Childhood Homelessness and Its Dire Implications

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It is increasingly evident that the homelessness problem in America is intensifying. An important component of this crisis is the scope of child and family homelessness, and the implications on the general welfare of children and their families, including their mental health.

According to the US Department of Housing and Urban Development's (HUD) 2019 Annual Homeless Assessment Report (AHAR), on a given night in 2019, an estimated 568,000 people were experiencing homelessness in the United States. Nearly two-thirds were staying in sheltered locations and more than one-third were in unsheltered locations deemed unsuitable for habitation. California itself has more than half of all unsheltered homeless people in the country. In fact, the number of unsheltered individuals in California rose 21% between 2018 and 2019, an increase of more than 18,000 people.[1] Despite having the highest Gross Domestic Product (GDP),[2] among US counties, Los Angeles has the largest census of the chronically homeless population.[3] In order to address this problem effectively, it is important to understand the elements of homelessness relevant to children and families. The Greater Los Angeles Homeless Count of 2019, a point-in-time estimate of homelessness, demonstrated an 16% increase for Los Angeles County.[3] Economic factors (eg, unlivable wages, rent) in many communities are driving the increase in homelessness. Excessive rental costs and insufficient affordable housing capacity is evident in some urban areas, for example as in Los Angeles, where it is a significant cause of homelessness.[4] Of particular concern is the alarming data provided regarding homelessness among children. It is estimated that there are currently more than 17,000 homeless children in the Los Angeles Unified School District alone. A staggering 80% of children in the school district meet the guidelines for poverty, well above the national average of 25%.[5] The National Center for Homeless Education[6] reports that there are more than 1.5 million homeless students nationwide. Recently, the US Government and Accountability Office[7] has conjectured that homelessness may increase during the COVID-19 pandemic in 2020 due to the related economic downturn, increasing unemployment and lifting of a moratorium on evictions.

Elements of Youth Homelessness

There are varying definitions of homelessness among youth; this varies among the different levels of government and agencies who serve said populations. The variation has significant implications for data collection. In addition, the youth are additionally classified by "typologies," ages, and duration of being homeless. Such complexity reflects the diversity of experiences and backgrounds among youth experiencing homelessness, who cannot always be placed into a single category. Another facet is that of "couch-surfing;" children who couch-surf are counted as homeless pursuant to the federal law known as the McKinney-Vento Act but are not considered homeless in other regulatory frameworks. Such heterogeneity has made it difficult to create targeted interventions for this vulnerable group and provide linkage to relevant services.[8] In California, the term "homeless youth" generally refers to unaccompanied minors ages 12 through 17 who are living apart from their parents or legal guardians, young adults ages 18 through 24 who are economically and emotionally detached from their families, and are experiencing homelessness or living in unstable or inadequate living situations.[9]

Youth who are homeless, according to the McKinney-Vento Act (MVA), are those "who lack a fixed, regular, and adequate nighttime residence;" and may share housing with others due to loss of housing. Such a youth may use a private or public space not ordinarily used at night for sleeping accommodations. A youth is, also, homeless if sleeping in public places such as

parks, abandoned buildings, and transportation centers according to MVA.

Previous studies have demonstrated that the vast majority of families experiencing homelessness were comprised of single mothers with two young children, often under the age of six.[10] These families tended to be residentially unstable, moving frequently, and often forced to live in sub-standard housing and low-opportunity neighborhoods due to lack of housing, lack of economic assistance, and housing unaffordability. The most salient risk factors for family homelessness include a childhood history of foster care placement of mother and history of mother having been raised in household in which primary female caregiver had substance use problem[11] as compared to homeless adults. Other risk factors include minority status, few resources and supports, conflicted relationships of mother, small social networks, frequent use of alcohol or heroin, and psychiatric hospitalization of mother within past two years. Violent victimization was not found to be a risk factor, although a frequently reported event.[11]

Many factors may account for the risk of homelessness in youth which are different from that of family homelessness. These factors include being Hispanic or Black, adolescent pregnancy and being unmarried. Additionally, family conflict and family rejection, sexual orientation issues relevant to LGBTQ communities, sexual activity, school problems, pregnancy, sexual and physical abuse and neglect, and substance use are primary risk factors.[12]

Children living in foster care have additional risk factors for homelessness including the number and duration of foster care placements, and frequency of elopement. Foster care placement is itself a risk factor for homelessness.[12] Youth in group or residential care are also more likely to run away from care than youth in traditional foster care or out of home placement. “Aging out” of the foster care or juvenile justice systems are other factors, most likely due to the loss of concrete social service benefits, including housing.

Additional Adversity Related to Homelessness

The potential for additional adversity among youth experiencing homelessness is vast; such has implications for a complex service array with the goal of ensuring that such youth maximize their potential. The lack of proper nutrition, which is common among homeless children, may be particularly significant for very young children when it occurs during the perinatal period.[13] Growth delay[14] and increased risk for poor health outcomes[15] is strongly suggested by research in such circumstances. Other consequences associated with unmet shelter needs include untreated mental health disorders,[16,17] language and communication disorders,[18] substance abuse, sexually transmitted diseases, sexual exploitation (including survival sex to meet basic needs), physical victimization and increased suicidality.[19] A research review[20] indicates that the prevalence of mental health problems is greater in school age children relative to pre-school children when comparing homeless and housed populations. The National Sexual Violence Resource center reports that one in three teens on the street will be sexually trafficked 48 hours within leaving their home.[11] The American Academy of Pediatrics has shared findings that youth experiencing recent family homelessness were twice as likely to have levels of emotional distress, self-injury, and suicidal thinking, and over three times as likely to attempt suicide within the last 12 months.[12] The adversity faced by youth experiencing homelessness are vast, and often require coordination across all human service sectors. The impact of adverse childhood experiences linked to homelessness should be viewed in a developmental framework and may have have life-long consequences.[21]

Recommendations for Child and Adolescent Psychiatrists

Treatment planning considerations. In order to address the needs of this population, child and adolescent psychiatrists, not unlike their pediatric colleagues,[22] will likely have to expand their clinical tool set beyond those interventions which one may use, for example, with a child living in stable housing, in tandem with a multidisciplinary treatment team to include the following:

1. Determine the level of housing stability. Inquire about the various settings and frequency of changes in housing. Linkage to housing resources should be facilitated.
2. Determine if youth has experienced out-of-home placement, eg, foster care.
3. Determine if medical care has been received, including that for sexually transmitted diseases in older youth, and is generally accessible. If necessary, access to healthcare should be facilitated.
4. Determine the adequacy of nutrition, degree of general food insecurity. Linkage to nutritional resources should be facilitated if necessary.
5. Determine the level of personal safety, including threats and actual acts of violence, especially during periods of homelessness, to which a youth and/or family has been subjected. Determine if youth and/or family has or is receiving child welfare services. Abide by mandatory reporting laws and regulations related to negligence and abuse.
6. Determine the academic trajectory of a youth and changes in school settings. Advocating for a minimum number of changes in school settings is optimal for educational achievement. Determine if school or school district has provided any special assistance for students who are homeless or in foster care.
7. Identify public resources from which the child and/or family would benefit. The youth's personal and family's priority concrete needs should be identified.
8. Develop treatment plans in collaboration with child or family and include barriers imposed by homelessness.
9. Provide linkage to developmentally relevant supportive services for youth, e.g., recreational.
10. Determine the need for medically necessary services for caregivers, including behavioral health services.

Advocacy Considerations

1. Become familiar with data relevant to homelessness in one's state or locality, for example, those published by US Department of Education and/or US Interagency Council on Homelessness.[3,6]
2. Become familiar with priorities related to homelessness identified by local elected officials and state officials through district offices or state offices, especially those of one's own elected representatives. This can easily be done by reviewing websites of elected leadership at the national (including congressional representatives), state and local government levels, eg, city council, other elected officials. Some legislatures have designated a task force or workgroup of experts to provide guidance on homelessness to state legislatures.
3. Become familiar with laws and regulations pertinent to special assistance provided by schools, eg, McKinney Vento Act, in anticipation of communication with school personnel.
4. Share your stories of patients, who are homeless, with one's personal elected officials. Partnering with other organizations which have a similar agenda related to this issue can maximize advocacy potential; this can be done as an individual or with one's local, state or national medical organization,
5. Discuss the needs of homeless children and families from a developmental perspective, eg, education, recreation, nutritional, among others, with elected officials and/or their staff.
6. Share success stories of homeless-experienced children and families with elected officials.
7. Advocate for temporary housing and permanent housing resources relevant to children and families in one's locality with elected officials. Reasonable shelter eligibility[22] has been shown to decrease high-end health costs, eg, emergency services.

8. Become familiar with issues of housing equity[23] in one's community. Advocate for housing equity, affordable housing issues, and housing subsidies.

9. Advocate for supportive resources[24] for adults, eg, mental health or substance use disorder treatment services, who may need such assistance in order to discourage the separation of families or those at risk of separation.

10. Advocate for minimum wages commensurate with local cost of living.

Summary

Homelessness among children, youth, and families is a critical aspect of the growing homelessness crisis in the US Effective strategies that are multi-systemic in nature offer the most promising solutions.

The ramifications of homelessness among children and families has potential long-term effects on these family units and society at large. The existing resilience evident among many of these children and families is buttressed by the access to an array of services, resources, support, and programs. Policy making bodies at all levels of government have a great potential to diminish the adverse impact on these children and families and to maximize their potential contributions to their communities and the general society.

Child and adolescent psychiatrists can influence the developmental trajectory of these children and families with both their clinical expertise and understanding of the array of service systems in their communities. Through active advocacy with state or national medical organizations and other organizations which share similar advocacy agendas, such influence can be maximized directly with policy makers and other decision-making bodies on behalf of this very vulnerable population of children, youth, and families.

Take Home Summary

Children and families experiencing homelessness comprise a significant component of the growing homelessness crisis nationwide with a myriad of potential adverse consequences for this population and societal ramifications. Child and adolescent psychiatrists are in a position to mitigate this mushrooming calamity.

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The authors have reported no funding for this work.

Disclosure: Drs. Abidi and Arroyo have reported no biomedical financial interests or potential conflicts of interest.

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This article was edited by Roya Ijadi-Maghsoodi, MD.