# Homelessness in Pediatric Populations

## Strategies for Prevention, Assistance, and Advocacy

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**KEYWORDS**

• Homeless • Experiencing homelessness • Pediatric • Children • Adolescent • Youth • Runaway • Trafficking

**KEY POINTS**

- Children and adolescents experience homelessness at higher rates than point-in-time counts suggest.
- Many pediatricians see patients and their families who are unstably housed or homeless without being aware of their status.
- Through increased awareness of the health issues facing pediatric patients experiencing homelessness, pediatricians can identify those at risk and provide links to needed care and support services.
- This article reviews current data about homelessness among pediatric populations in the United States and strategies for intervention.

### INTRODUCTION

Homelessness dramatically increases morbidity and mortality. Health issues also increase the likelihood of families experiencing homelessness.[1] Pediatricians have a unique opportunity to prevent and intervene in pediatric and family homelessness[2] because they are well versed in assessing social determinants of health, providing anticipatory guidance and working with schools and other community partners. This article provides an overview of health issues facing pediatric patients and their families when experiencing homelessness, ideas for identifying families who are currently

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experiencing homelessness as well as those at risk of becoming homeless. This article also suggests areas for advocacy and provides strategies for pediatricians to intervene, and ultimately, prevent homelessness.

## BACKGROUND

There have been 2 notable periods of mass homelessness: The Great Depression and the period from the 1980s to 2019.[3] The current wave of mass homelessness is, at least in part, attributed to the inadequacy of mainstream safety net programs to meet the high level of need. Programs, such as Medicaid, Temporary Assistance to Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), have had funding restrictions and increased documentation requirements, which have made them inaccessible for many families.[3]

The Stewart B. McKinney Homeless Assistance Act of 1987 was initially introduced to Congress in 1986 as the Homeless Person's Survival Act. On Oct 30, 2000, the legislation was renamed as the McKinney-Vento Homeless Assistance Act after the death of one of its lead supporters, Representative Bruce Vento.[4] This landmark legislation provided a clear definition of homelessness and areas for intervention.

Presently, there are several definitions of homelessness.[5] In the Runaway and Homeless Youth Act, a homeless youth is someone who is "not more than 21 years of age…for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement."[5,6] The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 consolidated 3 different programs under the McKinney-Vento Homeless Assistance Act into a single grant program in addition to revising and renaming Emergency Shelter programs and grants and creating the Rural Housing Stability program. The HEARTH Act definition includes the following 4 categories for homelessness:

1. "Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
2. Individuals and families who will imminently lose their primary nighttime residence;
3. Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition;
4. Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member."[7]

For homeless families, episodes of homelessness are part of a cycle of housing instability precipitated by living in deep poverty; lack of available, affordable, and safe housing; and "doubling-up," that is, living with family and friends in overcrowded settings to reduce financial stress. Before the first episode of homelessness, families are likely to have already been receiving services from safety net programs, such as Medicaid and SNAP, but an acute increase in financial or social stress disrupts the fragile balance. Severe illness, loss of a job, or change in family dynamics owing to incarceration, involvement with child protection services, or domestic violence is a common precipitating factor.[8]

Youth homelessness can be temporary or cyclic. As noted by Auerswald and Eyre,[9] there are definable phases of a youth's experience of homelessness when they are more likely to leave or return to the streets. Youth are more likely to access health

services during the "extrication" phase and more likely to access substance use treatment during the "disequilibrium" phase[10] (Fig. 1).

## EPIDEMIOLOGY

Data estimating the number of people experiencing homelessness are inherently limited by several factors, including variable definitions of homelessness and lack of fixed contact points for the study population.[11] These limitations result lead to oversampling of those in shelter; however, the number of shelters is very limited even in the largest cities. Many shelters do not take residents who are not part of what has been previously described as "traditional families," for example, gay parents, a single father with children; families with older teens, pregnant teens, or those suffering substance abuse or severe mental health problems. When counting homeless youth, there are additional challenges related to youth avoiding formal systems of shelter because of stigma, fear of legal action, or fear of being returned to abusive situations.[11–13]

The primary reference used to estimate the population of people experiencing homelessness in America is the point-in-time count, which is usually conducted on 1 night in January.[14] Data from the 2018 point-in-time count indicate that there were roughly 553,000 people experiencing homelessness in the United States, approximately two-thirds of whom were in shelter. For the point-in-time count, "people in families with children" are defined as "people who are homeless as part of a household that has at least one adult (age 18 or older) and one child under age 18." More than 180,000 of the approximately half a million people experiencing homelessness are people in families with children.[14] Data from previous point-in-time counts show that more than 75% of the adults in homeless families are women and that the adults in homeless families tend to be younger, between the ages of 18 and 30. Furthermore, 59% of people experiencing homelessness in families were children under age 18; almost half of these children were under age 6, and 10% were under 1 year old. "The age at which a person in the United States is most likely to stay in a homeless shelter is infancy (Fig. 2)."[7,15]

Approximately 36,000 people in the 2018 point-in-time count were "unaccompanied youth": people under age 25 experiencing homelessness away from their family. An overwhelming majority (89%) of these youth were "transition age youth" (TAY) between the ages of 18 and 24. More than half of the unaccompanied youth were unsheltered, which is significantly higher than the rest of the counted population.[14]

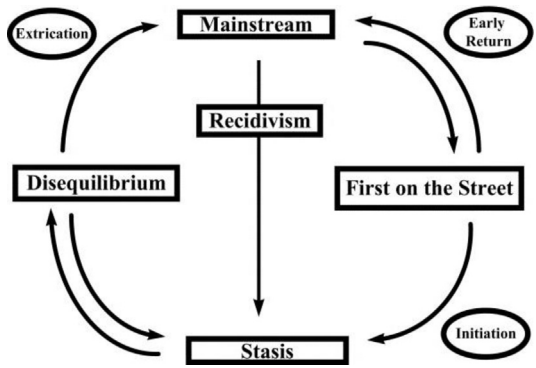


**Fig. 1.** The lifecycle model of youth homelessness. (*From* Auerswald CL, Eyre SL.Youth homelessness in San Francisco: a life cycle approach. Soc Sci Med. 2002 May;54(10):1497-512; with permission.)

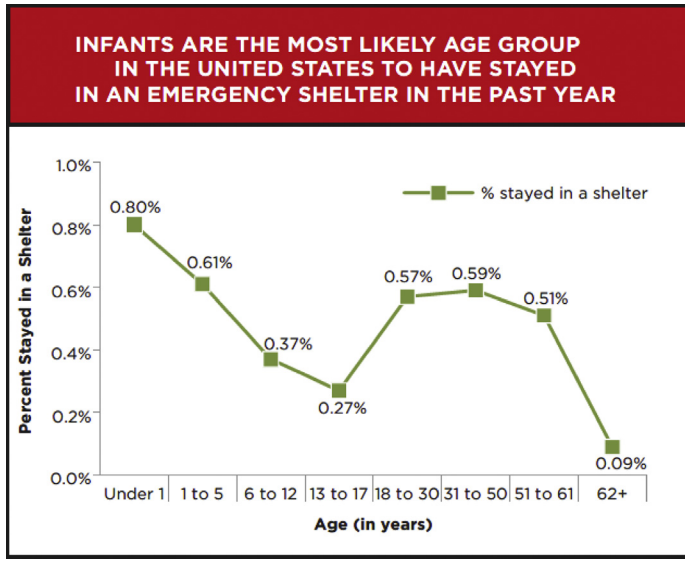


**Fig. 2.** Numbers experiencing an emergency shelter stay by age are from Homeless Management Information System Estimates for the 2013 Annual Homeless Assessment Report to Congress. (*From* Brown SR, Shinn M, Khadduri J. Homeless Families Research Brief: Well-being of Young Children After Experiencing Homelessness. Available at: https://www.acf.hhs.gov/sites/default/files/opre/opre_homefam_brief3_hhs_children_02_24_2017_b508.pdf.)

In an attempt to more accurately identify the population of homeless youth, Morton and colleagues[16] used a nationally representative phone-based survey to define the population of youth who have a variety of homeless experiences, including those who were "couch-surfing," that is, staying temporarily with friends or extended family members, in addition to those who met the traditional definitions of homelessness. Their data estimate that at least 660,000 youth aged 13 to 17 and 2.4 million youth aged 18 to 25 experienced at least 1 night of homelessness in 12 months before the study. In addition, there were no significant differences between those in rural versus nonrural counties. Youth who reported being unmarried with children of their own; lesbian, gay, bisexual, or transgender; black or African American; having not completed high school or passed a GED (General Educational Development) test; or with an annual household income of less than $24,000 were more likely to experience homelessness.

Data from the US Department of Education are congruent with those from the phone study indicating that more than 1.3 million children experiencing homelessness were enrolled in school for the 2016 to 2017 academic year. Of these students, almost a quarter million had disabilities, more than 118,000 were unaccompanied/living apart from their parents or guardians, and 16,170 were in migrant families. More than 75% of the 1.3 million children who were enrolled in public school and experiencing homelessness were "doubled up"; 3.7% were living in motels or hotels; 13.9% were living in shelters, transitional housing, or awaiting foster care placement; and 6.6% were unsheltered[17] (**Fig. 3**).

Youth who have been involved with the foster care system or who have been incarcerated are significantly more likely to experience prolonged youth homelessness. Prolonged youth homelessness is an umbrella term combining chronic homelessness,

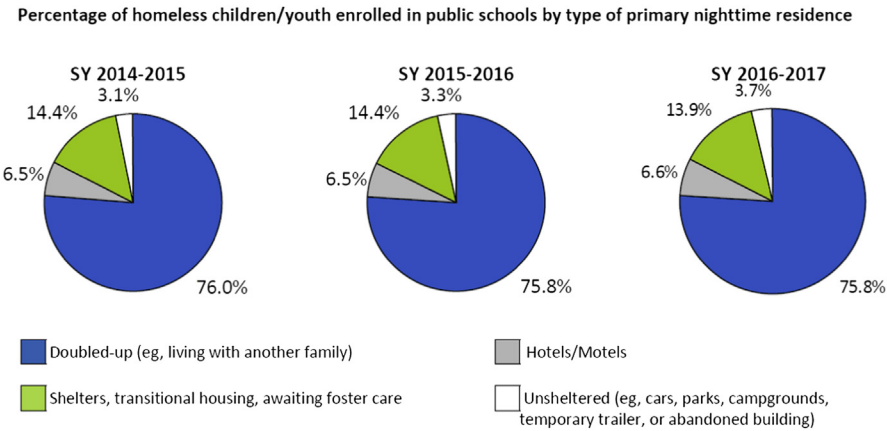


**Fig. 3.** Percentage of homeless children in grades pre-K-12 enrolled in public schools in the United States by type of primary nighttime residence. (*From* National Center for Homeless Education. National Overview. Available at: http://profiles.nche.seiservices.com/ConsolidatedStateProfile.aspx.)

which is 12 or more months of homelessness, and long-term homelessness, experiencing homelessness for at least 5 years.[18] In a study of TAY in Los Angeles, Rice[19] found that more than 61% of participants who had been incarcerated before age 18 experienced long-term homelessness.

According to the "Trafficking in Persons Report," "severe forms of trafficking in persons" is defined as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery." The report states "in the United States, traffickers prey upon children in the foster care system."[20] The enactment of the Justice for Victims of Trafficking Act in 2015 required states to change their laws to include any finding of commercial sexual exploitation (CSE) involving a minor to automatically meet criteria for child abuse and neglect.[21]

## HEALTH ISSUES

The issues of data accuracy in defining and counting the number of children experiencing homelessness extend to data regarding the incidence and prevalence of health conditions. Generally, most studies use the McKinney-Vento or HEARTH definitions of homelessness because recruitment is conducted at sites that use these definitions to assess eligibility for services. It is clear those experiencing homelessness are significantly more likely to have poor health and experience more adverse childhood events than those who are stably housed.[2,22–25]

### *Physical Health*

#### *Infancy*

A multistate study conducted from 2009 to 2015 found that children born to caregivers (parent answering the survey) who were homeless "prenatally and postnatally," or who were homeless "postnatally only" were significantly more likely to have a postnatal hospitalization, be described as having "fair or poor health" and to be at

developmental risk compared with those whose caregivers were never homeless. Those who were homeless "prenatally only" did not have the increased developmental risk, but they still had higher risks of hospitalization and poorer health compared with the never homeless group. In addition, infants who had been homeless for more than 6 months were more likely to have an overweight status in addition to the higher risks of hospitalization, poorer health, and developmental risks.[25]

### *Asthma*

Because of issues related to poor housing or being unsheltered, children and youth experiencing homelessness are more likely to experience exacerbations of asthma than housed youth. In 1 analysis of more than 70,000 pediatric asthma hospitalizations in New York State, youth who were identified as homeless were more than 31 times more likely to be admitted than those who were not homeless. The homeless subgroup was more likely to have been admitted from the emergency department and those older than 5 years old were more likely to require ventilation than patients older than 5 years old who were not homeless.[26]

### *Obesity/malnutrition*

The relationship between food insecurity, socioeconomic status, and obesity is complex. For many people with limited resources, inexpensive, low-nutrient, high-calorie foods are more easily available than more nutritious options.[27–29] Many shelters, drop-ins, and soup kitchens serve processed foods. People who are living in hotels, in cars, or on the streets will not have access to refrigerators and cooking facilities. Those who are doubled up may have limited access to shared kitchen space. Fast food becomes the most available option. In a study of children accessing care through New York Children's Health Project, which provides comprehensive primary health care to homeless children and families via mobile and on-site clinics at family shelters, domestic violence shelters, and a shelter for homeless youth, 39% of the children met definitions of overweight or obese.[27] Compounding the problem for children is the lack of safe places to engage in physical activity or play.[28]

### *Dental problems*

Dental problems are common for many children, but particular challenges exist for those who are homeless.[30,31] Children experiencing homelessness generally lack access to the basic tools needed for dental care, such as toothbrushes, toothpaste, and access to clean water.[30] In their study of youth aged 14 to 28 who identified as homeless and were accessing care at a community health center in Seattle, Chi and Milgrom[30] found that approximately one-third of youth surveyed reported their oral health as "very bad" or "bad" and had problems such as sensitive teeth, discolored teeth, toothaches, broken fillings or teeth, sore or bleeding gums, pain while chewing, a loose tooth, poorly fitting dental repairs, or tooth abscess. Obviously, these dental problems can affect nutritional intake and other aspects of health.

### *Vision problems*

Vision problems are common among pediatric patients experiencing homelessness.[32,33] Estimates of vision problems range between 13% to 26% of those studied.[33] Using a combination of the vision screening with a questionnaire developed in accordance with the American Academy of Pediatrics and Ophthalmology Policy Statement on "Eye Examination in Infants, Children and Young Adults by Pediatricians," eye-chart screening and referral to ophthalmologic examination for those who failed screening, Smith and colleagues[33] found a prevalence of vision problems of 25%. Myopia and astigmatism were the most common problems, but the

ophthalmologic examination revealed additional diagnoses of amblyopia, anisometropia, esotropia, hyperopia, myopia, nystagmus, and ocular albinism. Getting new glasses, or being able to replace or repair broken or lost glasses, is a significant challenge for many people experiencing homelessness because of insurance restrictions, lack of insurance, and limited availability of ophthalmology or resources to pay for glasses.[33]

### *Injury*

Injuries are common because of the unsafe living situations of children and youth while homeless, trauma, and substance use. Injury was part of the diagnoses for approximately one-third of adolescents and young adults who used the emergency department or were admitted for inpatient care in a recent Seattle-based study of patients aged 15 to 25 who were admitted to the emergency department or inpatient floors and whose address was listed as "homeless," "none," a homeless shelter, or a service agency.[34]

### *Infection*

Overcrowded conditions can also increase the risks of infection. There have been recent outbreaks of isoniazid-resistant tuberculosis among residents of homeless shelters in 16 states.[35] Outbreaks of hepatitis A, head lice, and body lice with associated *Bartonella quintana* have occurred among homeless populations in the United States in recent years.[36,37] Homelessness was recently reported as a risk factor for adult admissions and readmissions for respiratory syncytial virus in Seattle.[38] There are obvious implications for children exposed to adults with these infections.

Scabies is more common among those who are homeless or unstably housed with a prevalence of 10% compared with a prevalence of less than 1% among children seen in routine primary care practices. In addition, more frequent episodes of common pediatric conditions, such as otitis media and gastroenteritis, occur among children experiencing homelessness.[22]

### *Sexually transmitted infections*

Caccamo and colleagues[39] sought to estimate the prevalence of sexually transmitted infections (STIs) among youth experiencing homelessness by reviewing published studies from 2000 to 2015. They found that rates of chlamydia ranged from 4.2% to 11.6% in studies that relied on tested samples compared with 2.8% to 18.3% that relied on self-reported diagnosis. Gonorrhea prevalence from tested samples was 0.4% to 11% and from 1.0% to 24.9% from self-report. Prevalence of syphilis was 0.2% to 3.5%, and 1.1% to 11.8% for prevalence of herpes. There were only 3 articles reporting the prevalence of hepatitis B with rates ranging from 1.4% to 17%. The 2 articles reporting on hepatitis C noted a prevalence of 3.7% to 12%. Medlow and colleagues[40] found variability in rates of human immunodeficiency virus in studies of homeless youth in the United States ranging from 2.3% to 13.6%.

Not surprisingly, rates are higher among youth with a history of being victims of human trafficking or CSE. Recent studies of populations who experienced CSE found 21% to 37% were positive for STIs.[21,41]

### *Pregnancy*

An adolescent pregnancy may be the cause of homelessness for some youth or a result. An analysis of the National Longitudinal Study of Adolescent Health found that girls who ran away in the past year had over twice the risk of pregnancy compared with those who did not. These risks were higher for those who had been victims of sexual assault or those who identified as racial minorities.[42] An analysis from the Runaway/Homeless

Youth Management Information System supported the findings of higher risks of pregnancy among those who identified as African American or Hispanic.[43] Pregnant youth had higher rates of STIs, history of probation or felony charges, and history of emotional abuse by their mothers compared with nonpregnant homeless youth.[43] In their study of adolescent mothers who were homeless, Crawford and colleagues[44] found that approximately 56% had constant custody of their children and approximately 19% never had custody. Adolescents who have been pregnant and homeless have higher rates of mental health problems, such as major depression, posttraumatic stress disorder (PTSD), substance abuse, and antisocial personality disorder.[44]

### *Mental Health*

As with other health issues, studies of the prevalence of mental health conditions among homeless youth are limited.[40] Many youth meet criteria for more than 1 mental health condition.[45]

#### *Post-traumatic stress disorder*

PTSD prevalence among adolescents has been estimated at 2% to 6% in community samples and 12% to 15% in those with a trauma history. Among youth who had experienced trauma once on the streets, the prevalence of PTSD was 17.7%.[46] Female adolescents or youth who identify as sexual minority youth are more likely to meet criteria PTSD.[40,45]

#### *Depression/suicide*

At least one-third and up to approximately one-half of homeless youth meet criteria for depression.[40] In their study of homeless families, Barnes and colleagues[47] found that youth in families experiencing homelessness were twice as likely to report self-injurious behavior and suicidal ideation, and 3 times as likely to report suicide attempts compared with their nonhomeless peers.[47]

#### *Substance use*

Substance use is a common problem among homeless youth. In a study of homeless youth aged 13 to 19, Ginzler and colleagues[48] found more than 94% used tobacco, alcohol, or marijuana in the past year, and 23% to 73% reported using other substances, such as quaaludes "downers", cocaine, heroin, amphetamines, and hallucinogens. Of the sample, approximately 86% met diagnostic criteria for dependence or abuse. In a study of youth experiencing homelessness in 7 states, 20% reported nonmedical use of prescription drugs.[49]

## ACADEMIC PROBLEMS LEARNING DISABILITIES

As noted by Barnes and colleagues,[32] poor health is correlated with problems in executive functioning and some aspects of self-regulation, such as inhibitory or emotional control. Twenty months after an emergency shelter stay, children aged 18 to 41 months had higher risks of developmental delays and behavioral challenges and were disadvantaged in readiness for reading and math compared with their peers in national samples.[15] Of the more than 1.3 million homeless children and youth in school, almost a quarter million met criteria for a disability according to the Individuals with Disabilities Act.[17]

Frequent moves impact the ability to have consistent educational experiences and achievements.[2,50] Children and youth experiencing homelessness may come to school with little or no sleep or food. Those who are interested in participating in extracurricular activities may not be able to do so because they need to return to shelter or

do not have the resources to participate. Although the McKinney-Vento legislation and Every Student Succeeds Act have provisions to allow students to stay at their previous school and to help with costs for participating in extracurricular activities, children or their guardians may not be aware of this.

## ROLE OF THE PEDIATRICIAN/PUBLIC HEALTH ADVOCATE

The reader will note the use of the phrase "experiencing homelessness" rather than stating homeless children or homeless youth. Stigma associated with homelessness limits many people, but particularly children and adolescents from accessing services.[24] In addition, many adolescents or families might not consider themselves homeless when they are "couch-surfing" or doubled up.

### *Identifying At-Risk Families*

Providing quality health care is a team sport. Front desk staff, medical assistants, and nurses may notice that a family's contact information has changed often. They may recognize the provided address as the address of a shelter. Some of the staff may also hear conversations about the patient's financial or housing situation that can indicate risk. They should be encouraged to respectfully share this information with clinicians and social work in a confidential setting.

Screening all patients and families for social and financial difficulties is 1 way to identify families who are already homeless as well as those at risk of homelessness. Prefacing questions with a statement about the relationship of housing and other social issues to health can help patients and their families understand that a pediatrician's motivation is to help them address all aspects of their health and well-being.

The following list provides suggestions for assessment questions:

For parents and guardians of younger children[51]

- What type of housing does the child live in?
- During the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
- In the past 12 months, how many places has the child lived?
- Since the child was born, has the child ever been homeless or lived in a shelter?

Other questions that were developed from the US Department of Housing and Urban Development, Health and Human Services, and Veterans Administration include the following[52]:

In the last 60 days, have you

- Been concerned about losing your housing
- Changed residences more than twice
- Lived with a friend or family member you do not normally reside with due to financial hardship
- Been evicted or served an eviction notice
- Slept outside, in an abandoned building, in your car, in an emergency shelter, or in a motel due to financial hardship?

For older children, adolescents, and young adults, in addition to asking about who lives at home and the safety of the home environment when speaking to the adolescent alone, providers can ask, "Have you ever seriously thought about running away from home?" If the young person answers "yes," asking where they would go and why they thought running away can help identify those at risk. Another follow-up question is, "Have you ever run away from home?," if they do not volunteer this information.

Taking a sexual history is a key part of the adolescent psychosocial assessment. In addition to the typical HEADSS assessment,[53] the following questions can be used to screen for CSE[54]:

- Have you ever had to have sex in exchange for something you wanted or needed (money, food, shelter, or other items)?
- Has anyone ever asked you to have sex with another person?

### *Prevention*

All health care providers should be familiar with available resources for assisting homeless children and their families. Collaboration with social work, community health workers, and legal services is essential to identifying, assisting, and advocating for those experiencing homelessness. Because people experiencing homelessness have likely also had adverse childhood experiences (physical, emotional, or sexual abuse; physical or emotional neglect; household dysfunction: divorce, mental illness of a parent or guardian, witnessing domestic violence, incarcerated relative, or parental substance abuse) or other trauma, the authors recommend a strengths-based, resilience-building approach and trauma-informed approach to care.[24]

### *Food, Clothing, Shelter*

In addition to helping patients and their families apply for Women, Infants, and Children (WIC) and SNAP, clinic staff can maintain lists of food banks, soup kitchens, and programs that will provide lunch in the summer for children who receive free or reduced lunch during the school years.[2] Educational interventions in shelters can help improve the variety and nutritional value of foods that children and youth eat.[27]

Some clinics, emergency departments, and hospitals will keep extra clothes for families to take if their clothes were ruined while seeking care. Local shelters and drop-in centers often receive donations for youth to choose from. Many drop-in centers for youth will have laundry services.

Many clinical settings include posters and information about domestic violence shelters, youth shelters, and/or the trafficking hotline number in the examination rooms or bathrooms. To help ensure safety, the authors recommend asking the patient if they might be hurt if they were found to have brochures or handouts with information about shelters and hotlines.

*National Runaway Safeline:* **"**The mission of the National Runaway Safeline is to keep America's runaway, homeless and at-risk youth safe and off the streets."

1-800-RUNAWAY
https://www.1800runaway.org/resources-links/

*National Safe Place*: Sites go through training to provide connection to emergency shelter. Many institutions, such as fire stations, city halls, bus lines, hospitals, and clinics, have become safe places. Teens can text for help or go to any facility with the national safe place logo for assistance.

https://www.nationalsafeplace.org/

Including the following information in patient handouts may be beneficial:

TXT 4 HELP is a nationwide, 24-hour text-for-support service for teens in crisis.
If you're in trouble or need help, text SAFE and your current location (address, city, state) to 4HELP (44357) for immediate help.

*National Human Trafficking Hotline:* Connects victims and survivors of sex and labor trafficking with services and supports to get help and stay safe.

https://humantraffickinghotline.org/

Call 1-888-373-7888. Stating or writing the number as 1-888-3737-888 makes it easier to remember.

(TTY: 711)
Text 233733

### *Health care*

Many public assistance programs require frequent updates to paperwork for eligibility requirements. If a family moves often, they may miss the reminders to complete this paperwork and lose health insurance coverage. Some insurance companies require patients to have an annual physical examination by their listed primary care provider in order to maintain coverage. Pediatricians can help families maintain their insurance with reminders to complete preventive physical examination and update their information with the insurance company. It is important to know what policies and services are in place to help any patients who are experiencing a lapse in insurance. Many insurance companies will help provide transportation to appointments or provide gas reimbursement. These services can help families attend appointments and reduce out-of-pocket costs. Shelters and drop-in centers may have a medical provider visit. Some shelters have a clinic on site. These resources can provide continuity of care when a patient is not able to attend an appointment in the office. School-based health clinics, mobile clinics, and vans can also ease the burden of traveling to an office for an appointment.

The National Health Care for Homeless Council has several resources, including clinical guides, Webinars, online courses, and live training events (https://www.nhchc.org/) to improve health care delivery and skills for providers working with patients who are experiencing homelessness.

### *Education*

Thorough documentation of medical needs and immunizations in a resource that can travel with the patient can help avoid duplication of testing and gaps in services. Many families and youth are not aware that every state has a coordinator to help children and youth experiencing homelessness. Updated lists of State Coordinators and additional resources are available from the National Center for Homeless Education (https://nche.ed.gov/data/). Communities in Schools (https://www.communitiesinschools.org/) can help children and youth access resources and stay in school.

National Association for the Education of Homeless Children and Youth:

A national membership association dedicated to ensuring educational equity and excellence for children and youth experiencing homelessness. They include a fact sheet for school staff, teachers, principals, and other administrators: http://www2.ed.gov/policy/elsec/leg/essa/160315ehcyfactsheet072716.pdf.

https://naehcy.org/mission/
E-mail: info@naehcy.org
Phone: 866-862-2562
Fax: 612-430-6995

*National Center for Homeless Education*: Provides data, resources, and connection to the state health coordinator.

Phone: 1-800-308-2145
E-mail: homeless@serve.org
Find state coordinator at: http://www.serve.org/nche/states/state_resourcers.php

### *Legal*

Despite protections in the law, many people do not receive services unless they have legal help. Health care providers can help with the documentation of health conditions and the need for a healthy environment, for example, documenting that a patient has asthma and cannot be exposed to smoke, mold, or rodents; or the need for a patient with diabetes to have electricity to keep insulin cold. The Legal Services Corporation has a link on its Web site to help find legal aid: https://www.lsc.gov/.

### *Advocacy*

Policies matter. Legislative acts like the McKinney-Vento Act, Every Student Succeeds Act, and the Runaway and Homeless Youth Act help in the definition of and development of services for runaway and homeless youth, but they cannot be fully effective without adequate funding and continued support from elected officials.[55]

The following actions can help with improving health for children and adolescents who are experiencing homelessness or who are at risk of becoming homeless:

- Supporting and following the provisions of the UN Conventions on the Rights of the Child[24,56]
- Universal health coverage[1–3,24,56]
- Increased awareness of health issues common among those experiencing homelessness or housing instability[2,22]
- Assistance with connecting at-risk families and youth with resources to prevent homelessness or to exit homelessness[2,24]
- Partnering with community agencies[2,24,56]
- Increased affordable housing[1–3,57]
- Protection and expansion of funding for programs to support those families at risk of homelessness, such as WIC, SNAP, TANF, and so forth.[2,24,58]
- Increase in dentists trained to care for pediatric patients[31]
- Additional research into interventions that have helped prevent homelessness or help children, adolescents, and families exit homelessness[24]

## MODELS FOR PREVENTION

"Housing-first" models have been successful at improving health outcomes for children, families, and unaccompanied people experiencing homelessness. Some medical facilities are using their resources to provide a stable environment for patients in an effort to reduce readmissions.[57] These interventions can improve health outcomes for the patients and financial outcomes for institutions.[57]

Increased access to low-income housing prevents homelessness.[57] For those in shelter, access to health care, including age-appropriate dental and ophthalmologic services, and educational resources can improve outcomes for children and adolescents.[2,24,27,30–33]

Policies of the shelters also impact health care access. In Massachusetts, there was a more than 13-fold increase in the number of children presenting to the emergency department after a policy change requiring documentation of homelessness in order to access shelter.[59] Regular meetings among the various stakeholders, including those being served by programs, can help to avoid duplication of services and meet the changing needs of the communities.[24]

By treating every visit as an opportunity to meet acute and preventive health care needs, pediatricians can improve immunizations rates, decrease morbidity, and provide links to community services.[22] The lifecycle model shows that youth are more likely to exit the streets during times of crisis or disequilibrium. This time is also when they are likely to seek medical care.[10]

Mentorship programs for those who have survived CSE show some promise in decreasing health risks and continued exploitation.[21] Colleagues in family medicine, obstetrics and gynecology, and neonatology can help identify at-risk families before they are referred to pediatric care.

## ROLE OF TECHNOLOGY IN CAUSING OR MANAGING THE ISSUE

Many homeless youth and families will keep a cell phone or access the Internet at libraries, schools, coffee shops, or public spaces. Using patient portals of the electronic medical records may be a feasible way of staying in contact because phone numbers and addresses may change often. They can also help the patient have a record of past treatment to share with new providers when they move. Youth experiencing homelessness report continued access to the Internet and smart phones, but use is significantly less frequent than housed youth.[60] Having "charging stations" in clinic can help many patients and their families, including those who are stably housed.

## SUMMARY

Pediatricians are caring for a large and growing segment of the homeless population. Many patients and their families may not disclose their status because of concerns about stigma or lack of awareness of their situation. Pediatric providers can use their unique relationship with patients and their families to help them connect to resources to avoid or exit homelessness. Pediatricians must continue the strong tradition of advocacy to encourage legislation to prevent and reduce homelessness.

## DISCLOSURE

The authors have nothing to disclose.

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