Social skills are critical for effectively communicating, resolving conflict, getting along with coworkers or a supervisor, being part of a team, and being able to contribute to a positive work environment or community. Program staff can teach young adults skills such as how to communicate effectively, listen to others point of view, accept feedback, use a nonjudgmental tone, and articulate concerns without yelling or escalating. Success in work and relationships greatly depends on social skills. For young homeless adults, having opportunities to practice them in the context of trusting interpersonal relationships with providers can build resiliency.

There are many different coping skills to manage stress or traumatic reactions. What works for one person may not always work for another. Programs can help young adults manage stress and cope with emotional triggers and trauma by teaching them a range of skills and providing them with a menu of options from which to choose. For some, cognitive restructuring or learning how to reframe an issue, substituting negative thinking with positive self-affirming thoughts, is most helpful. For others, relaxation exercises such as deep breathing, listening to music, or meditating works. Still for others, engaging in creative activities like art or journal writing, or engaging in prayer and spiritual practice helps manage emotions and reduce stress. Exercise, walking, playing with children, laughing, and talking to supportive others are all healthy coping skills. Providers, in their everyday interactions with families, can actively work with young adults to help them develop adaptive coping skills to build resilience and reduce reliance on unhealthy coping behaviors.

Quick Reference Guide: Strategies & Interventions

<i>Target</i>	<i>Intervention for Parents</i>	<i>Intervention for Children</i>
Assessment	<p>Areas to assess include:</p> <ul style="list-style-type: none"> • Housing needs • Economic & educational needs • Developmental stage • Risk & protective factors including maternal mental health, trauma, depression, anxiety, history of suicide attempt • Parenting skills & degree of parental stress • Social supports • Cultural beliefs and needs 	<p>Areas to assess include:</p> <ul style="list-style-type: none"> • Developmental stage & functioning • Risk & protective factors including developmental delays & trauma • Quality of attachment • Social supports
Concrete Supports	<ul style="list-style-type: none"> • Basic needs-food stamps, WIC, income and transportation supports, clothing • Housing supports-vouchers, flexible funding • Instructional supports-navigating healthcare, social service, educational systems, how obtain employment, apply for school, student loans, and access treatment 	<ul style="list-style-type: none"> • Basic needs-food & clothing • Age appropriate toys • Age appropriate books and literacy materials • Enroll in daycare or school
Brain Development	<p>Teach:</p> <ul style="list-style-type: none"> • Problem-solving • Considering alternatives • Critical thinking • Realistic goal setting • Decision making <p>Increase knowledge of:</p> <ul style="list-style-type: none"> • Child development • Parent education <p>Use:</p> <ul style="list-style-type: none"> • Discussion about behavioral issues • Community restitution projects 	<p>Focus on the five R's:</p> <ul style="list-style-type: none"> • Relationships • Responsive interactions • Respect • Routines • Repetition
Social-Emotional Competencies	<p>Teach and strengthen:</p> <ul style="list-style-type: none"> • Coping skills • Relationship skills • How to ask for help 	<ul style="list-style-type: none"> • Ensure child safety • Provide play spaces & nurturing interactions • Teach self-soothing, how to get along with others, empathy • Provide vocabulary for feelings
Attachment Relationships	<ul style="list-style-type: none"> • Model responsiveness and respect • Support positive parent-child interactions • Build support networks 	<ul style="list-style-type: none"> • Support positive parent-child interactions • Build support networks

Evaluating Outcomes

Evaluation is a valuable component of service delivery. Built into regular programming, well-conducted evaluations assist providers in knowing if their services have a real impact on families' lives. Homeless service providers are under-resourced and may experience program evaluation as an additional, unnecessary burden. Yet, without evaluations, well-intentioned service providers may not know how their services are affecting the families they serve (DeCandia, 2012b; Metz, 2007).

Conducting evaluations allows programs to track families' progress and know what works. Programs need to be accountable to their clients as well as to funders. Evaluations enable programs to explain their services to clients, and speak about accomplishments. Logic models are useful tools to help programs design service systems and communicate the effectiveness of their methods. Logic models provide an organizing framework and enable programs to be intentional about their goals and allocation of resources. Through the use of logic models, programs can more effectively link service delivery to outcomes, ensure a common understanding of goals, and communicate its purpose and value in a brief snapshot (DeCandia, 2012b; Organizational Research Services, 2004). They also allow for mid-course corrections and refinement of services. Data collected during an evaluation helps providers better understand and improve program processes (Metz, 2007). Evaluation results can be used to guide decisions on whether or not to continue with the same program approach or try new ways of helping young families (DeCandia, 2012b; Metz, 2007).

Data collected by homeless programs are highly sensitive and care should be taken to ensure client privacy and security of the information. A data management system should be designed using either a single entry or if possible, a double entry method to ensure accuracy. Either way, training should be provided to all staff involved in data collection and data entry processes (DeCandia, 2012b).

Finally, when homeless or formerly homeless families are engaged in the evaluation process, the data tend to be more meaningful and complete. Focus groups are one way to facilitate this involvement. Having formerly homeless individuals on a program advisory board is another way to engage consumers in service delivery and in the evaluation. Consumers can offer a valuable perspective on the types of questions to be asked, potential challenges and barriers, and culturally relevant evaluation practices. Best practice dictates that the voices of families with lived experience of what it is like to be homeless or at-risk for homelessness inform a program's design and evaluation process.

Conclusion

Homeless providers are being asked to not only deliver services to families with complex needs, but to incorporate evidence-based best practices and outcome evaluations into their programs. Homeless families are not a homogeneous group. Young families represent a subgroup of the homeless population with unique needs related to their stage of development and high number of risk factors. Understanding young adult and early childhood development is essential for providers serving this subgroup. This guide provides a model for service delivery that meets the complex needs of young homeless families. This model includes trauma informed, culturally and developmentally appropriate services that improve housing stability, provide concrete supports, and facilitate the development of brain growth, social-emotional competencies, and secure attachments through strong collaborative partnerships. This cost-effective model can reduce risk factors associated with homelessness, and provide a foundation for healthier developmental outcomes for children and families.

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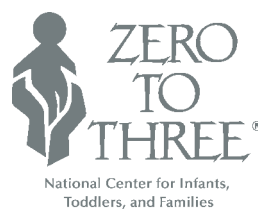
Strengthening At Risk and Homeless Young Mothers and Children is generating knowledge on improving the housing, health and development of young homeless and at-risk young mothers and their children.

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