ZERO TO THREE

MARCH 2019 • VOL 39 NO 4

Young Children and Families Experiencing Homelessness

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ZERO TO THREE JOURNAL

Young Children and Families Experiencing Homelessness

IN THIS ISSUE

ZERO TO THREE
Early connections last a lifetime

This Issue and Why it Matters

At any age or stage of life, homelessness brings a host of risks and vulnerabilities to affected individuals, but infants and toddlers are of particular concern. Inadequate and unstable housing is linked to health, developmental, and emotional problems, and children who lack a stable home environment are also often lacking in other basic needs and experience additional risk factors. We explore these topics in this issue of the Journal in collaboration with guest editor Grace Whitney, who is the director of Early Childhood Initiatives at SchoolHouse Connection and the former director of Connecticut's Head Start State Collaboration Office. Over the course of her 45-year career, Dr. Whitney has worked in a variety of contexts involving children without homes, and she graciously devoted her impressive wealth of knowledge and expertise to all levels of the planning, writing, and editing of the articles in this issue.

Stefanie Powers, Editor
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On my refrigerator is a photo of my parents' kitchen which still brings a visceral sense of belonging, of safety, of respite, and of hope. One's personal sense of home is etched early into the architecture of the brain, along with the deeply felt sense of security and belonging, or the lack of thereof. Homelessness stands in stark contrast to the image of home as refuge and safety, yet resources for families can be scarce and inadequate. From the perspective of the baby, it is vital to move away from definitions of homelessness that are based on shifting funding priorities and embrace a deeper understanding of homelessness as defined by how a child's environment provides, or fails to provide, the stable and nurturing home and relationships that are necessary to thrive.

In this issue, contributors explore how they are working to improve the experiences of families living in circumstances void of safe, stable, and adequate housing, thus thwarting their ability to create a sense of home for their young children. The authors describe a range of approaches being used to create networks of protective factors through partnerships, policies, and practices, primarily in public shelters, but these same protective networks are necessary for young children sleeping in cars and tents; on couches, floors, and sidewalks; amidst chaos and constant change; and with others who pose threats to their safety.

The articles in this Journal issue are dedicated to the late Dr. Staci Perlman, a colleague to many of the contributors, a creative scholar, an educator of many, and a gentle but fierce advocate for babies experiencing homelessness. Her mantra of "Yay Babies" was like a crusade, a reminder to approach our work through the eyes of the babies, to think about homelessness from their perspective right now and for how it will impact them later. Her laugh was as infectious as her passion. This issue is in part her continuing legacy.

Taken together, these articles demonstrate the need to take an ecological approach and to consider the complexity of the challenge, and collectively they offer myriad possibilities. May the issue inspire you to *see the babies* and to better understand and address *their* needs. Create that "picture on the fridge" in the brain architecture and sensory system of every infant and toddler whose lives you touch. Build the village. Yay babies!

Grace Whitney, Guest Editor
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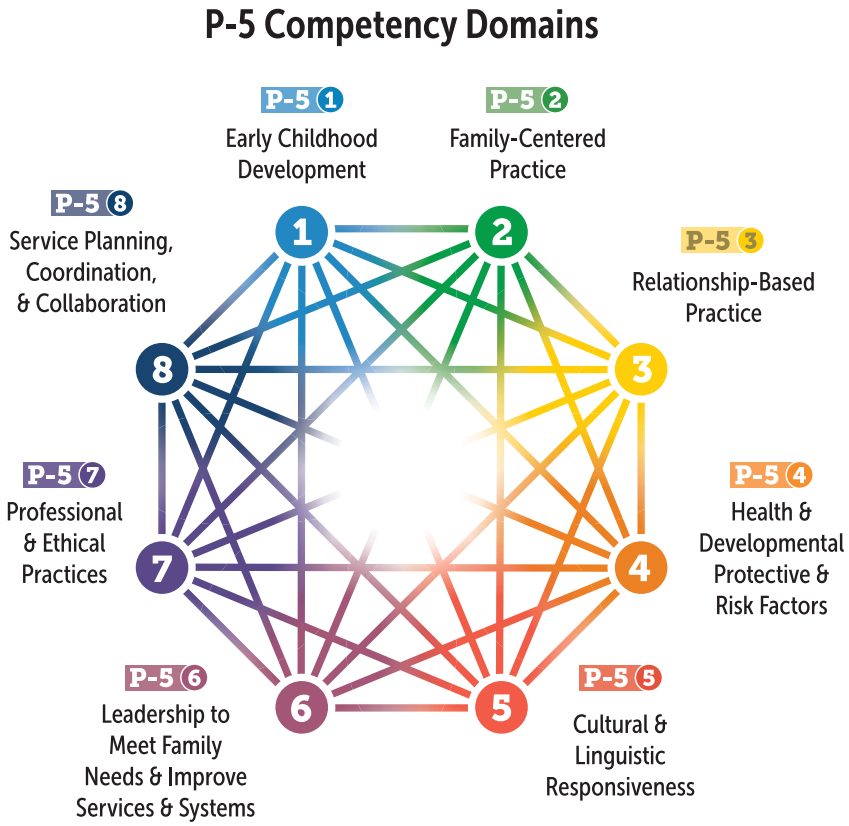
ALSO IN THIS ISSUE

ZERO TO THREE Competencies for Prenatal to Age 5 Professionals: *Understanding the P-5 Competency Domains*

The P-5 Competencies are organized by eight domains of professional practice. Each domain defines core knowledge, skills, and attitudes necessary for professionals in all disciplines working with young children and their families. Each of the P-5 Competency domains are equally important, and they build upon and reinforce one another. All of ZERO TO THREE's professional development are categorized by the P-5 Competency domains. Each article in the Journal includes a box at the bottom of the first page that identifies the P-5 Competency domains most strongly supported by the article. More information about the P-5 Competencies is available online at www.zerotothree.org/p-5.



An Introduction to Young Children and Families Experiencing Homelessness

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Abstract
The articles in this issue of the *ZERO TO THREE Journal* provide a sampling of policies, practices, challenges, and opportunities relating to homelessness that are facing the infant–toddler field today and the impact of persistent mobility and unsafe housing conditions on early development and family relationships. Articles span several service sectors including early care and early childhood programs, parenting supports, housing, pediatrics, and pregnant and parenting youth among others. The authors provide suggestions for continuing to grow capacity to address these complex issues and the critical need to include an understanding of homelessness into all aspects of child development and family services.

Homelessness continues to be a persistent life experience for too many infants, toddlers, and their families. What researchers know from observations and data is that young families continue to struggle to establish themselves in financially secure households and that the impact of such personal challenge shapes where they live and how well they can provide for their children. For the child, their family circumstances will greatly determine their experience of relationships and their own potential in life. Homelessness is just one factor in a cluster of hardships families and children face, and homelessness is generally not an isolated incident nor quickly and simply resolved. Although homelessness is not a new phenomenon, early childhood professionals are just beginning to explore the real and lasting impact of homelessness and how to specifically address the needs of infants and toddlers experiencing homelessness who—until quite recently—have been essentially invisible. Housing and homeless service providers have often sought child care so that parents could go off to work, as if reserving a parking space for a car, without knowing about subsidized resources that might be available and without understanding that quality matters greatly for vulnerable young children. Some adult and family service programs still do not even count children as clients. Early childhood providers tend to engage families less likely to need complicated supports and more likely to participate and pay regularly and neatly meet eligibility criteria based on such predictability. Thus young children experiencing homelessness have been systematically shut out of services and supports available to more stable and resourced families, and these children continue to fall further behind as the bar for requisite developmental mastery by kindergarten entry continues to rise.

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Photo courtesy of Grace Whitney

Author Grace Whitney as she toured a family shelter in Honolulu, Hawaii. Large shelters like this one offer little in the way of family privacy, individuality, or boundaries. Many shelters are still closed during daytime hours, sending families out of the building, often with no place to go.

The articles in this edition of the *ZERO TO THREE Journal* provide a valuable opportunity to focus on the unique issues facing infants, toddlers, and their families experiencing homelessness, and to advocate for respectful collaboration across systems. Adult-centric systems often do not accommodate babies, or the relationships adults have with their babies, nor tailor their efforts to babies' needs. Moreover, infant–toddler providers are distanced from conversations about policy and best practice, and they may be seen as competitors for scarce resources rather than partners in creating relevant solutions. Infants and their caregiving continue to be marginalized for a host of reasons, therefore the voices in this issue of the Journal are all the more important to share. Bringing diverse systems together, or it could be called "sharing the sandbox," can be tough! For that reason, the assembled articles provide a range of perspectives and of possibilities for consideration.

Homelessness is not an isolated nor simple issue. Families experiencing homelessness often experience life circumstances that include a cluster of serious challenges and so housing solutions are neither tidy nor universal. One size does not fit all, and typically families need a comprehensive array of resources, supports, benefits, and services that can be individualized to the specific needs of each family member. It is always more than just housing. The articles in this issue of the Journal provide an array of examples that can serve as models of what has been done in new ways. You are encouraged to take these ideas, grow them to meet your own community needs, change public policies, and modify current approaches to better support children and families by always taking their housing circumstances into account.

The Journal issue begins with an article that reviews the major potential sources of data on the number of infants and toddlers experiencing homelessness. Sara Shaw (this issue, p. 11) highlights some of the challenges to using available data because of the lack of a uniform definition of homelessness, a lack of adequate systems to collect data, and even confusion over definitions used by those who must collect and use data for reporting and compliance. She suggests ways to enhance data collection and data sharing to better understand what homelessness actually looks like for infants, toddlers, and their families in their communities, and how to better understand what may work in addressing their particular needs.

Livia Ondi and her colleagues (this issue, p. 21) provide a description of their efforts to reach into the housing world using their model of early childhood mental health consultation services in emergency shelters. This article includes a description of the development, implementation, and evaluation of a decade-long early childhood mental health consultation project at the University of California, San Francisco Infant-Parent Program that provides trauma- and equity-focused prevention, early intervention, and treatment supports to infants, young children, families, and staff in various shelter settings. Using a strong infant mental health approach, the authors share the unique characteristics of the consultant's role, stance, and practices developed in response to the need for mitigating the impact of trauma related to homelessness in young children within the context of their relationship with caregivers and shelter providers. The authors' sensitive attention to trauma experienced by parents and children, to the trauma experienced vicariously by staff, and the nuance of relationships to create healing is especially noteworthy.

Rebecca Cuevas and her colleague (this issue, p. 29) also report on a direct service context but one that results from two sectors reaching out to and into one another and the intentional alignment of systems. In this article, which describes an Early Head Start Home Visiting partnership with a local residential recovery program for women and their children, they connect homelessness with the recovery process and with the critical importance of creating sufficient space for promoting healthy parent–child relationships, child development, and recovery for women who are in residential treatment with their young children because they have no home. Instead of completing the recovery process only to go on to an emergency shelter to qualify for housing assistance, this article describes how multiple challenges are successfully addressed by working together on an ongoing basis from the time of entry into recovery to support families in a comprehensive manner.

Next, the article by Janette Herbers and Ilene Henderson (this issue, p. 35) includes a description of the development, implementation, and evaluation of curricula specifically designed for families in emergency and domestic violence shelters; describes the benefits and challenges of promoting parenting supports in unstable settings; and outlines the importance of tailoring curricula to address the complexities introduced by instability and the crisis nature of shelter settings. Again, although there may be a range of resources in communities to support families and provide parenting information and education, available

resources may not be tailored to take into account the stress of the emergency shelter experience, the high mobility of families, and the shelter environment itself. This article provides the opportunity to explore what accommodations might be critical in engaging families and creating successful interventions not only in parenting supports but in services for this population more broadly.

J. J. Cutuli and Joe Willard (this issue, p. 43) describe their years-long experience in knitting housing and early childhood systems together in the City of Philadelphia in their article on the BELL project. This piece includes a description of the scope and growth of this extraordinary collaboration led by Peoples Emergency Center, a housing provider operating 18 shelters and engaging health, early childhood, early intervention, philanthropy, research, and advocacy partners to ensure housing services are childproofed and family-friendly and that children are enrolled into early childhood services and programs. Philadelphia has a rich history in connecting housing and early childhood, going back to a unique data collection effort which combined government data across several state and city agencies to reveal that homelessness during infancy was related to later child welfare involvement and school failure. With remarkable champions and partnership, this collaborative approach has sustained and grown to change public policy and professional practice in meaningful ways for the benefit of young children and families. Although there may be publications that list myriad ways of systems working together, the BELL project is an example of how many of those strategies can be implemented in one large community and what the results can be when many systems work together.

And moving on to what potential may lie ahead, Richard Sheward and his colleagues (this issue, p. 52) describe their use of a tool that helps pediatricians assess housing risk. This article includes results of using their three-question housing assessment in pediatric clinics and during emergency exams to better understand the risks homelessness creates for child health and wellness. They share their experience of implementing their assessment strategy in the clinic setting and discuss implications for pediatric policy and practice more broadly. This article is especially instructive and further introduces an important area of emerging practice because it is rare that family housing situations are assessed, and it is even less likely that a strategy or standardized tool is used. Their description of how implementation at the Boston Medical Center resulted in the establishment of new networks to support families is helpful and instructive. In a recent early childhood pilot, researchers used the Quick Risks and Assets for Family Triage–Early Childhood tool (Kull & Farrell, 2018) to assess nearly 1,000 families entering an Early Head Start/Head Start program at the beginning of the program year. This assessment resulted not only in the identification of families at greatest risk and a focus of resources on those families identified, but it also provided a guide for staff on how to assess housing risk. It also opened up the discussion between family service staff and families so that ongoing discussions about safe and stable housing could take place. Sheward and his colleagues provide important validation for embedding housing risk assessment into pediatric practice, early childhood services, and all settings where homelessness must be better identified, addressed, and even prevented.

Photo: Alexandr Medvedkov/shutterstock

Homelessness continues to be a persistent life experience for too many infants, toddlers, and their families.

The final article, by Melissa Kull and her colleagues (this issue, p. 60), focuses on another emerging topic: pregnant and parenting youth. They summarize a Chapin Hall study (Morton, Dworsky, & Samuels, 2017) which revealed the prevalence of homeless youth who are pregnant and/or parenting, and they offer a critical review of the literature spanning several sectors that can serve as the foundation for future policy and practice. This team was unable to select a program that might illustrate best practice, which is not a surprise. Youth and early childhood policies and service sectors remain staunchly separate, and the Chapin Hall study was finally able to provide sound research data on how critical it is for these two sectors to begin to work together. The study of child development covers a span of many years from birth to young adulthood. While youth development programs may have expertise in developmental interventions because of their experience with pregnant and parenting youth, they may lack expertise and access to resources for infant development and parenting. And early childhood programs may not factor aspects of youth development into their supports for parents. Early Head Start does not even collect data on the age of parents it serves. Kull and colleagues discuss these points and it can be hoped that their work will encourage adolescent and early childhood fields to work more closely together to support a truly two-generational approach. Certainly, multiple systems and service sectors could delve more deeply into the unique complexities discussed in this piece and work to align efforts as they involve homelessness in particular.

In addition to what is in this journal edition, there remain additional queries to be integrated into the discussion to be truly comprehensive. For example, fathers play a unique role in the

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Fathers play a unique role in the lives of children and families, and housing and early childhood services must accommodate their needs.

lives of children and families, and housing and early childhood services must accommodate their needs. Some housing programs continue to separate fathers from their families in emergency shelters, and male youth who become parents may be rejected and forced to leave home, too. It is also important to address the child welfare system as it is clear that the lack of safe and stable housing is too often a cause for removal, and youth exiting foster care are at greater risk of homelessness, especially when they are parenting. Data available on housing and child welfare does not yet separate infants and toddlers from other age groups nor are various categories of maltreatment separated out by age, so it is difficult to understand how neglect, abuse, poverty, housing, and other adversity may interact to result in removal or determine choices for interventions. For infants and toddlers specifically, it is unclear whether interventions included partnering with early childhood programs, for instance home visiting services through Early Head Start or Maternal, Infant, and Early Childhood Home Visiting (Fowler, 2017). Although there have been demonstration projects involving family reunification and access to housing vouchers, one of which contributed to the development of the Quick Risks and Assets for Family Triage tool (Farrell, Dibble, Randall, & Britner, 2017) mentioned earlier, again, child age was not a factor in reporting collective results. The interplay of poverty, diversity, and implicit bias with homelessness for infants and toddlers and their families has yet to be fully understood. Researchers also have not explored the role of homelessness in court team projects and other projects for infants and toddlers and their families. In summary, there is much work to do.

We hope that this collection of articles will be just the beginning of a greater focus and wider discussion of homelessness and infants, toddlers, and their families, and that, as a result, national policy and professional practice will continue to align and reflect a growing sensitivity to this issue through increased resources, specific regulations, research, and additional best practices. Certainly a start would be acknowledging varying definitions of homelessness and ensuring this misalignment is openly addressed in any data collection, analysis, and reporting in the future. In addition, reforming public policy, for example the Homeless Children and Youth Act, in Congress and similar legislation in the states will help to align systems not only for data purposes but for increasing access to available supports and improving collaboration across programs through the creation of more informed regulations, systems, research, and direct services. Examples of policies and practices that would enhance supports for infants, toddlers, and their families experiencing homelessness are discussed by the authors, and the challenge is now to take the articles in this journal, use the resources referenced to refine current practice, truly prioritize homeless populations for service access, and bring to scale the supports proven to be successful. It is hoped that this volume will create the enthusiasm and partnership needed to make that happen.

Grace Whitney, PhD, MPA, IMH-IV, joined SchoolHouse Connection after 20 years as director of Connecticut's Head Start State Collaboration Office. She is a developmental psychologist and endorsed as an Infant Mental Health Policy Mentor. Dr. Whitney began her career as a preschool teacher in special education and as a home visitor for at-risk families of infants and toddlers and has since held clinical and administrative positions in early childhood, community mental health, and human services, and has served on aid teams abroad. She has taught full time and as an adjunct instructor in child development/developmental psychology, statistics, and public policy, and she has published on topics related to her work. Throughout her career, she has participated on local, regional, and national boards and has presented often at conferences and professional meetings including ZERO TO THREE, National Head Start Association, and World Congress for Infant Mental Health. She has designed government tools and publications, including three informational modules and related core knowledge and competencies for consultants to programs serving infants and toddlers, the original *Early Childhood Self-Assessment Tool for Family Shelters* and, most recently, the new interactive learning series *Supporting Children and Families Experiencing Homelessness.*

Over the 45 years of her career, Dr. Whitney has worked in a variety of contexts involving children without homes, including child welfare, community mental health, and early childhood systems and in orphanages abroad. While a graduate student she was a residential counselor with Second Mile for Runaways and helped start the National Runaway Switchboard. Her master's thesis focused on federal policy related to runaway youth at the time of passage of the Runaway Youth Act of 1974 which changed running away from a delinquent to a status offense. Dr. Whitney holds a bachelor's degree in child development/education and a doctorate in family studies from the University of Connecticut, a master's degree in human development from the Institute for Child Study at the University of Maryland, and a master's in public administration from Florida Atlantic University.

Marsha Basloe, MS, is president of Child Care Services Association (CCSA), a nationally recognized nonprofit working to ensure affordable, accessible, high-quality early care and education for all children and families. The organization accomplishes its mission through direct services, research, and advocacy. CCSA provides free referral services to families seeking child care, technical assistance to child care businesses, and educational scholarships and salary supplements to child care professionals through the T.E.A.C.H. Early Childhood® and Child Care WAGE$® Programs. Through the T.E.A.C.H. Early Childhood National Center, CCSA licenses its successful programs to states across the country and provides consultation to others addressing child care concerns.

Marsha was senior advisor for the Office of Early Childhood Development at the Administration for Children and Families, U.S. Department of Health and Human Services for 5 years where she was responsible for coordinating early childhood homelessness working closely with the Office of Head Start, the Office of Child Care, and the Interagency Workgroup on Family Homelessness. Her efforts resulted in multiple self-assessment tools on homelessness, 50 state profiles, and a Congressional briefing to raise the awareness of early childhood homelessness. She also worked on early childhood workforce initiatives, communications from the Office of Early Childhood, and interagency efforts and other initiatives aimed at young children and families.

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Current Data on Infants and Toddlers Experiencing Homelessness

Sara Shaw
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Abstract
During the first year of life children are at the greatest risk for experiencing homelessness (Perlman & Fantuzzo, 2010). Unfortunately, data on the number of infants and toddlers experiencing homelessness are extremely limited, and any data available are inadequate for a variety of reasons. There is minimal information on how many young children and families experiencing homelessness benefit from early childhood programs and support services aimed at addressing the needs of this vulnerable population. This article presents a summary of existing data and the challenges encountered in using this data to better understand the scope of homelessness during the first years of life. The author provides suggestions to improve data collection practices and the processes for identifying families and children experiencing homelessness to enhance access to early childhood services.

Teachers and the health manager at an Early Head Start (EHS) program were concerned that 8-month-old Jonell had been crying more than was typical for him for almost 2 weeks. They talk with Jonell's mom, Keisha, to learn whether she had noticed any changes or if they had experienced any changes at home that might help explain what was distressing Jonell. Keisha shared that, due to family violence, she and Jonell temporarily moved in with friends and, because she was focused on finding a job, Keisha had not been able to apply for any assistance yet. Money was tight and they had little food where she was staying. Keisha was still breastfeeding Jonell, but she was not eating and could tell Jonell was unsettled when she fed him. What they discovered together was that Keisha was not producing enough milk and Jonell was hungry. Both Keisha and Jonell were not getting the nutrition they needed. Together, Keisha and staff secured additional food supports, and soon Jonell was eating and settling down, though they all continued to monitor Jonell's development and health. Program staff supported Keisha to connect with community resources to address her other needs, most notably for stable housing.

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Infants and toddlers are among the highest risk for experiencing homelessness, but the knowledge base to understand the true scope of the problem is inadequate, due in part to the fact that data sources available for this population are extremely limited. In addition, the existing sources of information vary regarding how they define and measure homelessness, making it harder to collect and interpret the data. Specifically, there are two operational federal definitions of homelessness (see Box 1) used widely to collect data and establish eligibility for services and benefits.

One definition is included in the education subtitle of the McKinney-Vento Homeless Assistance Act (42 U.S.C. §11434a(2). This definition is used by programs and services administered by the U.S. Departments of Health and Human Services (HHS) and Education (DoEd), such as EHS and Part C early intervention services. The education subtitle definition takes into account families who stay in places not meant for human

Box 1. Federal Definitions of Homeless

McKinney-Vento Education Definition:

(2) The term "homeless children and youth"

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 11302(a)(1) of this title); and

(B) includes—

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 11302(a)(2)(C) [1] of this title);

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 6399 of title 20) who qualify as homeless for the purposes of this part because the children are living in circumstances described in clauses (i) through (iii).

Source: McKinney-Vento Homeless Assistance Act 42 U.S. Code § 11434a (2) (education subtitle)

McKinney-Vento Housing Definition:

General definition of homeless individual

(a) IN GENERAL

For purposes of this chapter, the terms "homeless", " homeless individual". And "homeless person" means – [1]

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

(5) an individual or family who—

(A) will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by—

(i) a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

(ii) the individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

(iii) credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause;

(B) has no subsequent residence identified; and

(C) lacks the resources or support networks needed to obtain other permanent housing; and

(6) unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who—

(A) have experienced a long term period without living independently in permanent housing,

(B) have experienced persistent instability as measured by frequent moves over such period, and

(C) can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse the presence of a child or youth with a disability, or multiple barriers to employment.

(b) DOMESTIC VIOLENCE AND OTHER DANGEROUS OR LIFE-THREATENING CONDITIONS

Notwithstanding any other provision of this section, the Secretary shall consider to be homeless any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

Source: McKinney-Vento Homeless Assistance Act 42 U.S. Code § 11302

habitation, such as motels and cars, as well as families who stay temporarily with others because of factors such as economic hardship, loss of housing, natural disasters, or family discord. This definition acknowledges that some families avoid shelters and fear entering shelters because many shelters are not safe for children, or because they may fear that entering shelter will result in child welfare involvement. It also recognizes the threat to child development and learning posed by mobility.

Another definition is included in the housing subtitle of the McKinney-Vento Homeless Assistance Act, and it is used by programs and services administered by the U.S. Department of Housing and Urban Development (HUD), such as emergency shelters and public housing. The HUD definition (42 U.S.S. §11302) is more narrow and aims to focus resources on those whose homelessness is most visible, such as those living on the streets or in public shelters. HUD has further narrowed and complicated its statutory definition through regulations. (Federal Register, 2011). HUD varies the application of its definition by prioritizing benefits and services for subpopulations, such as single adults, veterans, or, recently, non-parenting youth 18 to 25 years old, and uses such terms as "literally homeless" and "chronically homeless," thus adding even more ambiguity.

When federal definitions of homelessness vary this way, across federal programs and from year to year, providers of services and families themselves become confused. For infants, toddlers, and their families, data collection cannot be combined to enhance understanding of the scope of the problem. Barriers to service access may result simply because of a lack of understanding of criteria used for determining eligibility.

Data sources also vary widely in terms of the specific elements collected. While DoEd and HHS programs use the same McKinney-Vento definition of homeless, each funding stream collects data related to housing status differently. For instance, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs (part of the U.S. Department of Health and Human Services, Health Resources and Services Administration) collect data annually on "adult participants by housing status" and the Child Care and Development Fund (CCDF; part of the US Department of Health and Human Services, Administration for Children and Families) currently asks states to include "family homeless status" on monthly case-level data reports on children and families served, whereas EHS (part of the U.S. Department of Health and Human Services, Administration for Children and Families) programs collect data on "children enrolled using homeless criteria," "number of families experiencing homelessness that were served during the enrollment year," and "number of children experiencing homelessness that were served during the enrollment year." Each of these elements is likely to produce different data as they represent both child-level and family-level data and data for different periods of time. In addition to these differences, across the various federal programs, it is rare for providers to offer specific training on the McKinney-Vento education and housing definitions and when they are used; how best to determine homeless status using the various definitions; and how to access supports and services based on correct eligibility criteria to ensure comprehensive supports are successfully accessed for infants, toddlers, and their families.

This clear difference in both the definition of homelessness used and the type of data collected by federal agencies and programs makes the interpretation and synthesis of data across sources impossible (Shaw, Hirilall, & Halle, in press). It also means that there is no reliable way to establish the actual number of infants and toddlers experiencing homelessness nor to know how many children experiencing homelessness are accessing services from programs that support vulnerable families (Shaw et al., in press).

The Scope of Early Childhood Homelessness

Data published by the U.S. Census Bureau (2018) showed that infants and toddlers remain the age group most likely to be living in poverty and that extreme poverty is associated with homelessness. Although there is relatively little known about the housing status of infants and toddlers living in poverty, research does suggest that having a child under 2 years old puts families at an elevated risk for entering the shelter system (Shinn, Greer, Bainbridge, Kwon, & Zuiderveen, 2013). Furthermore,

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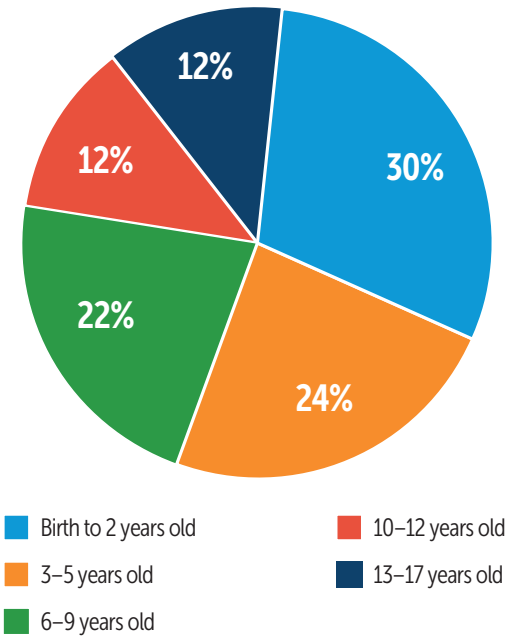
There is no reliable way to establish the actual number of infants and toddlers experiencing homelessness nor to know how many children experiencing homelessness are accessing services from programs that support vulnerable families.

children are at greatest risk of entering the emergency housing system during their first year of life (Perlman & Fantuzzo, 2010). In an analysis of HUD data, Solari, Shivji, de Sousa, Watt, and Silverbush (2017) found that children under 6 years old accounted for approximately half (49.6%) of all children served by emergency shelters in 2016. The Family Options Study, which looked at 2,282 families recruited in homeless shelters across 12 sites, found 50.4% of those families had a child under 3 years old and that 30% of the 4,528 children in shelters with their families were from birth to 2 years old (Gubits et al., 2018; See Figure 1).

Figure 1. Family Options Study: Ages of Children in Homeless Shelters



Note: Additional analysis from: Gubits et al., 2018.

Shinn (2017) analyzed HUD data from the 2015 Annual Homeless Assessment Report with U.S. Census Bureau data and found that the age at which one is most likely to be in a public shelter is during infancy (see Figure 2). Data from 2014 (Brown, Shinn, & Khadduri, 2017) showed 0.8% of all infants to have stayed in shelter during that reporting period.

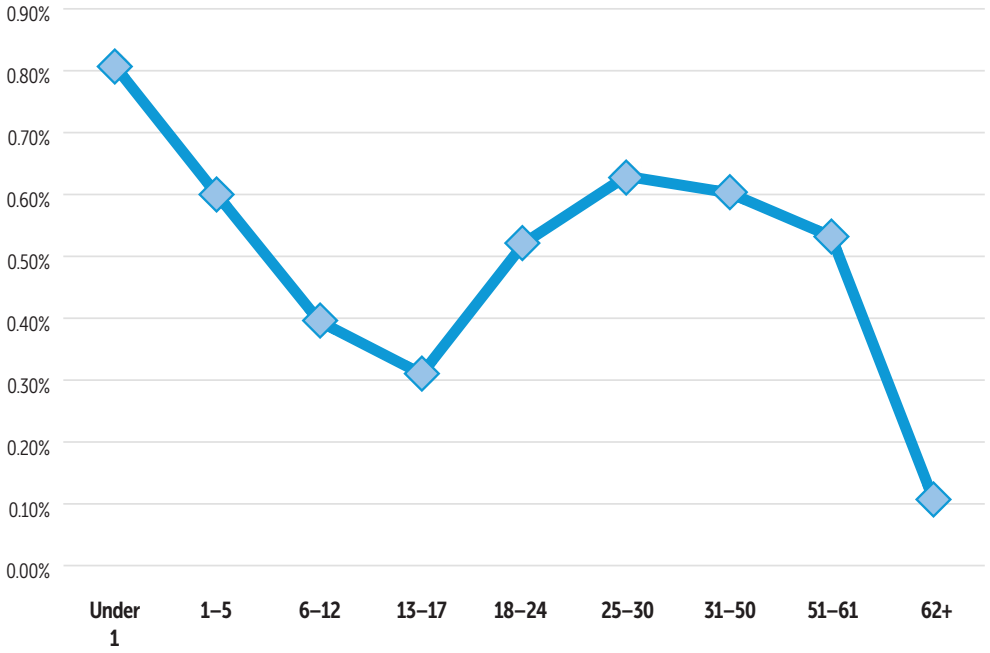
HUD not only relies on a narrower definition of homelessness, but these sources also depend primarily on emergency shelters and other housing programs as sources of information. This is problematic because using these data sources alone will greatly underestimate the true number of children and families experiencing homelessness (National Center for Homeless Education, 2017). DoEd data, collected from school districts nationwide and using the McKinney-Vento education definition, suggest that students from preschool through high school experiencing homelessness are more likely to be living doubled up than they are to be staying in a shelter, in a motel, or in inadequate housing. According to data from the 2015–2016 school year, there were 1,304,803 students identified as homeless, of which 985,932 students, or 75%, were living doubled up, compared to 315,025 students, or 25%, who were living in shelters, hotels, or unsheltered (National Center for Homeless Education, 2017).

Unfortunately, the relevant data is again not available specifically for children from birth to 3 years old, although it does include preschool-aged children. The Administration for Children and Families used data from HUD, DoEd, and HHS to estimate the extent of early childhood homelessness across the nation. The report suggested that more than 1.2 million, or 1 in 20, children under 6 years old experienced homelessness in 2016 (Administration for Children and Families, 2017). The report also suggested that as many as 92% of young children experiencing homelessness are not participating in early childhood care and education programs. Again, a limitation of this report is that data were not available specifically for infants and toddlers, most likely because infants and toddlers are underrepresented in early childhood services more broadly. It is important to note that these estimates are larger than numbers reported by HUD because they use the broader McKinney-Vento definition to determine homeless status, which includes highly mobile families and those living doubled up. These data are a good example of how the difference in the definition—as well as a lack of focus specifically on the experiences of infants and toddlers—can strongly influence understanding how prevalent the experience of homelessness is for infants, toddlers, and their families.

How Early Childhood Programs Are Addressing Homelessness

This section describes what is known about how four key early childhood systems— EHS, MIECHV, Individuals With Disabilities Education Act (IDEA) Part C Early Intervention (part of the U.S. Department of Education's Individuals With Disabilities Education Act), and child care subsidized through the CCDF—currently support infants, toddlers, and their families who are experiencing homelessness. In addition to describing what

Figure 2. Annual Shelter Use by Age (National %)



Source: 2015 Annual Homeless Assessment Report (HUD, 2016) and U. S. Census Data (Updated from Shinn, Brown, Wood, & Gubits, 2016)

researchers know about how these systems support these families, this section describes the limitations of researchers' knowledge from these systems.

EHS

Among all of the service systems designed to support vulnerable families and promote healthy child development, EHS was the first to direct its attention specifically to the challenges of homelessness. In fact, the federal Head Start Act (reauthorized in 1994) which established the EHS program was the first early childhood policy to specifically address the service needs of families experiencing homelessness.

Since the inception of EHS, *Head Start Performance Standards* (Federal Register, 2016) have required EHS programs to prioritize homelessness and gather data about children and families experiencing homelessness using the McKinney-Vento education definition of homelessness to determine categorical eligibility for program enrollment and to gather and report data. The EHS Program Information Report contains several data items related to homeless status, making it possible to identify the number of children and families served by each program who experienced homelessness during the program year. The Head Start National Center on Parent, Family and Community Engagement released a standardized set of interactive web-based training modules in 2018 to ensure staff are using the McKinney-Vento definition appropriately when determining child and family homelessness (Administration for Children and Families, 2018; see Box 2).

Box 2. Supporting Children and Families Experiencing Homelessness

This video series will help viewers learn how to identify families experiencing homelessness, conduct community outreach, and much more through knowledge checks, practice scenarios, and interactive learning modules intended to deepen understanding of family homelessness. Each module takes approximately 30 minutes to complete and provides a Certificate of Completion. The modules included are:

Module 1: Overview of Family Homelessness

Module 2: Understanding Family Homelessness

Module 3: Understanding the McKinney-Vento Homeless Assistance Act's Definition of "Homeless"

Module 4: Determining a Family's Homeless Status

Module 5: Identifying and Reaching Out to Families Experiencing Homelessness

Module 6: Enhancing Program Access and Participation for Children Experiencing Homelessness

Module 7: Building Relationships With Families

Module 8: Connecting With Community Partners

Source: https://eclkc.ohs.acf.hhs.gov/family-support-well-being/article/supporting-children-families-experiencing-homelessness

EHS data for the 2016–2017 program year showed that EHS programs served a total of 204,560 children and 15,526 of those (7.6%) were identified as experiencing homelessness (Office of Head Start, n.d.). Data on family services for this same period reported that a total of 183,741 families were served by EHS and 20,076 (10.9%) of those families received housing assistance from their EHS program including support with subsidies, utilities, and house repairs. In addition, 5,249 families acquired housing during the 2016–2017 program year (Office of Head Start, n.d.).

MIECHV

Information about home visiting programs that support homeless families comes primarily through the federal MIECHV Program. These federally supported and evidence-based home visiting programs (see Box 3) provide parents with valuable skills to help support their family's health and well-being. While each home visiting program has distinct goals, processes, and eligibility criteria, programs target their services to support low-income or high-risk families.

Home visiting programs may help families mitigate some of the risks associated with experiencing homelessness in infancy and toddlerhood (McDonald, & Grandin, 2009). Although a 2016 letter to grantees strongly recommended prioritizing families experiencing homeless for federal MIECHV services, at the time of this publication these programs are not

Box 3. Evidence-Based Home Visiting Programs

The following home visiting models have met U.S. Department of Health and Human Services criteria for evidence of effectiveness. (Health Resources and Services Administration, n.d.) Maternal, Infant, and Early Childhood Home Visiting grantees were allowed to select one or more of the models listed below for implementation using fiscal year 2018 funds.

- Attachment and Biobehavioral Catch-Up Intervention
- Child First
- Early Head Start–Home-Based Option
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up® for Children
- Family Connects
- Family Spirit®
- Health Access Nurturing Development Services (HANDS) Program
- Healthy Beginnings
- Healthy Families America®
- Home Instruction for Parents of Preschool Youngsters®
- Maternal Early Childhood Sustained Home-Visiting Program
- Minding the Baby®
- Nurse-Family Partnership®
- Parents as Teachers®
- Play and Learning Strategies–Infant
- SafeCare® Augmented

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Parents continue to struggle with finding high-quality care for their infants and toddlers.

required to prioritize the enrollment of families experiencing homelessness, and it is unclear what their collective policies are with respect to serving homeless families. In 2018, several new data elements were added to the MIECHV performance reporting measures to require programs to report on the number of adults experiencing homelessness that they serve. The first reports generated from these data are anticipated in early 2019. It is unclear that standardized training is offered to programs in how to use the McKinney-Vento definition to determine homeless status. Given this lack of consistency, coupled with the fact that home visiting data vary substantially across evidence-based models, there are currently no national data exploring the efficacy of home visiting in the lives of infants and toddlers experiencing homelessness. This lack of data also suggests that there has been no rigorous study of the potential benefits of these evidence-based models for families experiencing homelessness either.

Part C Early Intervention Services

IDEA Part C offers funds to states to deliver comprehensive early intervention services for infants and toddlers with disabilities. These services may be particularly beneficial to families experiencing homelessness because studies continue to show that children experiencing homelessness are at an increased risk for developmental delay (Brumley, Fantuzzo, Perlman, & Zager, 2015). Any state receiving Part C funding is required to prioritize children experiencing homelessness by ensuring that they are identified and evaluated for services (U.S. Department of Education, n.d.), however, there is no information on the extent to which this provision is implemented or whether states are actively reaching out to identify homeless families. Furthermore, Part C allows states flexibility to include children who are at risk under the definition of disability, although this is not true for Part B services for preschool aged children (Curran-Groome & Atkinson, 2017). Therefore, states may choose to include children experiencing homelessness using the McKinney-Vento definition under this at-risk category in order to provide comprehensive Part C services in shelters and anywhere homeless families may reside and follow them as they relocate and until the child is 3 years old.

Unfortunately, much like the other programs referenced in this article, very little is known about how many of the children and families experiencing homelessness are served by Part C. In fact, only 6% of programs link their Part C data with housing data (Derrington, Spiker, Hebbeler, & Diefendorf, 2013). This means that there is very limited information on homelessness and infants and toddlers with disabilities. Further, because of the authority states have to design their early intervention system and establish eligibility criteria for Part C services, states vary in the extent to which they partner with housing providers and ultimately identify and engage homeless families.

Child Care Subsidy

Parents continue to struggle with finding high-quality child care for their infants and toddlers. This fact may be particularly true for parents experiencing homelessness because there is wide variation in local eligibility criteria for subsidized care and financial assistance. The Child Care and Development Block Grant Act (reauthorized in 2014) included accommodations to support the enrollment of young children experiencing homelessness into the child care subsidy system. States were directed to use the McKinney-Vento education definition to determine eligibility for these accommodations. Although policy changes have been made, states (and sometimes local communities) have the authority to determine which accommodations will be implemented to decrease barriers to access for homeless families, and there are limited data on the extent to which families experiencing homelessness are actually accessing child care subsidy dollars. Because this policy change occurred fairly recently, the child care subsidy system is just beginning to adjust state data systems to collect data on homelessness (Shaw et al., in press).

The Administration for Children and Families released training on how to appropriately gather information about family homelessness and to determine eligibility using the McKinney-Vento education definition in 2018, and states and communities are beginning to ensure that subsidy staff, contracted agencies such as child care resource and referral agencies, child care providers, and others are receiving that training (see Box 2). As with MIECHV above, data will begin to become available in the coming years. Therefore, given how recently the legislation was passed, and the time it takes to implement new policies and data platforms, accurate information is not yet available to know how many children and families are able to access child care subsidies through CCDF.

Where to Go From Here?

Although very young children are one of the most vulnerable segments of the population, an accurate picture of just how prevalent homelessness is for infants and toddlers and their families—and researchers' understanding of how families experiencing homelessness are engaged through and actually

use early childhood services for infants and toddlers—is limited. The lack of information is due, in part, to the fact that very young children experiencing homelessness remain essentially invisible within both the adult and child services worlds. Without access to reliable, quality data, even the basic task of describing the scope of infant–toddler homelessness becomes difficult. Differences in the definition of homelessness also limit the ability to link and draw comparisons across data sources (Shaw et al., in press). Therefore, early childhood programs should pay careful attention to the ways in which they collect data on family homelessness—not only at program entry to determine eligibility and available accommodations but throughout each family's involvement with services. Housing and homeless service providers should be informed on the use of the broader definition of homelessness in early childhood programs to determine eligibility to ensure that families obtain priority access or other special accommodations because of their being homeless.

In 2016, HHS, HUD, and DoEd released a joint policy statement urging state and local early childhood, housing, and homeless providers, as well as policymakers, to come together to increase their focus on, and better address the needs of, young children experiencing homelessness (HHS, HUD, & DoEd, 2016). The joint policy statement recommended strengthening partnerships between housing and early care and education programs, home visiting programs, and early intervention services to better support the developmental needs of young children and to achieve stability for their families. Yet, findings from several reports have indicated that families experiencing homelessness still face numerous challenges and barriers in accessing early childhood services, particularly for infants and toddlers (Perlman, Shaw, Kieffer, Whitney, & Bires, 2017). These families are not equitably accessing early care and education services (Administration for Children and Families, 2017) nor are they equitably accessing essential services, such as nutrition services through the Women, Infants, and Children program, to meet their most basic needs (Burt, Khadduri, & Gubits, 2016).

Infants and toddlers remain the age group most likely to be living in poverty, and extreme poverty is associated with homelessness.

As a result, there is not yet an adequate understanding of the ways in which these services may benefit families with infants and toddlers experiencing homelessness. For example, in one study, 63% of a sample of 199 housing programs from across the country reported that they support families with enrolling in EHS, and 40% of these providers reported having a formal relationship with an EHS program (Shaw, 2018). With respect to CCDF, although there is some evidence suggesting that many housing programs are aware of and support enrollment in child care subsidy programs (Shaw, 2018), little is known about the extent of use of subsidies by homeless families who may be referred for subsidies and whether they are actually able to access financial assistance for child care and maintain enrollment in child care over time. The absence of data on the use of child care subsidies presents a missed opportunity to capture data from early childhood systems on infants and toddlers experiencing homelessness which, as previously described, is particularly important for children under 3 years old because early childhood systems are the only opportunity to capture data both on children defined as experiencing homelessness under HUD's definition as well as on those who are highly mobile or living doubled up and captured using the McKinney-Vento education definition.

Finally, although there is robust evidence exploring the effects of early childhood services including early care and education, home visiting, and early intervention on children's development, especially for children at risk, very little is known about whether children experiencing homelessness benefit from these programs. In particular, very little is known about how mobility affects efficacy, access, attendance, and participation:

> *Homelessness and high mobility are associated with higher risks than poverty alone. Findings strongly suggest that the goal of closing the achievement gaps observed for children in the United States is going to require explicit attention to homelessness and high mobility and that strategies that work for stable children may prove inappropriate or insufficient for mobile children as mobility itself poses challenges for interventions or policies aimed at addressing the issues of these children and families* (Masten, 2014, p. 111).

Therefore, more evidence is needed to explore both trends in the use of these programs as well as the benefits of these programs specific to the needs of infants and toddlers facing homelessness and whether they will need to be tailored to address mobility and other conditions that co-occur with homelessness. Researchers should consider the strengths of these programs, as well as ways in which these programs might be able to improve to better serve families facing housing instability and create an evidence base for use of models with special populations.

To this end, investigations are needed to explore whether changes in early childhood policies, performance standards and regulatory guidance for programs such as Head Start, MIECHV, IDEA Part C, and CCDF are removing barriers to equitable access and increasing the enrollment and ongoing participation of young children experiencing homelessness in early childhood programs and services, especially those highlighted above and others, such as Women, Infants, and Children, which are intended to serve high-risk populations. Finally, further study is needed to explore the implementation of early childhood policies, how implementation varies across states, and whether further guidance can ensure implementation even when dealing with the challenge of homelessness.

It is important to continue to develop a research agenda focused on understanding the scope of the problem, the complexity of needs, and the effectiveness of services and interventions intended exclusively for infants, toddlers, and their families experiencing homelessness. Doing so would help to inform the field of promising practices around supporting the engagement of infants, toddlers, and their families into early childhood services and, perhaps, the prevention of homelessness and its deleterious effects on this vulnerable population. In addition, this information may be used to advocate for children experiencing homelessness and ensure that they have access to the early childhood services they are entitled to and need.

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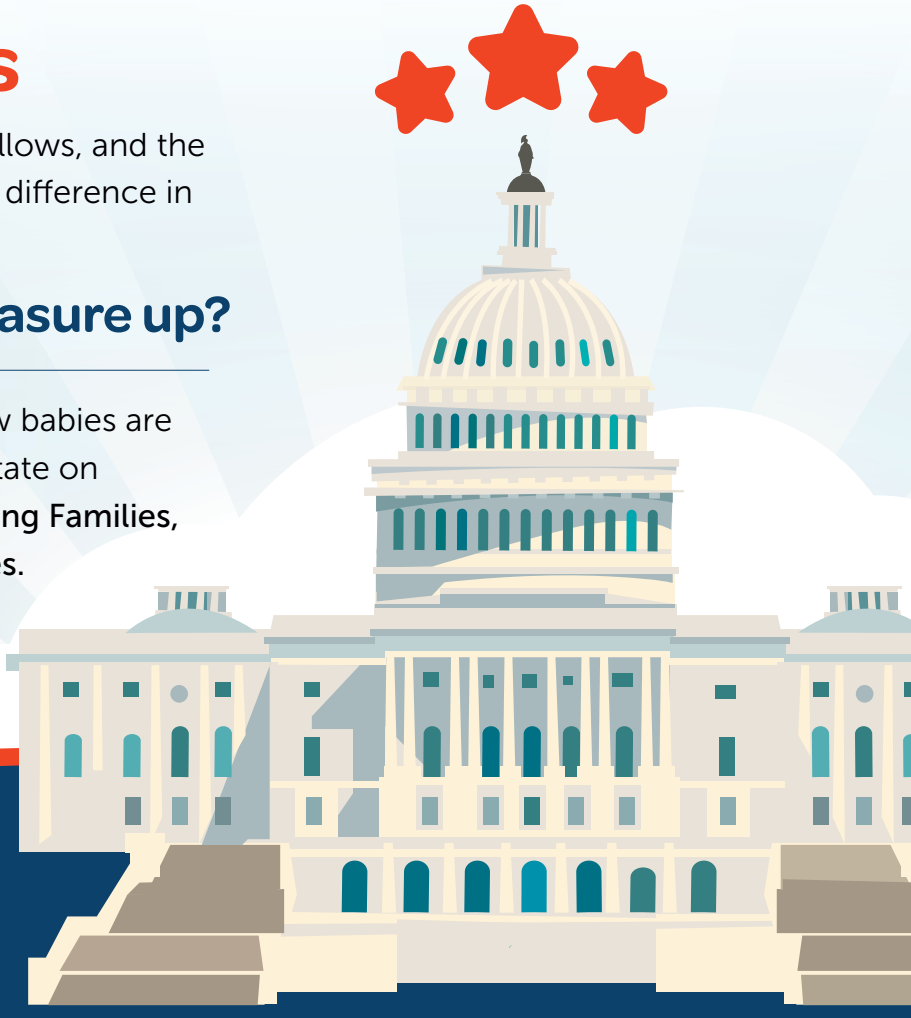

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Early Childhood Mental Health Consultation in Homeless Shelters

Qualities of a Trauma-Informed Consultation Practice

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Abstract
This article describes the conceptual approach to, and practical aspects of, the Infant-Parent Program's (IPP) decade-long experience providing early childhood mental health consultation in homeless shelters serving infants, young children, and their families. Illustrated by case examples, the authors discuss the characteristics of the consultant's stance, practices, and role with parents and shelter providers developed in response to the need of mitigating the impact of trauma related to homelessness in young children.

The experience of homelessness, marked by sudden changes, threats to safety, unstable relationships, and layers of loss, is traumatic for both children and adults and can heighten the vulnerability of infants and young children (Grant et al., 2007). Families of color are at a higher risk due to the disproportionately high number impacted by homelessness (U.S. Department of Housing and Urban Development, 2017). The very process of competing for scarce housing resources can further expose these families to implicit bias and systemic discrimination. When adults are impacted by acute stressors and trauma, their capacity to attune and respond to the needs of young children may be compromised as their own need for internal regulation, safety, and protection can be at odds with their desire to meet those same needs for their child.

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In providing shelter for homeless and traumatized families, it is a profound challenge to meet the variety, depth, and intensity of the needs. The focus on finding housing is necessarily prioritized over addressing mental and physical health issues, substance use/abuse, domestic violence, unemployment, discrimination, and other debilitating experiences. Meanwhile, the needs of infants and young children often recede to the background, or when attended to, their distress is typically understood and responded to as distinct from their caregiving circumstances. In their critical role of securing stable housing, shelter programs are placed in the untenable position of having to prioritize this goal over the myriad needs families are facing.

Nearly a decade and a half ago, aiming to mitigate the vulnerabilities homeless families face in the extreme housing shortage in San Francisco, the Infant–Parent Program (IPP) began providing early childhood mental health consultation (ECMHC) to homeless shelters. Bringing consultation, originally established for early childhood education sites, to shelter settings can enhance the staff's capacity to integrate all members of the family into a more comprehensive housing plan; one in

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When adults are impacted by acute stressors and trauma, their capacity to attune and respond to the needs of young children may be compromised.

which adult's and children's concerns may be understood in the context of their relationship to one another. Consultants aim to help staff build empathy for parents and children, whose behaviors often reflect the immense stress and pressure they are experiencing, by supporting staff to consider and understand the needs of infants and young children and how they can provide containment, consistency, and safety during a time of significant upheaval.

Case examples highlight the ways that families and staff in homeless shelters can benefit from a relationship-focused, developmental, and trauma-informed approach to ECMHC. The examples begin by describing possible opportunities for the consultant to bring infants' and young children's needs to the forefront. The authors then outline the ways the consultants address the needs for self- and co-regulation during acute and ongoing crisis and set the stage for reflective exploration of the family's needs and the staff's own experience.

Hearing the Voices of the Most Vulnerable

Claudia, in her fifth month of pregnancy, arrives at the Mother Teresa Emergency Shelter with her 3-year-old Carlos in tow. Carlos and his mother had to leave their previous shelter because of her angry outburst with the staff. He has a rare autoimmune disorder that requires regular blood transfusions. Restrained throughout the painful procedure, Carlos screams, kicks, and curses. During free play or when the clamor and chaos of shelter life scares him, Carlos tries to manage his fear by asserting himself, grabbing toys, hitting, and sometimes pulling other children's hair. This is what he saw his dad do to his mom when they lived together. Even though things at home were often scary, he misses his dad and wishes he was there to cheer his mommy up when she feels so sad that she can't get out of bed.

The consultant, who comes to the shelter every week, heard a lot about Carlos' family. Desiree, the case manager, shared her deep concern for Claudia's depression and anger issues and asked if the consultant could provide therapy and help Claudia to be able to follow through on the resources and referrals needed to secure stable housing. The children's program staff, meanwhile, were struggling to support Carlos and attributed his aggressive behavior to negative traits.

Although the consultant had only two chances to meet with Claudia, she quickly began to understand her struggles as a parent, both feeling powerless to bring relief to Carlos' pain and suffering and feeling lost in the face of his intense tantrums. Claudia also shared her hesitation to follow up with housing referrals as most of them were far away from where Carlos receives medical care. When the consultant inquired about Claudia's pregnancy, she shared how little internal capacity she had for caring and providing for another child.

With Claudia's permission, the consultant shared with staff the ways in which her worries regarding Carlos' medical care were contributing to her difficulty following up on housing referrals. Having a greater understanding of these stressors prompted the case managers to think with Claudia about partnering with Carlos' medical team to provide documentation for the family's need to be prioritized and housed closer to care. Learning that Claudia was feeling overwhelmed about her pregnancy led staff to help plan for her baby's arrival by referring her to the consultant's infant massage class.

Equally important, the consultant was in a position to represent to the children's services staff the ways in which Carlos' behaviors reflected his fear and insecurity given his difficult medical treatments, the family's history of intimate partner violence, and his loss of his father and repeated uprooting. With this understanding, staff was able to shift their perception of Carlos from an aggressive and defiant child to a child expressing an intense need for safety, trust, and predictability. Together with the consultant, the staff identified ways to support Carlos during free play time by narrating his experience and providing opportunities to engage in smaller groups with increased adult interaction. Having the staff hold the family's needs in mind helped Claudia to be more engaged and follow through on necessary steps needed to secure housing and allowed Carlos to develop a greater sense of security with the staff and with the free play routine.

For many working in shelter programs, holding in mind the seemingly competing needs of parents and children in systems burdened with the responsibility of housing families is a significant challenge. With many programs structured in ways that have staff working with either parents or with children, the mental health consultant is, at times, one of the few people in a position to create opportunities for bridging this divide by representing various voices, especially that of the child.

In the case with Carlos and his family, staff's negatively skewed perceptions of this little boy were primarily informed by their struggles with him during the program's free play time. The

consultant recognized that this was due, in part, to the strong pressure on shelter staff to focus on the need for housing which necessarily gives primacy to adults and their experience. Under this immense expectation, the equally urgent needs of infants and young children, and their interconnectedness to the needs of their caregivers, must compete for attention. The consultant's presence, relational focus, and knowledge of how trauma impacts early development assisted shelter staff in integrating both the child's and parent's experience in the context of case and crisis management and housing planning.

In addition to the external obstacles, internal and interpersonal barriers can also hinder adults' capacities to hold in mind the perspective of the child (Johnston & Brinamen, 2006). It may be difficult or painful for staff to consider the ways in which trauma or adverse experiences impacts the young child. Staff may also hold complicated feelings toward parents as they learn more about the families' history. Holding a trauma-informed perspective, the consultant understands staff's avoidance or overprotectiveness as a way to manage the pain of seeing an already vulnerable child's suffering. Maintaining a nonjudgmental, inclusive stance (see Box 1), the consultant seeks to establish a safe space in which staff are able to consider the experiences of both adults and children while acknowledging and collectively holding the feelings evoked in response to the families' vulnerabilities.

Entering From the Adult's Perspective

In many shelter programs, case managers hold the mighty task of supporting families in securing stable housing while assessing and identifying obstacles to this endeavor. Meeting with parents regularly, case managers learn a great deal about the adult's experience and may only learn about the child or infant's needs when they are immediate and pressing or, as in Carlos' case, may influence decisions related to housing. Case managers are often well-versed and highly skilled in working

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It may be difficult or painful for staff to consider the ways in which trauma or adverse experiences impacts the young child.

with adults, however they typically have limited experience with or knowledge of early development. Understandably, when engaging their mental health consultant, case managers initiate requests related to the mental health needs of their adult clients. Holding in mind that these adults are also parents and that how they are responded to will impact their capacity to attend to their children, the consultant looks for opportunities to introduce and amplify the children's voices.

The request for the consultant to address Claudia's depression came from a deep concern that if this mother didn't engage with the housing referrals offered, it might risk her and her children's safety and well-being. Although starting with providing such direct services to families is typically not how early childhood mental health consultants would lead in other settings, responding to the case manager's request was an important opportunity to both deepen the partnership with staff and to bring the child's and the parent's needs into focus. Understanding the immense pressures Desiree felt with the task of helping Claudia's family secure stable housing gave the consultant more empathy for the case manager's difficult position and for her request to provide brief therapy for the mother. In addition to supporting the case managers, responding to the direct needs of adults presents a portal for representing their parental role which, in turn, can lead to opportunities to consider the interconnected needs of the child. When shelter staff was able to hold Carlos' emotional and medical needs in mind, Claudia felt better understood by staff and was more engaged in the steps needed to secure housing.

While responding to the request to focus on particular families' immediate needs, the consultant looks for opportunities to expand her purview. Enhancing the shelter staff's and program's capacity to appreciate, attend to, and organize around the needs of parents and young children is a primary aim of ECMHC. Simultaneously, by consulting with parents and

Box 1. Consultative Stance

The consultative stance, developed by Johnston and Brinamen (2006), identifies 10 elements of the consultant's way of being that are central to supporting the co-creation of a relationship-based collaboration with consultees and stand as the most significant facilitator to positive change.

1. Mutuality of endeavor.
2. Avoiding the position of the expert.
3. Wondering instead of knowing.
4. Understanding another's subjective experience.
5. Considering all levels of influence.
6. Hearing and representing all voices—especially the child's.
7. The centrality of relationships.
8. Parallel process as an organizing principle.
9. Patience.
10. Holding hope.

providing direct services, such as infant massage, peer-centered playgroups, or child–parent workshops (see Box 2), consultants imbue an infant and early childhood mental health perspective throughout the shelter milieu.

Entering From the Child's Perspective

Because of the distinction of roles within many of these programs, children's experiences are often attended to by the children's services staff. This team is tasked with developing and offering activities for children from birth to 18 years old, celebrating birthdays, and working closely with the parents around referrals to child care, community resources, and treatment for their children. This staff and the case managers work diligently to attend to the needs of all family members during their stay. However, given the complexities of holding the competing needs of children and adults side-by-side, it is common that communication fails or becomes conflictual between the two services, one representing the child's experience, the other the adult's. The consultant supports shelter staff to consider the impact of parents' experiences on their children as well as children's experiences on their parents and encourages communication between the case managers and children services staff.

The consultant works closely with the children's services staff to think about the unique impact of homelessness on children and their relationships. Carlos is only 3 years old, but he has already experienced the loss of contact with his father. Significant disruptions of primary relationships are common and traumatic in children's lives while homeless. In addition to enhancing staff's capacity to provide consistency and continuity in their programming for children, the consultant works with staff to implement institutional rituals that support children's experiences. For example, through a goodbye protocol, space is created for children to say goodbye to peers and staff when they exit the shelter. When possible, staff prepares a gift basket for exiting families and provides opportunities for children to draw pictures or make goodbye books before leaving.

Trauma tends to fragment experiences both in individuals and in institutions. Using fragmentation as a way to cope, coupled with the pain of witnessing the suffering of people, especially the young and most vulnerable, influences how staff respond to families. In shelters where families' lives are organized around overwhelming experiences, incorporating a trauma-informed approach to ECMHC is an essential ingredient to enhance the voices of the youngest and maintain effective collaboration with staff.

Trauma-Focused Early Childhood Consultation Practice

When the consultant arrived at the Harrison Family Shelter for her regularly scheduled meetings, the first thing that caught her attention was a police car parked out front. As she walked in, she found three case

Box 2. Direct Services Enhancing Early Childhood Mental Health Consultation

In our consultation with shelter programs, the development and provision of direct clinical services has proven to be an essential element in establishing and building rapport. In addition, it affords the opportunity for the consultant and staff to appreciate, address, and attend together to the unique relationships between parents and children in their program. This offering of early intervention and direct mental health services often and intentionally takes place early in the timeline of the developing consultative relationship with the shelter staff. Holding in mind the need and value of providing definitive and concrete assistance within systems plagued by trauma, the consultant seeks to intervene in ways that address the pervasive sense of urgency, respond to need for co-regulation, and maintain a focus on the needs of infants and young children. The following are examples of the ways consultants have developed direct interventions in these programs:

Infant Massage

Mental health consultants with specialized training offer infant massage to families in the shelters as a way of supporting the infant–parent relationship and providing opportunities for playful co-regulation. Various experiences of touch are explored for both parents and babies as the consultant facilitates reflection and attunement to the cues the babies give in response to the massage. The consultant weaves in discussion on the infant's sensory integration and development, incorporating this into the massage practice. Infant massage strokes are taught over the course of several sessions from less to more sensitive body areas so that parents may practice incrementally as both parents and babies ease into this new experience of being with one another.

Child–Parent Workshop

A relationally focused child–parent playgroup was developed by the mental health consultant, in collaboration with the staff at a long-term housing program, as a way to offer a more experiential opportunity for families to meet the program requirement of attending regular workshops during their time in the program. The consultant and staff collaborate to offer activities for parents and their infants, toddlers, and preschoolers and build connections with the other families at the program. Together, they support the child–parent dyads with co-regulation, sharing mutually enjoyable moments of connection, and building curiosity about infants' and children's experiences. Despite their resistance toward mandatory events, families often described this open space as a moment of respite in their hectic lives.

Therapeutic Playgroup

In a shelter where there is an established child care center embedded within the program, the mental health consultant collaborated with staff to develop a therapeutic playgroup for those children of greatest concern. Cofaciliated with a member of the child care staff familiar to the children, this playgroup offered a weekly space where children were able to engage in exploration, develop age-appropriate play, and use the language of play to make sense of their experiences, all within the context of safe, predictable adult relationships. The consultant provides a model for engaging children and expanding on their play themes and ideas. Recognizing that this venue can evoke powerful feelings for the shelter staff who facilitate the group, the consultant meets regularly with the staff member to provide a space where they can reflect on the feelings, responses, and reactions which inevitably arise.

managers in the hallway, looking concerned and worried and talking through what needed to be done in that moment. Having met with the case managers weekly for the past year, the consultant knew that they cared deeply for the families in their program, where they often faced unpredictable and unsettling events. She quickly learned that Shawn and Kylie, two young parents who recently arrived with their 2-year-old daughter, Madison, had a loud physical argument in the hallway. Right before the consultant arrived, Kylie had thrown Shawn's belongings out into the hallway and locked herself in the apartment with Madison.

The consultant knew from her experience with this staff that during times of crisis, they sought out concrete ideas and expertise from her, and there was no time or tolerance for reflecting. She came to see these actions as necessary to re-establishing a sense of equilibrium and self-regulation within the staff. Listening to staff express their concerns and pressing questions, the consultant joined their problem solving in ways that supported their sense of agency and their own ways of knowing and led the team to identify steps ensuring the safety of the family and other residents. She intentionally worked to maintain her own sense of mindfulness and calm so that her presence offered an opportunity for co-regulation for the agitated staff who had witnessed the family's fight. Having a concrete plan of actions to respond to the urgency of the situation further supported the three case managers in regaining their sense of equilibrium.

With the staff feeling confident that the immediate safety concerns had been addressed, the consultant was able to engage them in considering Madison's experience, positing that she might feel confused and afraid. Knowing that the child was physically safe allowed the case managers to engage in reflecting on Madison's emotional needs in that moment. It became clear to them that they needed to help the parents have time and space to recover from their argument without the child witnessing more fighting. With the consultant's support, they considered how to best approach Shawn and Kylie, explaining their concerns for Madison and how they could support her in that moment. Together with the parents, the case managers were able to identify trusted adults in the program who could bring Madison to the program's playroom, offering Madison and the family time for respite.

The following week, when the consultant returned to the site, staff had more time and capacity to reflect, sharing their ongoing concerns about the family, particularly Madison's needs. Staff shared how the crisis with this family amplified their own feelings of stress and responsibility, and they reflected together on how their nearly insurmountable task of helping families find permanent housing in the Bay Area often left them feeling ineffective. The consultant felt deeply for the staff's experience. She, too, often had feelings of futility in her position. Only after validating their concerns and expressing her respectful appreciation for staff's efforts, did she find an opening to offer hope and reconnection to their values by highlighting the profound impact of their efforts on the families they serve.

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Mental health consultants with specialized training offer infant massage to families in the shelters as a way of supporting the infant–parent relationship and providing opportunities for playful co-regulation.

The consultant enters the shelters with the awareness that all families in these settings are impacted by acute trauma. Infants and young children, like Madison, whose development is dependent on their caregivers' emotional availability, are especially vulnerable and deeply impacted by their parents' compromised capacity to attune, attend, and protect due to their extremely high stress levels. The persistent, overwhelming experiences families face while navigating homelessness can leave infants, children, parents, and program staff with little opportunity to access calm states, with many oscillating between feelings of panic and exhaustion. The early childhood mental health consultant who values slowing down, wondering but not knowing, and avoiding taking the position of the sole expert in order to invite reflection (Brinamen, Taranta, & Johnston, 2012; Johnston & Brinamen, 2006), finds herself in a bind. Staff and families in states of acute crisis may deem these qualities unhelpful or even more dysregulating when quick, definite action is needed. The consultant has learned through many cycles of rupture and repair in the relationship with the staff that, in settings where the level of worry is intolerable and risks of safety call for immediate action, supporting regulation of the nervous system is necessary before reflective exploration becomes possible.

As Madison's vignette illustrates, many living and working in shelter programs experience continual moments of disruption and dysregulation. Strung together, staff in these programs experience the commotion as crisis and, in turn, feel a tremendous sense of urgency. Coupled with an acute awareness of what families have already lost and what is at risk in the moment, this urgency pushes staff toward immediate action in their effort to relieve suffering. In offering ECMHC to shelters, it has been essential to both respond and to reflect upon this sense of urgency and to be willing to understand

and partner with staff around their pressing concerns while inviting reflection in an effort to support informed action rather than reaction.

Under immense pressure in the midst of ongoing crisis, this sense of urgency becomes the norm, rather than the exception, leaving staff with little tolerance for exploration. Thus, even at times when there is not an immediate safety concern, the consultant's invitation to talk and reflect before taking action is perceived as unhelpful and potentially further dysregulating. With this awareness, the consultant working in trauma-infused settings assesses the level of activation in staff and chooses the most fitting response from her therapeutic repertoire. With a careful balance of maintaining her own state of emotional regulation and responding to staff's concrete needs, the consultant supports staff to modulate their own sense of urgency and return to a balanced state without compromising necessary action.

The consultant aims to support staff's capacity to regulate their own arousal not only through "what we do" and how quickly we do it but, also through "how we are" (Pawl & St. John, 1998). Engaging in active problem solving, offering expertise when it enhances quick decision making, and providing direct therapeutic services to families are settling to staff. These responses address the urgent need for relief, enhance staff's sense of effectiveness, and convey an understanding and appreciation for the pace and pressures of life in shelter settings. However, it is equally important that these actions are provided in the context of the consultant's regulating presence. With the intention to leverage the human capacity to co-regulate through relationships, the consultant aims to bring an attuned, emotionally balanced, and supportive presence to staff and families in the midst of heightened stress and crisis. The mental health consultant patiently waits for a port of entry to gently invite, acknowledge, normalize, and help contain feelings evoked in staff by their exposure to and empathy for the families' pain and suffering. In this way, staff are supported in their capacity to return to a state that is neither too alarmed nor too exhausted, which allows for natural opportunities to arise for reflecting and making meaning of the events and one's own experience in response to them. In these moments, the consultant shifts her approach to support reflection by stepping away from the role of an expert, wondering instead of knowing, and exploring multiple perspectives, including the staff's own experience (see Box 3). Strengthening adults' capacities to regulate their own arousal is central to supporting their ability to attune and respond to the parallel needs of the infants and young children residing in these settings.

Just like staff, the consultant is not exempt from being impacted by witnessing the traumatic experiences and injustices infants, young children, and their families are exposed to while on the journey toward housing stability. Maintaining a nonjudgmental, nonreactive container for family's and staff's intense or confusing emotional experience requires the consultant to be in touch with her own reactions and feelings without being overwhelmed by them (Pawl & St. John, 1998). Through regular reflective supervision, the consultant is supported by the very process she brings to the staff and families at the shelter. This additional layer of support is a crucial part of consultation that enhances the consultant's capacity of presence, empathy, regulation, and reflective capacity. Reflective supervision also provides a place where the consultant explores her own implicit bias and position on the social map and how it influences her practice and relationship with staff and families.

Box 3. The Impact of Consultation—Quotes From Shelter Staff

The following comments from case managers and children's services staff illustrate the various ways ECMHC has expanded their capacities of holding the infant–caregiver relationship in mind, considering multiple perspectives, and practicing self-regulation, while supporting the families at their shelter program.

"Consultation has been very useful to me in building relationships with families who do not express their needs. Through talking with the consultant, I am able to get a different perspective on how to best approach these families and their children."

"Consultation has been hugely beneficial for me; my experience there would have been very different without it. Sessions helped me clarify my thinking about what had occurred in my sessions with the children that week. I am a fairly emotional person and often took the clients' struggles and hardships very much to heart, so going over events helped me enormously to process and let go of experiences I was finding particularly difficult."

"As the Children's Activities Program coordinator, my job would be impossible to do if it wasn't for the reflective processing that enabled me to help and support the families and children with their needs. The reflective processing allowed me to be mindful about the children's developmental, social, and emotional needs. For instance, the consultant helped us understand the importance of 'tummy time' in babies' development and helped us facilitate an ongoing class for parents who had limited time and energy or didn't know of the benefits of babies playing while lying on their tummy."

Conclusion and Lessons Learned

In shelter settings where pressing adult needs are prioritized in order to overcome insurmountable obstacles for successful housing, ECMHC brings infants and young children's voices into focus with the hope that both the child's and parent's needs can be addressed in the context of their housing decisions. The consultant is positioned to hold the child and the parent's experience jointly and looks for opportunities to bring the child–caregiver relationship to the forefront of awareness. This is achieved partly by addressing adults' needs directly while highlighting their role as parents and by helping staff to consider the meaning of children's behavior in the

context of their caregiver's stress, trauma, and compromised capacity to provide attuned caregiving.

Advocating for the voice of the young child in shelter settings must be embedded in a trauma-informed consultation practice. With the understanding of the impact of ongoing elevated stress on one's capacity to regulate strong feelings and internal sensations, the consultant swiftly but carefully assesses the level of urgency and regulation in her consultee and adjusts her interventions accordingly. While maintaining her own regulated presence, the consultant takes a more directive stance when modulating dysregulated states during crisis or crisis-like situations. It is the combination of leading with expert opinion and direct therapeutic contact with parents and their children along with providing co-regulation through the consultant's own calm and responsive presence that supports the consultee to modulate her own arousal. When the sense of urgency settles, the consultant switches to a more open stance that promotes exploration and reflection leading to a better understanding of the child and parent's experience and opening space for reflecting on staff's own experience. Adjusting the stance in these ways supports addressing the impact of trauma and leads to increased capacities for staff to self-regulate, reflect, and hold multiple perspectives in mind, which in turn allows them to enhance the same capacities in parents helping them to be more available to their children.

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Better Together

An Early Head Start Partnership Supporting Families in Recovery Experiencing Homelessness

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Abstract
This article describes the ongoing impact of one Early Head Start grantee's participation in a statewide initiative to connect the state's network of residential substance abuse treatment programs for women and their children with their local Early Head Start program. The initiative was designed to enhance child development and parenting supports using a self-assessment tool; to childproof the residential recovery program; to prevent homelessness by connecting families with ongoing housing supports upon completion of recovery services; to ensure Early Head Start access and participation; and to increase cross-training, collaboration among staff, and overall coordination of services to families.

Since 2009, Area Cooperative Educational Services Middlesex County Early Head Start (ACES EHS) has been providing comprehensive home visiting services to children and families in six Connecticut communities. Investments in early care and education are an investment in a thriving and successful future for children across Connecticut and the nation. ACES EHS emphasizes the role of the parent as the child's first and most important teacher. It is through relationships that all early development takes place. Along with the support of home visiting staff, ACES EHS's focus is on the home as the child's primary learning environment. Recognizing the importance of the parallel process, the relationship of the home visitor to parents, caregivers, and expectant families is central to the program's effective service delivery. This relationship becomes the vehicle through which to strengthen the parent's ability to nurture the healthy development of the children.

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ACES EHS uses both the evidence-based Early Head Start Homebased Model (U.S. Department of Health and Human Services, 2018) and the evidence-based Parents as Teachers curriculum (Parents as Teachers, n.d.) to provide parent education primarily through home visits and group meetings. ACES EHS uses Parents Interacting With Infants (PIWI, n.d.) in socialization experiences. This model promotes the healthy social–emotional development of infants and toddlers. ACES EHS also uses Creative Curriculum Teaching Strategies GOLD (Teaching Strategies–GOLD: Birth Through Kindergarten (n.d.) to ensure and assess that children are meeting early learning goals and objectives. The number of trauma-impacted families in ACES EHS continues to grow because of an increase in program participants who are, or have been, homeless, as well as those impacted by substance use disorders. This is in part due to ACES EHS's involvement in the third cohort of statewide outreach initiatives to target these populations for enrollment into EHS and Head Start services. ACES EHS has continued to see an increase in its enrollment of women with substance use disorders who often also have had experiences of sexual abuse, intimate partner violence, homelessness, lack of social supports, inadequate parenting, poor nutrition, and psychiatric comorbidity.

A Collaboration Between EHS and Residential Treatment for Women and Children

ACES EHS's participation in the statewide targeted outreach initiative from May 2016 to January 2017 was sponsored by the Connecticut Head Start State Collaboration Office which partnered with the Connecticut Department of Mental Health and Substance Abuse Services (DMHAS) to pair each of its women's residential treatment programs with its local EHS provider. The partnership with DMHAS was the third cohort of local collaborations involving Head Start and EHS grantees and local emergency shelters and residential treatment programs. It was common for women to move from residential recovery into emergency shelters because they had no homes and needed to "become homeless" to qualify for housing supports. Thus, it was important for EHS and women's residential treatment programs to work more closely together to prevent homelessness and create enduring supports that reinforce the recovery process and also promote healthy child development and strong families once residential treatment services ended.

Goals of the Collaboration

Overall, there were three goals for this community partnership effort: (1) working together to make residential settings more child friendly, (2) enrolling young children into EHS and Head Start programs, and (3) strengthening cross-sector partnerships to align and improve services for families. The initiative offered training and technical assistance to participating staff from EHS/Head Start programs and Women's Residential Services, and it provided small grants to support purchases that would make residential settings and their services more child-friendly.

Designated lead staff members in each of the EHS/Head Start programs and women's residential treatment programs worked together as teams to complete the *Early Childhood Self-Assessment Tool for Family Shelters* (U.S. Department of Health and Human Services, 2015) at the start and end of the initiative. They developed an action plan based on the self-assessment that was then used to guide purchases for the residences and joint activities, and to compile progress reports at the midpoint and end of the project period. They documented the number of children enrolled in EHS and Head Start, their shelter enhancements and collaborative activities, any policy or practice modifications made to better coordinate and align services, and other resultant changes they attributed to the initiative. In Cohort 3, staff members also completed the Network Data-Collection Instrument (Provan, Veazie, Staten, & Teufel-Shone, 2005) and Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2001) tools at the start and end of the initiative to measure changes in collaboration.

The results of Cohort 3, which included ACES EHS, were reported in a poster presentation at the ZERO TO THREE Annual Conference 2016 in New Orleans, LA. Notable among the results was evidence that when teams completed the tool together, more gaps in child-focused services were identified. The early childhood team members used the assessment tool to help the members of the residential team to better understand the developmental needs of the children in their care and to know where to obtain items and connect with community resources that could address identified needs.

The Connection's Hallie House for Women and Children

The Connection's Hallie House for Women and Children, a residential treatment program for expectant mothers and mothers of young children, is one example of how the formal statewide partnership initiative helped to deepen and expand collaboration between EHS and a local residential treatment program. Using the Early Childhood Self-Assessment Tool for Family Shelters (U.S. Department of Health and Human Services, 2015; see Box 1), designated lead staff at ACES EHS and Hallie House worked together as a team to assess practices at Hallie House in the areas of health and safety, wellness and development, workforce standards and training, programming, and food and nutrition. The team created an action plan based on their assessment which then guided their efforts to childproof the environment and Hallie House services. They created a more child- and parenting-friendly setting by creating spaces for parents and children, identifying and incorporating resources for families and staff, and increasing referrals to EHS. As a result, service coordination and family goal setting were dually addressed by both programs. In addition, referrals to ACES EHS became part of the Hallie House program participation policy. ACES EHS was able to provide families with early learning experiences, trainings, resources, and various on-site activities such as infant massage, which, in response to the individual needs of families, have now been offered as both group and individual sessions of infant massage. In some cases, staff learned that some families didn't participate in the group sessions for fear of being judged. The infant mental health consultant suggested offering individual sessions, and engagement by those families increased.

Box 1. Early Childhood Self-Assessment Tool for Family Shelters

The Early Childhood Self-Assessment Tool for Family Shelters (U.S. Department of Health and Human Services, 2015) is intended to help shelter staff ensure their facilities are safe and appropriate for the development of young children. It can be used in any residential setting that serves families because most operate using an adult-centric model. The tool addresses five areas:

1. Health and Safety
2. Wellness and Development
3. Workforce Standards and Training
4. Programming
5. Food and Nutrition

During the period of this statewide initiative, ACES EHS was able to develop a collaborative referral process through which case managers and support staff from both ACES EHS and Hallie House increased their knowledge of one another's programs. Hallie House became familiar with ACES EHS's eligibility verification, thus decreasing potential enrollment delays. ACES EHS became more familiar with the state's 211 central intake process linking families with housing services and specific requirements of housing supports, such as supportive housing programs in the catchment area, and the staff at ACES EHS have maintained regular communication with the local housing authorities to ensure that all families who qualify complete the application process and regularly monitor their progress on the waitlist. ACES EHS also learned about the collaborative outreach activities for homeless families through DMHAS and became more familiar with resources specifically addressing domestic violence in the community.

Since the end of the statewide initiative ACES EHS has continued its relationship with each of these community partners and it continues to strengthen collaboration by ensuring all ACES EHS staff, including leadership, are aware of homeless services and housing eligibility criteria. The leadership has taken a hands-on approach with the housing application process and holds regular collaborative meetings to ensure families and staff receive ongoing guidance. ACES EHS made changes in 2017 to their selection criteria to consider the unique needs of families that are experiencing housing issues. In addition, the director of housing development became a member of the ACES EHS Policy Council. Although Connecticut reported a decrease in the number of homeless families, ACES EHS has seen a significant spike in those families that fit the McKinney-Vento definition (see Box 2) of homeless in their catchment area.

The 2018 program information report revealed the highest number of homeless families since opening its doors a decade ago. There were 31 families deemed homeless for the program year out of a total program capacity for serving 98 families. The majority of those families have come to ACES EHS as a result of referrals from Hallie House.

Innovative Services

As mentioned previously, this targeted partnership initiative resulted in a number of innovative services for families through ACES EHS. Infant massage was one example a unique opportunity introduced to families at ACES EHS. Facilitated by the ACES EHS infant mental health consultant, these sessions are intended to help parents get to know and understand their child in new ways, to bond and relax together, and to encourage overall well-being. Another innovative opportunity introduced for families was the Lullaby Project, a unique collaboration with the music department at Weslyan University to foster closer relationships both in the community and in families (Carnegie Hall, n.d.). Through the Lullaby Project, ACES EHS expectant families can create personal lullabies to sing to their newborns. One goal of the Lullaby Project is to invite more families residing in shelters and to address the barriers preventing participation in overall program activities. The Lullaby Project has the potential to be introduced to other community partners that work closely with ACES EHS.

Photo courtesy of Rebecca Cuevas

Christie Arnold, vice chair of the Policy Council for Area Cooperative Educational Services Middlesex County Early Head Start, and her two children enrolled in the program, with Rebecca Cuevas, program coordinator. The parent voice and shared decision making is an essential piece of the Early Head Start experience.

Box 2. McKinney-Vento Definition

The term "homeless children and youth"
(A) means individuals who lack a fixed, regular, and adequate nighttime residence and includes
(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;
(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
(iv) migratory children who qualify as homeless for the purposes of this part because the children are living in circumstances described in clauses (i) through (iii).

Source: 42 U.S. Code § 11434a (2)

Photo courtesy of Rebecca Cuevas

Area Cooperative Educational Services Middlesex County Early Head Start staff members: (from left to right) Kolby Bowen, system program specialist; Dionne Lowndes, maternal child health manager; Jennifer Cronin, home visitor; Rommy Nelson, ERSEA assistant; Sherri O'Shea, mental health professional; Heather Haouchine, home visitor; Sharon Redmann, quality assurance consultant; Melinda Moore, home visitor; Rebecca Cuevas, program coordinator; Taneone Hurlburt, data clerk; and Cindy Smernoff, education manager

Positive Impacts of Collaboration

These opportunities have been offered in different settings and components within ACES EHS and have increased staff knowledge around child development, attachment, engaging differently with clients, and supporting the parent–child dyad in an effort to improve child and family outcomes. As illustrated by the stronger relationship between Hallie House and ACES EHS, community partnerships play a significant role in helping families. These important partnerships are central to the coordination of services while in the program but are just as important with the transitions out of the individual programs and from one program to another. It is program policy for all ACES EHS staff to work toward a plan of transition with families 6 months prior to completing EHS services. ACES EHS staff begins talking with parents in recovery about transitioning out of residential treatment based on their projected date of exit from the residential facility. Transition planning is important because a critical need among mutually served and shared families is housing. However, this planning had not been policy in the past. A major reason for the statewide initiative was that families often completed the recovery program only to be discharged into an emergency shelter because they had nowhere else to go. Families in recovery need a higher level of service coordination and support in gaining safe and affordable housing. When providers and families work together from early in the recovery process, families not only can move to safe and stable housing but they also report feeling already fully engaged in a supportive program that can continue to promote recovery as it promotes strong family relationships, healthy parenting practices, and optimal child development.

For parents in recovery who have limited supports and no place to go once they leave residential treatment, recidivism rates are likely high as are risk factors for their babies. ACES EHS and other EHS programs participating in the statewide initiative observed that families in recovery found EHS to be a community that could welcome them and their young children and support their parenting as they moved away from past unhealthy relationships and ways of coping and created new possibilities for their families. In the past, recovery programs like Hallie House did not see the children as their clients, and they did not have evidence-based parenting supports as a part of their service system. By partnering with ACES EHS, they could add these valuable child development and parenting components and together work with families to comprehensively address future needs and access available services from multiple sectors.

The comprehensive services model used by ACES EHS and its family partnership process elevate the focus of services and supports on what parents and caregivers need to feel successful. Since ACES EHS opened its doors in the community, Middlesex Health has been one of its highest sources of referrals because of the program's positive impact on families and on the community. Mary Doyle, a perinatal social worker at Middlesex Health, stated

> *EHS meets parents where they are and makes efforts to understand what they are going through. Working*

collaboratively with community providers can lead to early recognition of the family's priorities. Many families experience immense isolation, fear judgement, and wish for simple direction. It really requires careful listening which helps to create a more meaningful family goal-setting process. The formulation of realistic action steps can lead families to successful attainment of housing, child care, food, and health care.

The Connection's Hallie House values the partnership they have strengthened with ACES EHS. Through the same statewide initiative's Cohort 3, The Connection also partnered its Mother's Retreat residential program in Groton with the Thames Valley Council for Community Action's EHS/Head Start program. Staff at The Connection identified a barrier to aligning their efforts with EHS:

Work needs to be done to align the different definitions of homelessness across agencies. Early Head Start/Head Start programs can prioritize families using the McKinney-Vento Act definition of homelessness, as specified in the Head Start Act and Head Start Program Performance Standards. *This enables Early Head Start/Head Start programs staff to coordinate services and complete necessary paperwork to determine a family's eligibility as homeless while other agencies find they are not allowed to use the same eligibility criteria. One clear example of this lack of alignment is when seeking resources for homeless individuals and completing housing applications, which use a different definition of homelessness and require different eligibility criteria and documentation. This hinders the process for families to secure housing vouchers and other housing supports and hinders some providers from working together to access needed services for families.*—Sherrie Weaver, program director, The Connection's Women and Children Substance Abuse Treatment Programs

Looking to the Future

ACES EHS has seen an increased rate of turnover in the last 2 years with families who wish to stay in the program finding it difficult to gain the financial means to remain in the community. ACES EHS is committed to working with shelters and community providers on how to support families in their effort to stay in the area. When there are little to no familial supports or social networks, families leave the area within 6 months. Affordable housing and child care are major reasons that families relocate outside of the service area. ACES EHS would like to build capacity in the community to help families remain in EHS and in the community by strengthening its own networks with its partners.

ACES EHS would also like to strengthen its organizational structure to include trauma-informed care. The goal is to expand the program to include infant–toddler center-based care with staff that have experience in trauma-informed care. ACES EHS has long provided services with a strong mental health component, and ACES EHS staff have sought formal credentialing with The Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®; Michigan Association for Infant Mental Health, 2019) through the Connecticut Association of Infant Mental Health to bring quality support and experiences into homes with the goal of promoting the importance of relationship-based practice and healthy attachment. Of note is that, as a result of the partnership, staff of women's residential recovery programs are now attending training in infant mental health and several are working toward endorsement.

Rebecca Cuevas, MSW, LMSW, is the program coordinator for Area Cooperative Educational Services Middlesex County Early Head Start and a social worker with more than 30 years' experience working with families, early education, and home visiting initiatives in Connecticut. For the past 15 years, she has worked at Area Cooperative Educational Services, with 10 of those in Early Head Start. Born and raised in New Haven CT, she grew up with a strong sense of family and community. She has long believed that parents play an important role in their children's lives and that families thrive when they feel supported within their communities. She earned her master's of social work from the University of Connecticut School of Social Work and bachelor's degree in psychology from Albertus Magnus College. She is a board member of the Connecticut Association of Infant Mental Health and the Connecticut Head Start Association. Rebecca has been a life-long resident of Connecticut and continues to live there with her husband and two children.

Grace Whitney PhD, MPA, IMH-IV, joined SchoolHouse Connection after 20 years as director of Connecticut's Head Start State Collaboration Office. She is a developmental psychologist and endorsed as an Infant Mental Health Policy Mentor. Dr. Whitney began her career as a preschool teacher in special education and as a home visitor for at-risk families of infants and toddlers, has since held a variety of clinical and administrative positions, and has frequently taught courses in child development and public policy. She's shared her work with colleagues in Connecticut using the Early Childhood Self-Assessment Tool for Family Shelters at conferences of ZERO TO THREE and the World Congress for Infant Mental Health.

Learn More

Area Cooperative Educational Services (ACES) is a Regional Educational Service Center dedicated to serving communities with an array of services and programs. These include Early Head Start, adult and vocational programs, inter-district educational programs, Open and Magnet School Parent Choice programs, Minority Teacher Recruitment initiatives, behavior services for individuals on the autism spectrum, occupational/physical therapy, professional development, and technology services.

The Connection's Hallie House for Women and Children
https://www.theconnectioninc.org/our-organization

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My Baby's First Teacher

Supporting Parent–Infant Relationships in Family Shelters

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Abstract
Infants who stay in emergency shelters with their families are most likely to demonstrate resilience despite homelessness if they experience positive, nurturing relationships with their parents. We discuss the strengths and challenges of infants experiencing family homelessness as well as intervention and research evaluation in those contexts. Next, we describe our collaborative efforts to implement and evaluate a unique parenting intervention, My Baby's First Teacher, which was designed specifically for supporting positive parenting for infants in shelters.

> *I am in this position, no home right now, living here in this shelter, as you know, it is a little stressful because I don't have my own space where my family can be ourselves. We are always around people. That's the one thing that frustrates me the most, it's not my children, it's the other people, like I can't—I don't have anywhere to be alone.*
> —Mother staying in emergency shelter with her children

As this quote illustrates, staying in emergency housing involves a host of stressors that compound the already daunting crisis of family homelessness. In this article, we discuss the strengths and challenges of families with infants in emergency housing as well as the strengths and challenges of intervention and research evaluation in those contexts. Next, we focus on My Baby's First Teacher, a unique intervention designed to support positive parenting for infants experiencing homelessness or other contexts of very high risk. We provide a detailed description of the program, then briefly describe our collaborative efforts to evaluate the program's effectiveness toward establishing an evidence base for what works.

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Infants who experience family homelessness face varied threats to their well-being (Haskett, Armstrong, & Tisdale, 2015). Efforts to buffer these threats and support healthy infant development depend on understanding what all babies need, how episodes of homelessness complicate these needs, and how to leverage strengths that have the most potential to nurture and protect babies in the face of adversity. It is well known in resilience science that children can best weather challenges when they have positive relationships with caring and competent adults. For babies, the most important relationship is with a parent who not only cares for their basic needs, but also provides a foundation for their learning about the broader world. A clear target for supporting resilience in babies experiencing homelessness, then, is to support their parents and foster that key relationship. Efforts to intervene with parent–child relationships in emergency housing must consider the unique characteristics of families who stay in shelters and the shelter environments themselves. Understanding what works in these contexts also requires that intervention efforts be evaluated with rigorous research designs (Herbers & Cutuli, 2014).

Parenting Infants in the Context of Shelters

Because parents have such central roles in their babies' lives, they can be a primary source of strength and protection

Photo: shurkin_son/shutterstock

Children can best weather challenges when they have positive relationships with caring and competent adults.

against adversity when they are functioning well, or they can contribute to vulnerability or even threat to children when their own functioning is compromised. As such, efforts to support healthy infant development often target parents with the goal of building or strengthening a positive parent–child relationship. Infants depend on caregivers to meet their varied and substantial needs. For healthy development, caregivers must provide not only conditions for survival, but also nurturing social interactions that form the foundation of both cognitive and social development (Zimmer-Gembeck et al., 2015). Not yet capable of managing or regulating their own emotions and actions, infants rely on their parents for co-regulation. Co-regulation refers to interactions through which caregivers respond to infants' needs and also establish patterns of social interaction. Positive co-regulation involves being sensitive and responsive to the infant's signals, mimicking infant vocalizations and actions, guiding the learning of new skills, and soothing or calming infants when they are too distressed or excited (Calkins & Hill, 2007). These earliest social interactions support the development of a secure attachment relationship, a foundation for developing confidence, positive expectations, and trust (Feldman, 2007). As such, positive co-regulation predicts a range of developmental outcomes for children including better emotional and behavioral self-regulation, academic achievement, peer relationships, and mental health (Herbers, Cutuli, Supkoff, Narayan, & Masten, 2014; Zimmer-Gembeck et al., 2015).

In the context of family homelessness, it can be especially challenging for parents to provide the co-regulation that infants need (David, Gelberg, & Suchman, 2012; Volk, 2014). In addition to severely limited economic and educational resources typical of living in extreme poverty, these parents tend to be young and to have substantial histories of life stress and trauma. Mothers who are homeless in particular report having been victims of domestic violence and experiencing childhood abuse, neglect, and foster care at very high rates (Narayan, 2015). Interpersonal losses, incarceration, and witnessing violence in unsafe communities also occur frequently in parents' lives. With their own turbulent histories, parents experiencing homelessness often struggle with mental illness or significant distress, and they may lack role models of good parenting in their own lives. Caregivers who are coping with financial stress, traumatic experiences, and depression are less likely to engage their infants with consistency, sensitivity, and responsiveness. Parents experiencing homelessness also tend to lack social support to mitigate feelings of distress and helplessness.

Furthermore, emergency housing itself presents unique challenges. In shelters, families may encounter rigid rules and expectations at odds with their own routines and their children's developmental needs (Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012). For example, set meal times with limited food choices in cafeteria-style dining areas may not work with school and work schedules or with the nutritional needs, preferences, and schedules of young children. Curfews and prohibitions on visitors may disconnect parents and children from relationships with supportive adults outside the shelter. Aggregate living and lack of opportunities for privacy can lead to "parenting in a fishbowl," when parents perceive interference or criticism by other residents or shelter staff observing their children's behavior and their parenting practices. Together these challenges can disempower parents and compromise the quality of foundational developmental processes of responsiveness in parent–infant relationships.

Parenting Interventions and the Evidence Base

Aspects of homeless episodes and emergency housing also can complicate efforts to reach families with parenting interventions. On the one hand, shelters represent an opportunity to identify and gather high-risk families. On the other hand, the time that families spend in shelters can be brief as well as busy, while parents work to secure more permanent housing and connect with other helpful services in their broader communities. Given all they must balance, these parents may resist required or time-intensive programming. An effective parenting intervention should be brief and focused, aiming to initiate a cascade of change by tapping into malleable factors within the parent–child relationship. Programs for families experiencing homelessness also should take a trauma-informed approach that emphasizes nonviolence and empowerment (Guarino, 2014). Considering a typical shelter's capacity, financial resources always are limited. Most staff do not have advanced degrees or specialized training in child development or therapeutic interventions. While passionate about their work, they are frequently underpaid, overworked, and prone to burn-out and high turnover. Thus interventions that depend on specialized skills or costly, intensive training of staff will not be sustainable. A number of programs are being used to enhance parenting in

families experiencing homelessness (see Box 1 for examples). However, hardly any research evidence exists to demonstrate whether these programs actually produce positive impacts with families in shelters (Haskett, Loehman, & Burkhart, 2014; Herbers & Cutuli, 2014) and there are no articles that assess the impact of parenting programs for parents of infants and toddlers specifically. Further, it is unclear how many parenting and home visiting programs reach into shelters and other housing programs or bring families out of housing settings into mainstream parenting programs and activities.

Limited resources in community settings such as homeless shelters are geared toward providing services, not research and evaluation. This reality makes the establishment of an evidence base simultaneously more difficult and more critical; if the programs in use are not in fact effective, these limited resources should be redirected to other efforts that can meet the needs and bolster the strengths of infants experiencing homelessness with their families. In many cases, bridging the gap between programs offered in shelter settings and intervention research will depend on collaborations. Next we describe in detail a brief parenting intervention, My Baby's First Teacher (MBFT), which was designed by Ileen Henderson (one of the authors), to meet the needs of parents and infants staying in emergency housing. Through our strong community–university partnership, we are currently implementing MBFT in a number of Philadelphia, PA, shelters as we evaluate its effectiveness for enhancing the quality of these crucial relationships.

Box 1. Parenting Programs in Family Shelters

The following are some examples of parenting programs that have been offered to families staying in shelters.

Specifically for young children:

- Therapeutic Nursery at PACT
  https://www.kennedykrieger.org/community/initiatives/pact/program-services/therapeutic-nursery
- Pyramid Model
  https://www.acf.hhs.gov/sites/default/files/ecd/supporting_childrens_social_emotional_well_being_in_ma_homeless.pdf
- SafeCare Model
  https://www.camba.org/programs/housing/homelessshelters/familyshelters/flagstonefamilycenter

For children of all ages:

- Triple P-Positive Parenting Program*
  https://www.triplep.net/glo-en/find-out-about-triple-p
- Family Care Curriculum
  https://www.chop.edu/services/family-care-curriculum
- Circle of Parents
  http://circleofparents.org

* There is a Baby Triple P, however no evidence of its use in shelter settings http://www.imhpromotion.ca/portals/0/IMHP%20PDFs/Intro%20to%20Triple%20P_IMHRounds%2006-03-2014.pdf

Photo: © Joshua J. Nase

Understanding their trauma and using the core components of trauma-informed care, classes are taught from a positive, strengths-based perspective, creating a safe place for community and seeking to inspire self-esteem through success.

Development of MBFT

The MBFT program uses a self-teaching module designed to be flexible for a variety of settings, with varied infrastructure, length of stay, and program requirements. Its flexibility is intentional to aid the agency's ability to deliver a basic, consistent parenting program despite challenges of the shelter context and populations. The program materials include a series of videos to guide the lessons and a manual for the facilitator, with operational mandates considered integral to the core learning goals of the program, but with room for individualization by program. Predicated on the importance of a primary caregiver's individualized understanding of the child, this trauma-informed program addresses the fundamental needs of both a parent and child to create and heighten the early attachment that has the potential to mitigate a young baby's stress during an unstable time. MBFT aims to provide parents with skills and information related to infant development and simple and core concepts integral to early parenting. In addition, it provides an opportunity for parents to observe their baby's unique qualities in a safe and controlled setting and receive quality accessories as tools to implement the newly acquired parenting skills.

Nearly a decade ago, while working for Bright Horizons Family Solutions as a center director, I (Ileen) had the opportunity to become a volunteer for the Bright Horizons Foundation for Children, a nonprofit created by employees of Bright Horizons to develop developmentally appropriate play spaces in homeless shelters and other places where young children are experiencing trauma. As part of the process touring the 20 Philadelphia family shelters, I was struck by the juxtaposition of my own well-resourced child care program for employees against the under-resourced space, materials, and training in the shelters. I held multiple focus groups at each location during which I talked to consumers, children, teens, parents,

staff, and administrators to understand the challenges of creating a safe place for children to heal in that context. With a team of housing providers, the City of Philadelphia, and my colleagues at Bright Horizons, I worked to create 20 unique, child-friendly settings, equipped with materials and designed with a trauma-informed approach.

In each of these spaces, I made sure to create places for infant "tummy time," crawling, and safe exploration for their developing potential. After we opened the rooms for use, I paid close attention to what was working and what was not. Immediately, I recognized that the staff and the parents did not seem to understand or value the space and materials for the young infants. After only a month, I found that the mats and baby toys had been stored in a closet because, "the babies didn't need anything; they were safely with their mothers in strollers and would begin to learn when they turned 3 or so." Observing mothers with good intentions but without good information about infancy, I began to teach a class, designed to be short and experiential, to communicate what I felt was the most crucial, basic information about the importance of the first year of life and the interaction between a parent and baby. As I taught, I realized that the parents were making reasonable choices that kept their babies safe, rather than selecting alternatives that could enhance their development. For instance, mothers kept their babies in cribs, strollers, and car seats to protect them from soiled floors and other children. These decisions were rooted in their natural bond as well as a powerful desire to do the best for their babies.

This first effort to teach these core concepts inspired me to develop a program blending such learning opportunities with careful attention to the inherent challenges of aggregate housing and parenting in public. I asked the parents to make a contract with me to attend only four classes with their babies, and I promised them a graduation celebration at the end. For each lesson, I selected a "gift" for the babies that could support the information the mothers were receiving about development. I requested they take their gift and try out the newly learned skill at least once between lessons. I bought pizzas and arranged for child care for siblings so that the mothers could sit on the floor with their babies, alone, sometimes for the first time, in a circle with the other mothers and infants. The mothers began to look forward to the pizza suppers, the break from splitting attention between their other children, and a focused hour to observe and interact with their new babies. They looked forward to the gifts, used them well, and came to the subsequent lessons with comments and conversation about the successes and challenges they had using their new skills. The fifth class was designed to celebrate their efforts, and they each were called out as graduates, cheered by family and peers, and given a framed diploma. The program was so well received that I invited a brilliant young videographer, Josh Nase, from the local university to record our sessions. Knowing that I could not continue teaching these classes over time, I worked with him to create a video that could guide other instructors to work with the parents through the program materials.

After nearly 10 years of honing the video, and individualizing the facilitator guide and instructions, I have disseminated the MBFT program across the country through the Bright Spaces® program created by the Foundation, with more than 50 classes successfully graduating parents. The anecdotal feedback from staff and participants has been exciting, with wonderful stories of expectant mothers, first-time mothers, and seasoned mothers of multiple children expressing their newfound confidence and understanding of their babies.

Tailored Programming for Shelter Contexts

All aspects of the MBFT program were designed and refined to meet the structure and needs in shelter settings, including shelters for domestic violence, emergency or transitional housing, and programs for teen mothers. The following four characteristics make MBFT sustainable and straightforward to implement in these challenging settings.

- **Brief and group-based.** A full cycle of MBFT occurs in just 5 weeks, with four lessons and a graduation. Up to 10 parents gather together with their babies and a staff facilitator for about 1 hour each week. Simply providing that time and place for new parents to be alone with their babies, without the stress of their other children, and to sit together with other mothers and share knowledge in itself may be novel and beneficial. The group can be offered at any time in the week that works for the staff and families.
- **Straightforward training for staff.** Staff who facilitate this program do not need any special qualifications or clinical skills. Any staff person familiar and comfortable working with parents and infants can adequately prepare by reviewing the entire MBFT video and reading through the facilitator guide. It seems that the individual's personality and demeanor, and the standing relationships with the participants, are the key factors for successful facilitators. In cases of staff turnover that are common in shelter settings, new staff can learn the program with efficiency and without cost to maintain continuity in the programming offered.
- **Trauma-informed.** This program was designed with a knowledge and sensitivity to the lives and history of the participants. Understanding their trauma and using the core components of trauma-informed care, classes are taught from a positive, strengths-based perspective, creating a safe place for community and seeking to inspire self-esteem through success.
- **Agency buy-in and engagement.** Messages sent by staff at all levels create a foundation of learning for the participants as well as a culture for the agency. MBFT facilitators are urged to share the videos and lessons with their colleagues so that the experience of support for new parents developing crucial skills can extend beyond the five group sessions. Building knowledge and respect for the first year of life into all of the programming and messaging sent by the staff can make a profound difference in the takeaway

information of the parents of babies as well as the growing program evolution of the organization.

One MBFT graduate said

> *Well my mom was in a facility like this before, a shelter... but I want to say our parenting isn't the same..... Our situation is similar but our parenting is just different, because my mom, she turned to drugs, abused drugs and everything, so...I am glad to have this class and learn better ways to be a mom.*

Core Concepts of MBFT

Next we briefly describe how the five lessons of MBFT present its core concepts.

Lesson One: Brain Development and Tummy Time

The first lesson is intended to help parents appreciate current knowledge about brain development during the first year of life. The video and facilitator use a toy to represent neurons and synapses, sharing the science in straightforward terms to describe how interactions with people and the environment support healthy brain growth. A core concept of the first lesson is that by engaging their baby early, parents are building the foundation for life success. Next the participants learn about the importance of tummy time to build core muscle strength and also create opportunities for cognitive, physical, social, and emotional learning. The parents receive a beautiful baby mat, full of black and white shapes, Velcro-attached mirror, and toys, to use during the lesson and to keep. Parents are encouraged to place their babies on the mat and observe with delight as the babies lift their heads, arch their backs, and look around at the world. They discuss how these experiences related to the rapid brain development occurring during infancy.

Lesson Two: Language Acquisition and Communication Skills

In the second lesson, the facilitator first reviews the first lesson material and fosters a conversation about how parents felt using their baby mats, what they saw their babies doing and learning, and what challenges they faced implementing this skill within the structure of the shelter. Next, they discuss the new core content, learning about how babies first communicate with cries, coos, and babbling, and how parents can respond to engage them in "the verbal volley." Parents learn about "motherese," or infant-directed speech, and how responding to a whole range of the baby's needs communicates care and love to build trust. The gifts for this lesson include teething rings and a cloth book with finger puppets. The teething rings have multiple textures to help parents observe their babies mouthing objects as a way of learning about the world. The book supports responsive communication as parents read and use the finger puppets attached to give and receiving language with their babies. Parents reported that trying out this lesson on their own with their child was a source of delight and amusement, and connected them with their own inner child.

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Lesson Three: Touch and Physical Closeness has always been reported as the favorite of most parents and the one that consistently opens their mind and heart to the uniqueness of their new baby.

Lesson Three: Touch and Physical Closeness

This lesson has always been reported as the favorite of most parents and the one that consistently opens their mind and heart to the uniqueness of their new baby. Parents sit on the floor with their babies on the baby mats from lesson one. They are provided with wholesome massage oil and a book on massage as they are guided through a few baby massage strokes, incorporating eye contact, verbal volley, and the messages of touch. Watching this lesson and observing the connections between parents and babies has been a source of delight for me and other program facilitators. Next, the parents learn the value of heart-to-heart connection, particularly for premature and small babies, and how to fit and use a high-quality, front infant carrier for their comfort and convenience. With this gift, the parents have the option and the motivation to keep their babies close when moving around rather than relying on restraint in a stroller or car seat.

Lesson Four: Movement and Cause and Effect

At the end of the first year, babies begin to master their bodies and start their journey toward being upright and walking. Some parents believe that walking quickly is a sign of developmental advancement and, along with the reality of shelter life, encourage babies to stand and walk before they are ready, skipping the important stage of crawling. Many parents in shelters lack good information about what is developmentally appropriate as their babies grow. In addition, this is the time

that babies develop an important desire to stretch their limits out beyond close proximity to their primary caregiver to test the qualities of the world around them. Caregivers in shelter settings in particular may assess these developmentally appropriate inclinations as rejection, defiance, or misbehavior or as unsafe. Lesson four lays the groundwork for a different paradigm, with the babies learning through scientific inquiry and its corollary to success in school and life. Instead of responding with anger, fear, and restrictions, parents can see that their child is working toward becoming a thoughtful and curious adult. The lesson also includes brainstorming and suggestions for how to ensure that crawling is clean and safe in the shelter setting.

Lesson Five: Graduation

Many parents who stay in shelter have not experienced graduation, successfully accomplishing a goal and the pride that comes from that accomplishment. An essential component of the MBFT program is to use the fifth and final lesson to create this atmosphere of congratulations, valuing parenting as a skill and celebrating success with the community. Host agencies are encouraged to invite families, have a cake, and create framed diplomas presented to the parents at the ceremony. The community acknowledges and praises the parents for following through with completion of the lessons, for their commitment to their children, and to the overall goals of continuing healthy growth and development. Agencies and participants have reported their pride at completing the program and being recognized as an informed parent, teacher, and expert on their child. In addition to the diploma, parents receive a high-quality diaper bag as a graduation gift.

Evaluating Effectiveness of MBFT

Recognizing the need for empirical evidence of MBFT's impact, Ileen sought partnerships with researchers in the Philadelphia area. We connected initially through our mutual friend and colleague, the late Dr. Staci Perlman, and began our collaborative effort to build a rigorous research evaluation effort around the implementation of MBFT in a number of Philadelphia family shelters. With ongoing input from shelter staff and directors as well as other community stakeholders, we completed a pilot study that is yielding promising results.

Forty-five parent–infant pairs from three different family shelters participated in the project, with two rounds of data collection occurring at each shelter location. The rounds were randomized such that about half the families had an opportunity to participate in MBFT at the shelters while the other half did not. At pre-test and post-test research sessions, parents responded to interview questions about their families and participated in 15 minutes of free play with their infants, which was video-recorded for observational coding of relationship quality. Results of our analyses are showing improvements in the responsiveness between parents and their infants for the MBFT group (Herbers, Cutuli, Fugo, Nordeen, & Hartman, 2019).

Based on these encouraging pilot efforts, Dr. Herbers was awarded a research grant from the National Science Foundation to scale-up the evaluation of MBFT. The grant-funded project will also include a comparison group of infants and parents not currently experiencing homelessness in order to better understand risks of homelessness beyond risks associated with extreme poverty. Our hope is to build on the evidence base for MBFT, which has demonstrated feasibility and appeal for use in shelters across the country. Such tailored programs have great potential to deliver quality interventions to underserved populations. Furthermore, the benefits of such promising programs can be documented and understood through collaborations among program designers, child development researchers, and community providers who serve at-risk infants and their families.

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Building Early Links for Learning

Connections to Promote Resilience for Young Children in Family Homeless Shelters

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Abstract
This article describes the Building Early Links for Learning (BELL) initiative in Philadelphia, PA. BELL looks to promote resilience in young children staying in emergency housing for homeless families. The goal is to make the settings more responsive and supportive to children's developmental needs as they adapt to experiences of homelessness and other adversities. BELL strives to increase the developmental appropriateness of shelter contexts while helping to make high-quality early childhood programs more accessible. Activities emphasize building relationships between emergency housing and early childhood program staff, along with trainings, shelter improvements, and advocacy in a context of collective impact.

The Building Early Links for Learning (BELL) initiative in Philadelphia, PA, looks to promote resilience among young children staying in emergency housing with their families. It primarily focuses on increasing the developmental appropriateness of shelter practices, policies, and spaces; increasing connections between the emergency housing and the early childhood education systems; and furthering advocacy efforts. We describe BELL as the product of cooperation and coordination between housing, education, advocacy, philanthropic, and research efforts.

Resilience as the Product of Interconnected, Dynamic Systems

Young children are more likely to show resilience if they are in settings that support typical development and positive adaptation to adversity. Consistent with an ecological-systems perspective (Bronfenbrenner, 1979), children who experience family homelessness are embedded in multiple dynamic systems, spanning family, shelter, early childhood programs, and local, state, and federal policy contexts, to name a few. These systems can support resilience for young children, especially when they are aware that young children are experiencing adversity and are well informed about how to encourage positive adaptation. Sometimes this support is direct, such as when children receive positive parenting within the family system, when shelter staff respond to the needs of children and families, or when children attend high-quality early childhood programs that are sensitive to their experiences of adversity. Other times the support is indirect, such as when local, state, and federal policies initiate and sustain effective programs and practices. BELL operates by catalyzing relationships, both formal and informal, within and between these dynamic systems so that they can be more responsive to the needs of young children experiencing homelessness.

Young children in homeless families experience co-occurring threats to their development and are at-risk for poor developmental outcomes (Brown, Shinn, & Khadduri, 2017). Families staying in emergency shelter are more likely to be living in deep poverty, headed by a single parent, be from racial minority backgrounds, and have experienced other

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Young children are more likely to show resilience if they are in settings that support typical development and positive adaptation to adversity.

recent adversities like residential mobility, loss of possessions and relationships, and exposure to violence (Cutuli & Herbers, 2014). These experiences are underscored by the recognition of early childhood as a period of increased plasticity. Unprotected negative contexts can be particularly detrimental while enriching contexts can have especially positive effects (Knudsen, Heckman, Cameron, & Shonkoff, 2006).

Despite high levels of risk, many children in homeless families show resilience (Cutuli & Herbers, 2014). Resilience is the product of dynamic systems that respond when children and families experience adversity, helping to support healthy development and allowing children to avoid the negative implications of risk (Cutuli & Herbers, 2018). Not a trait or immutable personal characteristic, resilience describes when a child has experienced some threat to her development but has gone on to show good functioning, nonetheless. Resilience happens because of one or more assets or protective factors in the lives of children (Cutuli, Herbers, Masten, & Reed, in press). Powerful assets and protective factors, such as positive parenting, supportive relationships with mentors or teachers, or attending a high-quality early childhood program, buffer the negative effects of adversity. The presence of these positive factors signals that the dynamic systems making up the child's ecology are responding in ways that aid successful adaptation. Development is more likely to go in a positive direction when assets and protective factors are present, despite the threats of adversity.

The BELL initiative recognizes that homelessness can interfere with some ordinary assets and protective factors that otherwise would help children and families successfully navigate trauma, deep poverty, and homelessness itself. When families move into emergency housing, parents find they are unable to control developmentally insensitive aspects of shelter. These include practices that interfere with family routines, a lack of developmentally appropriate spaces and activities, exposure to other families in crisis, lack of privacy, and other aspects of congregate living foreign to typical family contexts (Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012). Furthermore, many families relocate to a different geography when they enter shelter. Many become disconnected from their communities, programs, and supports, including early childhood programs or informal care arrangements with friends and extended families.

In response, BELL was designed to bolster the developmental appropriateness of emergency housing for young children while increasing connections between shelters and nearby early childhood programs. Families are embedded in these systems, and these systems are embedded in municipal, state, and federal policy contexts. Consequently, BELL also involves organizing for collective impact and advocacy. BELL achieves its goals largely through catalyzing relationships between family shelter and early childhood program staff to improve communication, thereby increasing the likelihood that these systems will share their respective areas of expertise and be able to respond to children in homeless families. BELL engages families directly to provide support and incorporate their experiences in the generation of data-based knowledge. BELL represents these lessons to policy decisionmakers and other allies to best sustain effective programs and innovate new approaches to promoting resilience among young children.

Young Children and Family Emergency Housing in Philadelphia

Philadelphia is the poorest of the 10 largest cities in the United States, with young children experiencing relatively high levels of various risk factors that threaten their development (Fontenot, Semega, & Kollar, 2018; Murphey, Epstein, Shaw, McDaniel, & Steber, 2018). Municipal agencies in Philadelphia have had an increasing interest in coordinating services and using city data to more effectively reach out to families with children from birth to 5 years old to offer services. Pioneering work integrating Philadelphia social service and education data demonstrated that homelessness and child welfare involvement are two salient risk factors for poor functioning in early elementary school (Perlman & Fantuzzo, 2010). As a result of this and similar research, there have been multiple recent initiatives in Philadelphia not only to reduce risk experiences for young children, but also to promote assets and protective experiences such as the creation of a municipally funded preschool subsidy. The BELL initiative benefits from this emphasis on young children and serves as a resource to help other initiatives in Philadelphia engage and be sensitive to the needs of families in emergency housing.

In Philadelphia, as in many cities, most children who stay in emergency housing (encompassing both emergency shelter and transitional housing programs for families) are under 6 years old. These children stay in more than 18 publicly funded emergency housing programs. There had been little explicit emphasis on developmental considerations across the emergency housing system for young children in Philadelphia besides certain education services for older children and mandates about food

and nutrition. The emergency housing programs varied widely on how they accommodated young children.

The BELL initiative is possible because the different family-serving emergency housing programs in Philadelphia cultivated relationships among themselves to better serve young children. In 2009, the Philadelphia family emergency housing providers challenged the Philadelphia Deputy Mayor for Human Services to develop a focus on children and youth who experience homelessness. The deputy mayor, in turn, challenged the family providers to work with his departmental leadership to identify issues and solutions that could be addressed without funding and within 1 year. The providers then organized a collaborative that became the "Children's Work Group." Members convened monthly to surface issues and concerns that arise in their programs with respect to serving young children. One service provider and one city employee served as co-chairs of the committee, and more than 40 professionals participated. The Children's Work Group became a means of collective impact for the Philadelphia family emergency housing system. It allowed members to establish a common agenda to address specific issues through changes in practice while advocating for policy change. The Children's Work Group continues today and is also a context of frequent communication in which agencies share promising practices and information about outside resources. In addition, this collective serves as a more effective way to engage outside groups, allowing policymakers to simultaneously interface with multiple agencies through the Children's Work Group or as a mechanism for philanthropy to support initiatives that engage multiple agencies at once. The collective's activities reinforce the partnership as the different agencies work together on their shared agenda.

Specific changes resulted. Agencies together advocated to mandate that emergency housing programs offer parents an established, standardized developmental screen. One agency received a grant to build capacity within the system by providing a one-on-one service to staff and parents. Philadelphia municipal services funded the committee to deliver a training curriculum to more than 300 emergency housing staff annually. Meanwhile, the group published combined data from multiple sources to help articulate needs to local policymakers. Overall, this shared commitment, shared practice, and shared measurement not only resulted in practice change across multiple agencies, but also produced a clear practice model supported by data to be used in advocacy.

Children's Work Group leadership worked with leadership from Allegheny County, which encompasses Pittsburgh, to develop an action plan and advocate for new state legislation requiring that each county's early intervention administration proactively screen every young child under 3 years old in shelter for developmental concerns, offer early intervention services, and monitor their development (Early Intervention Services System Act of 2014). The Children's Work Group has been an effective means of organizing disparate agencies within the emergency housing sector in the service of collective impact.

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The three primary aims of BELL are to build relationships between systems to support families and children, increase developmental friendliness of shelter contexts, and systematically generate information to share with stakeholders.

BELL: Relationships Within and Between Systems

The BELL initiative grew in the context of the Children's Work Group. Following the general model of collaboration and engagement that sustains the Children's Work Group as a whole, BELL responds to key concerns raised by providers about supporting young children from within their programs and through partnerships with early childhood programs as important assets to promote resilience.

Systematic Information Gathering: Opportunities and Challenges Between Systems

BELL continuously generates information to inform its activities, to monitor areas of success and challenges in the dynamic context of Philadelphia, and to constantly engage stakeholders. In the early stages of BELL, our partners undertook several systematic studies. The first involved a series of focus groups with emergency housing provider staff, local early childhood program staff, and families with young children staying in emergency shelter (Hurd & Kieffer, 2017). These sessions surfaced important perspectives on the availability and accessibility of quality early childhood programs. Although there is a literature on the intersection of homelessness and early childhood programs in other cities (Perlman, Shaw, Kieffer, Whitney, & Bires, 2017; Taylor, Gibson, & Hurd, 2015), the Philadelphia focus groups allowed BELL to give voice to the perspectives of families and providers to understand the particulars of the relevant family, emergency housing, and early childhood systems in the specific context of Philadelphia.

Results from the focus groups generally affirmed that parents highly value early childhood programs and are committed to finding quality care. This result contrasted with perceptions of some early childhood program providers and emergency

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Powerful assets and protective factors, such as positive parenting, supportive relationships with mentors or teachers, or attending a high-quality early childhood program, buffer the negative effects of adversity.

housing staff who believed that families were less motivated to enroll their children in early childhood programs. Additional themes from parents and early childhood providers suggested an "empathy gap" and knowledge gap with respect to how early childhood staff interact with families in shelter. Families emphasized the need for trauma-informed care (Cutuli, Alderfer, & Marsac, in press), particularly with respect to how early childhood staff understand especially elevated parent concerns about safety, security, and behavior management for children in crisis. Logistic barriers were also discussed, including the sharing of information with families about high-quality programs close to shelter, difficulties obtaining subsidies for early childhood programs, and scarce availability of quality programs for very young children (birth to 3 years old). Finally, emergency housing providers and early childhood staff emphasized the need for more cross-systems communication.

BELL teammates also completed an analysis of best practices in early care and education for young children in family shelter in other communities (Curran-Groome, 2017). They considered how other locales attempt to support children experiencing homelessness through early childhood programs, and then evaluated the feasibility of those options given the policy context of Philadelphia. Organizations emphasized strong relationships between emergency housing and early childhood staff. Sometimes these relationships were formalized with a memorandum of understanding outlining a shared commitment. Many organizations maintained dedicated staff who helped families navigate transitions and effectively participate in early childhood programs. Meanwhile, states and municipalities established outreach procedures to especially engage families experiencing homelessness to make early childhood supports available. Some municipalities established referral and tracking systems to help homeless families effectively make use of supports for young children.

Responding to the above lessons, the BELL team developed a process to periodically count the number of children staying in emergency housing who are enrolled in early childhood programs. The approach relied on close collaboration with the Philadelphia Office of Homeless Services, the municipal agency that oversees emergency housing. Twice a year, staff from the Office of Homeless Services inquire with emergency housing staff at each site, asking about every young child known to be staying there. Over time, many emergency housing providers recognized the importance of this information and began collecting it routinely. Many shelters incorporated questions about families' preferences for early childhood programs into intake interviews, case management meetings, or other routine interactions. Currently, emergency housing providers share information with BELL staff to help support discussions with families about early childhood program participation. BELL partners monitor enrollment rates and locations for children in shelter to this end. These data help guide BELL activities and are shared back in aggregate with providers and other stakeholders across emergency housing and early childhood systems. The aggregate data also inform advocacy initiatives.

Building Relationships to Connect People and Systems

In partnership with the Philadelphia Office of Homeless Services, BELL has helped encourage each family shelter to designate an educational liaison, which is a staff member dedicated to assisting families who want to enroll their children in early education programs. BELL staff work on-site at each shelter to support these shelter-based liaisons in multiple ways. Foremost, BELL encourages strong relationships between education liaisons and staff from nearby early childhood program providers. Early childhood staff now regularly attend the monthly Children's Work Group meetings as partners who share in the commitment to serve children experiencing homelessness. There are quarterly "Meet and Greet" events where staff from both systems network and deepen collaborations. BELL hosts shared trainings and professional development sessions on topics of common value for both systems, including basics of early childhood development and resilience, trauma-informed care, family homelessness, the importance of high-quality early childhood programs, applying for early childhood program subsidies, and other topics aimed at increasing developmental sensitivity for young children.

BELL also provides information about local early childhood programs to each liaison tailored to their specific geographic area. These packets contain lists of high-quality early childhood programs within 1.5 miles of the shelter, information on how to locate high-quality programs in other sections of the city or state, descriptions of different sorts of early childhood programs (e.g., Early Head Start, Head Start, center-based child care, home-visiting programs), and requirements of different subsidy programs and how to apply. This information is meant to be shared with families to help them know what early childhood programs might be available. Other topics are important information for the shelter education liaisons, such as how to effectively document a family's homeless status and help advocate for their rights as a priority group. This activity is

in direct response to families' comments in BELL focus groups asking shelters to provide more information about quality early childhood programs in the immediate area.

BELL also supports education liaisons with a team of specialists who can provide training and technical assistance as needed. The BELL specialists dialogue with liaisons regularly to encourage shelter staff to have conversations with families about their preferences for participating in early childhood programs. Specialists encourage having at least one conversation each month to learn whether the child is enrolled in a quality program and whether the parent would like assistance in enrolling the child or overcoming any barriers preventing the child from regularly attending. Education liaisons share information with the BELL team to document when these conversations have occurred and any challenges, concerns, or requests that arise from families. BELL specialists help shelter staff problem-solve specific situations that arise, such as when a family has trouble obtaining child care subsidies or has difficulty enrolling in a program. In addition, BELL specialists regularly coordinate with shelter education liaisons, the School District of Philadelphia, and other early childhood program providers on special events to connect families to the early education system. This coordination includes planning information sessions and enrollment drives for families in shelter during key months or at other times when BELL data suggests there are many parents in a shelter who may be interested.

Early Childhood Self-Assessment Tool for Family Shelters.

BELL facilitates annual completion of the Early Childhood Self-Assessment Tool for Family Shelters (Early Childhood Development, n.d.) at each city-funded shelter. This activity furthers each of the three primary aims of BELL: build relationships between systems to support families and children, increase developmental friendliness of shelter contexts, and systematically generate information to share with stakeholders. On the surface, the self-assessment is a measure of developmental appropriateness of shelter spaces, practices, and programming with respect to young children. Items are recommendations in the areas of health and safety, child and family wellness and development, staff/workforce and training, programming, and nutrition and food. Shelters receive summary scores based on the responses to recommendations in each area. All self-assessments are done on-site at the emergency housing provider as a tour of the facility.

BELL pairs emergency housing staff at each shelter with staff from a nearby early childhood program provider each time the self-assessment is completed. This serves two purposes. First, it is a relationship-building activity as the shelter and early childhood program staff work together to complete the self-assessment. Many of these staff continue to communicate afterward, often to assist in enrolling children staying in shelter into early childhood programs. Furthermore, the activity allows for two-way sharing of information. Early childhood program staff share their knowledge of early childhood development. They help interpret each item on the self-assessment through the lens of early development and apply that understanding to each specific shelter context. Simultaneously, shelter staff dialogue with the early childhood provider on the realities of family homelessness. This communication includes perspectives on the families' experiences before and during their shelter stays, as well as more practical considerations specific to opportunities and limitations of the emergency housing sector.

As part of the self-assessment process, the emergency housing and early childhood program provider review their responses to each item. The pair generates an action plan to improve any areas as needed. These action items can include specific shelter policy changes (e.g., access to special snack and meal breaks for nursing mothers), needed staff trainings (e.g., food allergy safety, trauma-informed care), and capital improvements (e.g., breastfeeding areas, age-appropriate toys). BELL works with other social service agencies to either develop and provide trainings on requested topics, or to make relevant trainings in other sectors available to emergency housing staff. For example, the Homeless Health Initiative of the Children's Hospital of Philadelphia provides expertise to emergency housing staff and families in health care, managing common chronic conditions, supporting breastfeeding mothers in shelter, and it collaborates with other partners to provide parenting and developmental education (Sheller et al., 2018). Already-established convenings, such as the Children's Work Group, serve as a natural context for some of these trainings because many emergency housing and early childhood provider staff already attend.

The BELL team works with philanthropic partners to provide many requested improvements, leveraging the systematic self-assessment process to assure funders that requests represent specific shelter needs informed by experts in early development. For example, the William Penn Foundation in Philadelphia supported the initial phase of the BELL initiative, including funding to support improvements identified through the self-assessment process. Another example is through an existing partnership with the Bright Horizons Foundation for Children. The Bright Horizons Foundation operates the Bright Spaces program that helps shelters design and maintain areas to support the developmental needs of families with young children. Not only does the Bright Horizons Foundation assist in outfitting developmentally appropriate Bright Spaces, but they also work to connect volunteers from Bright Horizons early childhood programs with shelters to deliver programming.

Based on data from the first 2 years of BELL, shelters appeared to become more developmentally sensitive to the needs of young children. Shelters completed the self-assessment each year with the opportunity to act on their action plan in between. This permitted a pre-post type analysis of changes in scores. Even though scores were generally high at the first self-assessment, the average scores across emergency housing providers increased at the second self-assessment, achieving

statistical significance in three areas: Wellness and Development, Workforce Standards and Training, and Programming. These improvements were shared with stakeholders, including providers from both systems and philanthropic partners, to demonstrate impact and reinforce the utility of a systematic process of identifying ways to help support early development (Cutuli & Vrabic, 2018).

Connecting to Other Partners

The BELL initiative represents the needs of young children experiencing homelessness to systems beyond emergency housing and early education in Philadelphia. BELL enjoys a close relationship with the Pennsylvania Head Start State Collaboration Office, charged with facilitating partnerships between Head Start agencies and groups like BELL that work to benefit low-income children. Through this partnership BELL provides professional development presentations focused on the unique needs and barriers for families in shelter to Head Start staff from around the state. Because the Collaboration Office is part of the state agency responsible for providing human services and education to young children, this partnership is also a means of suggesting ways that state program agendas attend to the needs of young children in shelter.

The BELL initiative represents the needs of young children experiencing homelessness to systems beyond emergency housing and early education in Philadelphia.

BELL staff facilitate community-researcher partnerships to further the goals of shelter and early childhood program providers. For example, there is low availability of programs for children from birth to 3 years old in Philadelphia, and there are no evidence-based parenting or early childhood programs specifically for families with young children in shelter (Herbers & Cutuli, 2014). BELL participates in a partnership with university research teams and the Bright Horizons Foundation for Children to implement and test effectiveness of the My Baby's First Teacher program developed for families with an infant staying in shelter (Herbers & Henderson, this issue, p. 35). Other BELL partnerships at earlier stages look to develop other models to address this gap for very young children, including alternative models of Early Head Start and Head Start delivery that blend home-based programming in shelter coupled with family supports during the transition out of shelter and the option to transition to center-based care once the family is residentially more stable.

Advocacy and Dissemination

As mentioned previously, BELL proactively shares information to engage stakeholders. These stakeholders include not only provider staff within the emergency housing and early education systems but also representatives from philanthropic agencies as well as decisionmakers and other staff in municipal, state, and federal policymaking. Information dissemination takes several forms. Regular newsletters and policy briefs update stakeholders on policy-relevant changes, updates, or initiatives. BELL staff put these developments in a local context, often using data and provider perspectives specific to Philadelphia. BELL has advocated in the state's capitol with other network leadership for increasing resources for home visiting, child care, and Head Start. BELL has increased its network of contacts through joining other initiatives focused on young children locally, and BELL staff have joined and co-organized statewide stakeholder groups and initiatives.

BELL staff and partners also regularly present on its activities, data, and proposed innovations. BELL convenes annual forums in Philadelphia to provide data-based reports and discussions on the impact of BELL activities. These forums are attended by providers as well as policy decisionmakers at different levels of government. The forums involve Philadelphia-specific content that is contextualized by experts working at the state and national levels. Furthermore, BELL collaborates with national advocacy groups such as Schoolhouse Connection and the National Association for the Education of Homeless Children and Youth to disseminate information broadly. These efforts include presentations at national conferences, informing state and federal testimony, blog posts, and webinars.

Summary and Recommendations

The BELL initiative looks to promote resilience in young children experiencing family homelessness by making their contexts more responsive and supportive to the developmental processes of adaptation in early development. It relies on a shared commitment to the well-being of these young children by diverse providers within the emergency housing system and with early education programs. BELL activities catalyze and sustain relationships between programs and staff so that they can better respond to the needs of young children and families in shelter, including efforts to improve the developmental appropriateness of shelter while increasing accessibility of quality early childhood programs. BELL also engages in advocacy to represent the needs of young children experiencing homelessness, and the systems that serve them, in local, state, and national deliberations. These activities are informed and sustained by the constant generation of data-based knowledge as a key tool for planning, guiding activities, and informing advocacy. This initiative informs the dynamic systems that make up children's experiences of family homelessness, helping those systems be more coordinated and more equipped for supporting the developmental processes of positive adaptation for young children.

Preliminary evidence suggests that BELL has helped improve the developmental appropriateness of shelter spaces while also increasing preschool enrollment for children staying in

emergency housing programs, though more work is needed to generate higher-quality evidence (Cutuli & Vrabic, 2018). Even so, lessons learned from the early stages of BELL in Philadelphia, and from programs in other locales (Curran-Groome, 2017), suggest that communities interested in supporting young children in emergency and transitional housing should first recognize the complexity of those embedded, dynamic systems that guide children toward or away from resilience. Communities and programs should seek out ways to support the family system directly, such as through deploying promising parent programs for families with young children. Individual shelter spaces can work to become more developmentally appropriate through using tools like the Early Childhood Self-Assessment Tool for Family Shelters. More important, providers in local emergency and transitional housing systems can build relationships. These include relationships among different local emergency housing providers, themselves, to help share information and resources while also forming a collaborative for collective impact. Supporting families also involves having relationships with providers in other systems that promote resilience in early development. Relationships with early childhood programs are key in this regard, both to infuse developmentally appropriate experiences into the lives of children and to inform early childhood programs about the experiences of young children in homeless families. Effectively engaging families with young children in shelter seems to require personnel in both systems dedicated to outreach and to helping families navigate transitions, such as understanding early childhood program options, locating quality programs, applying for subsidies, and ensuring trauma-informed care once enrolled. Data-based knowledge is central to these sorts of collaborations, serving to help keep partners engaged, to constantly generate evidence and guide new approaches, and to engage broader audiences through advocacy efforts to develop and sustain quality programs. In these ways, the systems that serve young children in families experiencing homelessness can be more attentive to their developmental needs and be more effective at promoting resilience.

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Promoting Caregiver and Child Health Through Housing Stability Screening in Clinical Settings

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Abstract
Within the health care sector, researchers, clinicians, and payers increasingly recognize the importance of the social determinants of health for improving maternal and child health. This article focuses on existing and emerging approaches to screening families for unstable housing circumstances. The authors describe how housing stability screening helps health care providers to better understand risks for caregiver and child health and wellness. They urge clinicians to screen more actively for housing stability, not just homelessness, hospitals to pursue incentive payments and alternative financial models to address housing instability, and policymakers to expand investments in housing as a health-promoting policy opportunity.

Unstable housing circumstances have been associated with a wide range of negative health outcomes, including lead exposure and toxic effects, asthma, and depression (Shaw, 2004). Housing instability is a social determinant of health variably defined by high housing costs relative to income, poor housing quality, unstable neighborhoods, overcrowding, and homelessness (Johnson & Meckstroth, 1998; Satcher, 2010). Additional metrics have included multiple moves; eviction; and difficulty paying rent, mortgage, or utilities (Geller & Curtis, 2010; Cutts et al., 2011; Gilman, Kawachi, Fitzmaurice, & Buka, 2003; Kushel, Gupta, Gee, & Haas, 2006; Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007; Stahre, VanEenwyk, Siegel, & Njai, 2015; Suglia, Duarte, Chambers, & Boynton-Jarrett, 2013). Children's HealthWatch has previously examined health, developmental, and anthropometric correlates of housing insecurity among children younger than 3 years using crowding (> 2

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people per bedroom or > 1 family per residence) and multiple moves (≥ 2 moves within the previous year) as indicators (Cutts et al., 2011). Our previous research also reported that infants whose mothers' experienced homelessness prenatally had significantly increased adjusted odds of low birth weight compared to infants of mothers consistently housed and infants experiencing postnatal homelessness only (Cutts et al., 2015; Sandel et al., 2018b). We have also demonstrated that homelessness during infancy was associated with higher adjusted odds of fair or poor infant health and developmental risk, and higher adjusted odds of fair or poor health and depressive symptoms among homeless mothers (Cutts et al., 2018). Subsequent research from Children's HealthWatch demonstrated the stress of prenatal and postnatal homelessness combined is associated with the greatest increased risk of adverse infant and early childhood health outcomes relative to those never homeless (March et al., 2011).

On the basis of our previous research and a review of the literature, in 2018 we identified distinct dimensions of housing instability associated with inadequate access to care and adverse health outcomes (Cutts et al., 2011; DeWit, 1998; Kushel et al., 2006; Simpson & Fowler, 1994). Our research found three specific housing circumstances: behind on rent in the past 12 months, two or more moves in the past 12 months, and history of homelessness in the child's lifetime. Each circumstance was individually associated with increased odds of adverse caregiver and child health and material hardship (Sandel et al., 2018a). This article builds on our prior research and explores the current state of pediatric housing screening, the use of a three-question housing stability screen (the Housing Stability Vital Sign), and emerging future opportunities to better understand and promote caregiver and child health and wellness.

Why Should Health Care Screen for Housing Stability and Other Social Determinants of Health?

The United States spends increasingly more money per capita on medical care compared to other industrialized nations, while spending increasingly less on social services (Bradley & Taylor, 2013). While health-related social needs have historically been a concern for public health, social service, and religious and charitable organizations, the health care sector now recognizes its expanded role in identifying and addressing housing instability and other social needs. Increasingly, this rethinking of the role of health care leads states and institutions to squarely position the social determinants of health within, and not separate from, systems of health care delivery. Previous innovations and advances in pediatric practice and the patient-centered medical home have provided convincing evidence that screening for unmet basic social needs, including housing instability, is a necessary step to facilitating successful connections to community resources, with resulting improvements in health and well-being (Garg,

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Homelessness during infancy was associated with higher adjusted odds of fair or poor infant health and developmental risk, and higher adjusted odds of fair or poor health and depressive symptoms among homeless mothers.

Jack, & Zuckerman, 2013; Gottlieb et al., 2016). Housing stability screening provides important information for health care systems and communities, essential to decisions about program development and reimbursement rates.

How Should Health Care Providers Screen for Housing Stability in Clinical Settings?

Historically, there has been wide variation in how researchers and health care organizations develop, validate, and implement tools for identifying/addressing patients' housing and other social needs (LaForge et al., 2018). This lack of standardized workflows/screening tools has largely resulted in ad hoc efforts to assess patients' social needs with varying degrees of success and validation in terms of sensitivity, specificity, or evidence that outcomes are altered (Adler & Stead, 2015). The variation and lack of standard screening tools is due in part to the fact that no universally accepted definition of housing instability exists, and as a result, there is no national "gold standard" survey module (Coleman-Jensen, Gregory, & Rabbitt, 2017). Furthermore, though there is a great deal of research on housing quality, there is little research exploring different forms of housing instability compared side-by-side rather than in isolation from one another to identify associations with increased risk for adverse maternal and child health outcomes (Evans, Saltzman, & Cooperman, 2001; Krieger & Higgins, 2002). For this reason, we sought to develop a Housing Stability Vital Sign to accurately screen for a household's housing stability and ultimately promote caregiver and child health and wellness.

Aside from the Housing Stability Vital Sign, other widely acknowledged screening tools exist. The Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Model screening tool asks two housing questions. The

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The health care sector now recognizes its expanded role in identifying and addressing housing instability and other social needs.

first housing question was adapted from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool developed by the National Association of Community Health Centers and partners which was intended to identify patients who are homeless and are at risk of losing their housing for any reason, including inability to pay a mortgage or rent. The second housing question was adapted from a question developed by Nuruzzaman and colleagues which was intended to identify beneficiaries who are living in substandard housing (National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, & Institute for Alternative Futures, n.d.; Nuruzzaman, Broadwin, Kourouma, & Olson, 2015). The Boston Medical Center Health System's Thrive™ screener asks patients a three-part housing question adapted from the CMS tool's first housing question (Buitron de la Vega et al., in press).

While there is no agreed upon standard for screening for and assessing housing stability, previous research and current pilot projects have indicated the need to include questions that not only identify patients currently experiencing the most severe form of housing instability—homelessness—but also to identify patients and families experiencing instability that puts their health and well-being at risk.

The Housing Stability Vital Sign

Children's HealthWatch developed the Housing Stability Vital Sign screening tool in the context of understanding the landscape of common housing questions used to screen for housing stability (i.e., homelessness and substandard housing) and of our previous research exploring various forms of housing instability (i.e., homelessness, overcrowding, multiple moves). We realized that a measure of affordability was missing and sought to examine potential associations with maternal and child health and well-being as well as other family social needs.

Research data we obtained from using a housing instability tool that included questions regarding being behind on rent, multiple moves, and homelessness confirmed that it was useful to ask about housing stability in clinical settings. For clinical sites interested in screening for housing stability, this research supported the use of three housing stability questions (as adapted from our Children's HealthWatch research survey), which for consistency may best be asked in reference to the past 12 months:

a. Was there a time when you were not able to pay the mortgage or rent on time? (Answer is yes/no, positive screen if answer is yes);

b. How many places have you lived? (Answer is number of places lived, positive screen if answer is three or more, i.e. ≥ two moves in 12 months.); and

c. At any time were you homeless or living in shelter (including now)? (Answer is yes/no, positive screen if answer is yes)

When we compared unstably housed families who screened positive with the Housing Stability Vital Sign to families who were stably housed (after controlling for confounders), we found an association between each housing instability circumstance and adverse caregiver health outcomes, child health and development outcomes, and household hardships among families with children under 48 months old (Sandel et al., 2018a).

Limitations to the Housing Stability Vital Sign

First, as previously stated, because there is no agreed upon definition of circumstances that define housing instability, there is no gold standard housing stability screening against which these housing circumstances can be compared. For this reason, investments in future research to create robust standard testing of a diagnostic tool, such as sensitivity and specificity analysis, is warranted. Second, data used in the analyses included a large clinical sample of predominantly urban, low-income families of very young children and their primary caregivers. Although there is a strong link between poverty and housing instability, these housing circumstances have not been tested in populations of varying socioeconomic status, rural populations, or families without young children. Third, the cross-sectional design of the study demonstrates association, not causation, and we acknowledge that the associations (e.g., housing instability and maternal depressive symptoms) may be bi- or multi-directional. Finally, as with any self-report measure, these housing circumstances and some of the outcomes are subject to reporting bias and shared method variance. Despite these limitations, these three forms of housing stability have important clinical implications for all practitioners who work with children and families. Together, they represent an effective way to identify families at risk for adverse health conditions and hardships associated with unstable housing that can be administered in pediatric offices,

by clinicians or practitioners working with young families in social service settings (e.g., departments of social services, school systems, housing assistance programs), or by housing and community groups to assess individual and community-level needs.

Experience at Boston Medical Center—Screening and Intervening in Housing Stability

At Boston Medical Center (BMC), New England's largest safety-net hospital, screening for housing instability and for other social determinants of health has proven a critical first step in assessing the unmet resource needs that can contribute to poor health outcomes. The Thrive™ hospital-wide screening tool, which was implemented in the pediatric outpatient clinic in 2017, provides patients and families with the opportunity to report needs and request resources that might be of assistance in addressing these needs (Buitron de la Vega et al., in press). The Thrive tool is available in the six languages most commonly spoken in the hospital and assesses needs in eight areas: housing, food, utilities, medications, transportation, caregiving, employment, and education. For each of these areas, resource sheets are available within the electronic health record and can be easily printed and given to families during a visit. During the first year of screening in the pediatric outpatient setting, almost half of all families indicated at least one area of need, and 15% reported current housing instability or homelessness.

The practice of screening for housing insecurity and homelessness is an essential first step toward identifying families who are experiencing urgent or immediate housing needs. Ideally, screening can also provide an upstream opportunity to support families who are experiencing housing instability and can assist in making connections to resources to avert eviction and homelessness. By extension, when screening for needs in the areas in which financial stress may first become evident—difficulty paying for food and utilities, for example—appropriate referrals can support families in accessing resources that ideally can improve overall financial stability and help prevent housing instability and homelessness.

As indicated previously, neglecting to address the impact of social determinants of health generally, and housing specifically, stymies the provision of effective medical care. When screening tools identify housing instability or homelessness, however, it is incumbent upon those administering the screening to provide meaningful referral options to families who have trusted the medical team by sharing what may be very sensitive information about their housing needs.

At the same time, immense challenges face all service providers seeking to support families experiencing housing instability or homelessness. As in other metropolitan areas, families in Greater Boston face an extreme scarcity of affordable housing. Families seeking reasonable market-rate rental units may be forced to live far from their communities and workplaces or may have to double up or endure severely overcrowded

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Screening for unmet basic social needs, including housing instability, is a necessary step to facilitating successful connections to community resources.

conditions in order to maintain geographic proximity. Families who are homeless will enter an overburdened shelter system and may be placed in a distant facility without a realistic route to continuing in established school or employment.

In our clinical setting, addressing families' reported housing needs involved developing an approach that prioritized collaboration between front-line staff, medical providers, and community-based organizations. We are fortunate to have strong longitudinal existing partnerships with two innovative organizations—Health Leads and MLPB (formerly known as Medical Legal Partnership | Boston). A new funding stream provided us with an opportunity to add a co-located housing specialist from Metro Housing | Boston, a nonprofit housing agency in Boston, to the care team.

Making appropriate and efficient referrals to the co-located housing specialist depended on effective collaboration between the many stakeholders in this equation. We laid the groundwork for this collaboration by first holding a series of meetings that included hospital-based patient navigators, family advocates, social workers, and other front-line staff who would be most likely to make referrals to the new housing specialist. These evolved into regularly scheduled meetings, or Housing Rounds, that provide an opportunity to build capacity in referring providers with regard to the complicated housing landscape in Greater Boston. Housing Rounds also function as a sounding board for complex cases, facilitate sharing of expertise from multiple perspectives, and provide a forum for brainstorming around barriers and challenges.

Another step in streamlining the process of making referrals was the development of a written referral pathway that could serve as a point of reference for deciding on when and how to make a referral. This document resulted from our first round of meetings and incorporated the input of partner organizations and service providers in order to troubleshoot commonly encountered questions and scenarios. We also developed a referral form, a release of information, and an information sheet to provide to families at the time of referral.

A final component of our approach was to train the medical team in the pediatric clinic on how to respond to positive screens for housing emergencies when support staff and community partners were not readily available to assist—during the weekend and evening clinic hours, for example. We created a simple referral algorithm outlining how to provide support and resources to families reporting a housing emergency with no place to stay that night. We provided training to all staff on this algorithm, including call center and front desk staff, medical assistants, nurses, nurse practitioners, and physicians.

In summary, universal screening for housing and other resource needs in our clinical setting identified families at risk for eviction and homelessness whose needs might not have previously been recognized. The opportunity to offer families a referral to a housing specialist was a key component of being able to provide meaningful assistance in response to a positive screen. Collaboration with other partners in our clinical setting enhanced the reach of our referral process and built stronger working relationships between hospital staff and community organizations jointly working to address the formidable challenge of connecting families with stable, affordable housing.

Universal screening for housing and other resource needs in our clinical setting identified families at risk for eviction and homelessness whose needs might not have previously been recognized.

Practice and Policy Considerations for Housing Stability Screening in Clinical Settings

Housing instability among low-income households raises numerous health care practice and policy concerns, namely its large contribution to inefficiencies within the U.S. health care system. For example, the top 5% of hospital users—overwhelmingly poor and housing unstable—are estimated to consume 50% of health care costs (Blumenthal & Abrams, 2016). A general lack of stable housing is a key driver behind the fact that households living in poverty in the U.S. are often the most expensive to treat. By identifying unstable housing in clinical settings, efforts designed to prevent family homelessness and improve housing stability can be extremely effective from both a public health and child development perspective. Moreover, the American Academy of Pediatrics recommended social screening within health care (Council on Community Pediatrics, 2016). We recommend practitioners screen patients for housing stability, document its prevalence and associated health risks in order to advocate for more resources, and drive innovations in addressing housing stability as a clinically important social determinant of health (Sandel et al., 2018a). Clinicians should more actively conduct housing stability screening, hospitals should pursue incentive payments and alternative financial models, and policymakers should expand investments in housing as a health-promoting policy opportunity.

Potential interventions include targeting homelessness prevention services for at-risk families (Shinn, Greer, Bainbridge, Kwon, & Zuiderveen, 2013); creating permanent, supportive housing initiatives aimed to reduce health care usage among the chronically homeless; and investing in housing production and services to respond to housing needs among patients (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010). For example, the Camden Coalition of Healthcare Providers in New Jersey and Hennepin County Health Center in Minnesota use housing vouchers to reduce health care costs; United Healthcare has invested in new housing across the country; Bon Secours Health System in Baltimore, Maryland, and Nationwide Children's Hospital in Columbus, Ohio, have built affordable housing units; and Boston Medical Center in Boston, Massachusetts, has invested in a variety of affordable housing projects throughout Boston (McCluskey, 2017; Sandel & Desmond, 2017).

Outside of clinical settings, homelessness and housing instability assessments have been implemented by public health agencies as well as early care and learning settings, such as Head Start centers, child care centers, preschools, and family child care, to determine eligibility for programs and services (U.S. Department of Health and Human Services, 2016). For example, the Healthy Start in Housing (HSiH) program is a collaborative initiative of the Boston Public Health Commission and the Boston Housing Authority that helps housing-unstable, high-risk pregnant and/or parenting families, with a child under 5 years old who has a complex condition requiring specialty care, to secure and retain housing. The goals of HSiH are to improve birth outcomes and to improve the health and well-being of women and families. Key strategies include the provision of housing as well as intensive case management aimed at housing retention and participant engagement in services and interventions that contribute to achievement of their identified goals. Boston Public Health Commission helped determine eligibility and facilitated the intake process. It is worth noting among initiatives and interventions such as HSiH, and health care-based housing supports, that program eligibility may vary depending on the definition of housing instability or homelessness used (i.e., broader assessments of housing risk such as the Housing Stability Vital Sign, the McKinney-Vento definition of homeless, versus the very narrow definition of homelessness used by the U.S. Department of Housing and Urban Development).

Although there is much to learn from these promising efforts, they remain an outlier approach to improving patient health and are often limited in their scale due to inadequate funds as well as a narrow focus on highest-need, highest-cost patients, who are often adults. Children who are unstably housed in early life may form the pipeline to being the future high-need, high-cost adults. Thus continued research, innovation, and development of policies and programs are urgently needed.

Efforts that foster innovation and flexibility through the use of Accountable Care Organizations (ACOs) and Medicaid waivers can play an important role. One of the biggest investments in the field is the CMS innovation initiative of $157 million toward creation of the Accountable Health Communities Model (Alley, Asomugha, Conway, & Sanghavi, 2016). One promising aspect of this model is the use of "bridge organizations" tasked with the engagement of all the relevant service providers within a community (including health care services, public health, and social services) to achieve shared goals for a defined population (Billioux, Conway, & Alley, 2017). Funding for community service providers is a missing link in this model, and future efforts should ensure not just that the bridge exists but that the services provided are supported financially. At the state level, Massachusetts' Medicaid 1115 waiver demonstration ACO program integrates a social needs screening measure into its ACO measure slate, which factors into an ACO's quality score (Center for Health Care Strategies, 2018).

To significantly reduce health disparities through effective housing platforms, far more resources are needed. The Center for Health Care Strategies recently released a report that recommended CMS embrace adapted pay-for-success models, which would allow states and Managed Care Organizations to enable investments in addressing patients' health-related social needs by paying only for "what works" (Center for Health Care Strategies, 2018). States and Managed Care Organizations could then invest in a portfolio of housing-based supports such as: legal assistance and payments that secure housing (i.e., one-time payment for security deposit and first month's rent). In November 2018, U.S. Department of Health and Human Services Secretary Alex Azar suggested Medicaid may soon allow hospitals and health systems to directly pay for housing (Barr & Dickson, 2018). Yet ultimately, building healthier communities—with plenty of safe, decent, and affordable housing for all family configurations— will be required to improve the well-being of children who, if nothing changes, may be the future's highest-need and highest-cost patients.

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Developmental Consequences of Homelessness for Young Parents and Their Children

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Abstract
When families experience homelessness, both parents and children are adversely affected. The effects of homelessness may be even more profound when both the children and parents are young. Using developmental and ecological lenses, the authors describe how homelessness complicates the tasks facing young parents and their children in the early years of children's lives. They also draw on the (limited) existing literature to make recommendations for practices that may reduce some of the adverse consequences of homelessness for young parents and their children.

Family homelessness affects far too many young parents with young children in the United States. Approximately one third of all people who experienced homelessness on a single night in 2017 were in families with children, meaning about 184,000 people or 58,000 households, and 12% of these people were in families with a parent under 25 years old (U.S. Department of Housing and Urban Development, 2018). About half of the children in these families were younger than 6 years old, including 11% who were infants under 1 year old. Estimates from the Family Options Study (Gubits et al., 2015) found that 27% of families with children who are homeless are headed by a person under 25 years old, suggesting that the experience of being a young parent while homeless is more widespread than initially estimated.

A number of studies have examined the deleterious consequences of homelessness for young children (Brown, Shinn, & Khadduri, 2017; Obradović et al., 2009; Sandel et al., 2018a; Ziol-Guest & McKenna, 2014), but relatively little attention has been paid to the fact that the parents of those children are often young themselves; in fact, little is known about how programs can effectively serve young families experiencing homelessness. In this article, we use a developmental and ecological lenses to focus on the requisite needs and tasks of young parents and their children in the early years of children's lives, and we explore the ways in which homelessness can interfere with optimal health and development for both young parents and children. We then discuss implications for practice, focusing particularly on the types of programs that may address the distinct needs of both young parents and children in families experiencing homelessness.

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Pregnancy and Parenthood Among Youth and Young Adults Experiencing Homelessness

Over the past two decades, pregnancy and birth rates among U.S. adolescents and young adults have declined dramatically

(Kost, Maddow-Zimet, & Arpaia, 2017). In contrast, data collected as part of Voices of Youth Count (VoYC, see Box 1; Dworsky, Morton, & Samuels, 2018), a national policy research initiative aimed at advancing knowledge about homelessness among unaccompanied youth and young adults, suggest that pregnancy and parenthood are common among the nearly 4.2 million young people who experience homelessness each year; in fact, many young parents who are homeless are homeless with their children. According to VoYC's estimates, 1.1 million children had a young parent between 18 and 25 years old who had been homeless in the past year (Dworsky et al., 2018).

One explanation for this situation is the heightened risk for pregnancy among young women experiencing homelessness (Crawford, Trotter, Hartshorn, & Whitbeck, 2011; Haley, Roy, Leclerc, Boudreau, & Boivin, 2004); another is the increased risk for homelessness and housing instability among young women who become pregnant or give birth (Kull, Coley, & Lynch, 2016; Shinn et al., 1998). Several young women who participated in the in-depth interviews component of VoYC described their pregnancy as yet another source of conflict or cause for parental rejection in a dysfunctional or abusive family that ultimately led to their leaving or being kicked out of their home (see Box 2, Gina's story).

Homelessness During Pregnancy

Pregnancy is widely recognized as a critical developmental period. Even with housing and intact social supports, pregnancy can be physically and emotionally demanding for young women. It can be far more stressful for young women who are homeless and have few, if any, supports. Pregnant women who are homeless are less likely than their housed peers to receive early and consistent prental care (Bloom et al., 2004), in part because of health insurance problems and lack of transportation (Fleming, Callaghan, Strauss, Brawer, & Plumb, 2017). Feelings of social isolation associated with being homeless may be especially pronounced during pregnancy (Weimann, Rickert, Berenson, & Volk, 2005). This isolation may explain why some of the young women who were interviewed as part of VoYC sought support from family members during pregnancy or after their child was born (Dworsky et al., 2018).

Pregnant women who are homeless tend to have more physical health problems and more symptoms of depression than do pregnant women who are housed (Cutts et al., 2015, 2018; Meadows-Oliver, 2009; Tischler, Rademeyer, & Vostanis, 2007). The stress of homelessness can disrupt fetal brain development and can have long-term negative health effects (Berkman, 2009; National Research Council & Institute of Medicine, 2000; Shonkoff & Garner, 2012). Moreover, homelessness is associated with an increased risk of exposure to violence, victimization, drug use, and trafficking (U.S. Interagency Council on Youth Homelessness, 2018), which can also have severe developmental repercussions for children when experienced in utero (Bandstra, Morrow, Mansoor, & Accornero, 2010; Talge, Neal, Glover, & the Early Stress, Translational Research, and Prevention Science Network, 2007).

Box 1. Voices of Youth Count

Despite federal, state, and local policies and programs, far too many young people in the United States continue to experience homelessness. Voices of Youth Count (VoYC) is a national research and policy initiative designed to fill critical gaps in researchers' knowledge about the scale and scope of the problem. Using multiple research methods, VoYC sought to gather data from a wide variety of sources that could be used to guide policy, practice, and future research.

The VoYC research activities included:

- brief surveys with about 4,000 youth experiencing homelessness in conjunction with point-in-time youth counts in 22 diverse counties across the US;
- surveys of service providers and Continuum of Care leads in the same counties;
- in-depth interviews with about 200 youth who had experienced homelessness in 5 of the 22 counties;
- partnership with Gallup, Inc., to collect survey data from a nationally representative sample of more than 26,000 adults about homelessness and housing instability among youth in their households during the past year and to conduct follow up interviews with 150 of the respondents; and
- consultations with stakeholders representing a number of different systems.

More information can be found at voicesofyouthcount.org

Box 2. Gina's Story

One of the young people we spoke with as part of Voices of Youth Count's (VoYC) in-depth interview component was a 20-year-old woman named Gina* who was living in Texas. She had been living with her parents when she became pregnant at 17. She had a poor relationship with her father, whom she described as emotionally unstable. Her pregnancy added to the conflict between them, and she was forced to leave home. "I got pregnant at a young age, so [my father] didn't like that." Gina moved among friends and relatives until she returned to her parents' home, where she was living when she gave birth to her daughter. Gina continued living with her family after the birth of her child; howevever, problems with her father persisted. She reported "I didn't wanna stay on the streets with my daughter, so I had to give [money] to [my dad]. But I didn't want to." Gina eventually entered a shelter for women and children, which helped her access Temporary Assistance for Needy Families and employment resources, got her on the waitlist for supportive housing, and provided her with reliable child care. "They can help me like get a place, so I don't have to keep going back and forth to my mom and dad's." With the shelter's assistance, Gina was able to achieve some semblance of stability for herself and her daughter.

1 "Gina" is a pseudonym.

Photo: SewCream/shutterstock

Homelessness can interfere with optimal health and development for both young parents and children.

Given the experiences associated with an inability to access safe and secure housing, being homeless during pregnancy increases the risks for birth complications, low birth weight, preterm birth, and effects related to poor maternal nutrition or substance abuse (Chapman, Tarter, Kirisci, & Cornelius, 2007; Cutts et al., 2015; Little et al., 2005; Sandel et al., 2018b; Stanwood & Levitt, 2004; Stein, Lu, & Gelberg, 2000). These risks have been found to adversely affect children's cognitive, physical, and social–emotional development. In addition, children whose mothers were homeless while pregnant were more likely to be hospitalized and to experience fair or poor health than children whose mothers had never been homeless (Cutts et al., 2018; Sandel et al., 2018b). Furthermore, the longer their mothers were homeless, the higher the children's odds of experiencing negative health outcomes (Sandel et al., 2018b). Together, these findings raise concerns about the health and well-being of both mother and child when young mothers experience homelessness during their pregnancies.

Homelessness During Infancy and Toddlerhood

Children's early experiences and interactions with their environments set the stage for future well-being (Center on the Developing Child, 2009), which is why homelessness during this critical period may lead to changes in brain architecture that can have long-lasting developmental effects (Berkman, 2009; National Research Council & Institute of Medicine, 2000; Shonkoff & Garner, 2012;). For example, homelessness during infancy and toddlerhood is associated with delays in social and emotional skill development (Brumley, Fantuzzo, Perlman, & Zager, 2015; Haskett, Armstrong, & Tisdale, 2015), cognitive functioning (Brown et al., 2017; Obradović et al., 2009; Ziol-Guest & McKenna, 2014), and the acquisition of language and literacy skills (Brown et al., 2017; Obradović et al., 2009; Ziol-Guest & McKenna, 2014). It has also been linked to lower levels of academic achievement and school engagement (Obradović et al., 2009; Perlman & Fantuzzo, 2010) as well as higher rates of behavioral problems (Bassuk, Richard, & Tsertsvadze, 2015; Brown et al., 2017; Fantuzzo, LeBoeuf, Brumley, & Perlman, 2013).

At the same time, homelessness interferes with children's access to important early learning opportunities (Bassuk et al., 2015; Fantuzzo et al., 2013). During the 2014–2015 school year, only 8% of the more than 1 million children under 6 years old who experienced homelessness participated in Head Start, Early Head Start, or McKinney-Vento–funded early childhood education programs (U.S. Department of Education, 2015; U.S. Department of Health and Human Services, 2015). This statistic indicates that the vast majority of children most in need of safe and secure spaces to learn, consistent and predictable routines, and supportive social interactions are not exposed to critical learning opportunities.

Family homelessness typically does not occur in isolation. Rather, family homelessness is often part of a larger constellation of adversities such as poverty, domestic violence, parental mental health or substance use problems, and food insecurity, which exert a cumulative negative impact on child health and development (Shonkoff & Garner, 2012). The compounded, prolonged exposure to these adverse events through childhood may result in the biological embedding of stress, which has long-term health and developmental consequences stretching from infancy through adulthood.

Homelessness and Parenting Young Children

Newborns have substantial physical and emotional needs, and caring for a newborn is both physically and emotionally taxing. For young parents who are homeless, the demands of caring for a newborn are compounded by the stress of not having a safe and stable place to live or the financial resources to meet their children's basic needs. Indeed, children who experience homelessness during the early years of life are more likely to experience food insecurity and have reduced access to medical and dental care (McCoy-Roth, Mackintosh, & Murphey, 2012). Many young mothers experiencing homelessness also lack social support, have histories of family instability including placement in foster care, and have mental health and substance abuse problems that affect parenting (Levin & Helfrich, 2004; Saewyc, 2003). Homelessness can result in child–parent separation and heightened levels of parental stress, leading to diminished parental responsiveness, fewer material resources, and lower quality parent–child relationships at a time when such investments are most valuable (Coley, Lynch, & Kull, 2015; Crawford et al., 2011; Gershoff, Aber, & Raver, 2007; McCoy-Roth et al., 2012; Sandel et al., 2018a). Furthermore, the homelessness-related challenges that parents face in caring for their young children can also hamper their efforts to stably exit from homelessness. Webb and colleagues (2003) found that a wide swath of women of childbearing years in Philadelphia had

previously experienced an incident of homelessness and that the risk of homelessness increased as the number of dependent children increased.

In addition to their physical needs related to safety and sustenance, babies also have substantial emotional needs; infancy is a critical time for bonding and the development of the attachment relationship between parent and child that sets the foundation for future relationships and social–emotional functioning (Lyons-Ruth, 1996). Unfortunately, the parent–child bond can be undermined by homelessness, which often includes frequent moves between unpredictable or chaotic environments (Swick, 2008), as well by continued interpersonal family issues that young parents may experience when they are doubled up with friends or family. As babies begin to grow, explore their worlds, and interact with others, parents are integral in helping their toddlers and young children develop requisite social–emotional and self-regulatory skills. Responsive, sensitive interactions with parents support the development early social–emotional and self-regulatory skills, but extreme residential instability and general family chaos may impair the parent–child relationship and decrease children's health and well-being (Coley et al., 2015; Sandel et al., 2018b).

Recommendations for Practice

Young parents experiencing homelessness need developmentally appropriate services and supports for both themselves and their young children. They also need resources to help them become economically self-sufficient. Unfortunately, research to date reveals little about the effectiveness of programs specifically for young parents who are homeless. A systematic evidence review conducted as part of VoYC (Morton, Kugley, & Epstein, in press) found only one rigorously evaluated intervention exclusively for young mothers experiencing homelessness, namely, a transitional housing program with wraparound services. The results of the evaluation were inconclusive due to high attrition (Duncan et al., 2008). In addition, although a quarter of the homeless youth and young adults served by transitional living programs and maternity group homes funded by the U.S. Department of Health and Human Services are pregnant or parenting (youth.gov, n.d.), the impact of those programs on young parents and their children has not been rigorously evaluated. Research has also failed to engage young parents meaningfully in the construction of solutions and systems intended to promote their well-being and that of their children.

Even as researchers and service providers acknowledge the lack of evidence-informed models for prevention and intervention with young parents experiencing housing instability and homelessness, the field is well aware that these young families are not in a position to wait. In the absence of comprehensive empirical findings, there are lessons to be drawn from the larger literature on homelessness, early adulthood, and parenting. As researchers and service providers endeavor to engage young parents as partners in model development, test interventions, and adjust them accordingly, there are opportunites to integrate what is known to increase the chances that the needs of young parents and their children who are homeless will be addressed. In response to this need, we identify five priority lessons from the literature that, if implemented on a broad scale, could advance the well-being of this population.

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Newborns have substantial physical and emotional needs, and caring for a newborn is both physically and emotionally taxing.

Connect Young Parents Who Are Homeless With Their Children to "Two-Generation" Programs

Homeless service providers should develop partnerships with two-generation programs that can address the individual needs of parents and children as well as the collective needs of the family by integrating parent-focused and child-focused service provision. The programs typically involve engaging young parents in education, career training, and employment opportunities; promoting parent–child bonding; improving parent and child health and well-being; and linking families with economic, social, and other supports (National Human Services Assembly, 2015; Seimer Institute, 2017). Examples of two-generation approaches include the Special Supplemental Nutrition Program for Women, Infants, and Children, home visiting programs, and early childhood education programs such as Head Start and Early Head Start. Indeed, long-term findings from the Nurse-Family Partnership, an evidence-based home visiting program with comprehensive child and family supports, showed that 12–15 years after participation in the program, children were less likely to engage in delinquent behaviors, and mothers reported having longer interpersonal relationships and a greater sense of personal mastery (Olds, Henderson, & Cole, 1988; Olds, Kitzman, & Cole, 2010).

Prioritize Children Experiencing Homelessness for Enrollment in Early Childhood Programs

Communities should ensure that young parents and children experiencing homelessness are being served by early childhood programs. Although federal law requires Head Start and

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Most programs for homeless families do not serve minor parents, and many programs for homeless youth do not serve youth who are parenting.

Early Head Start programs to prioritize children experiencing homelessness for enrollment, that mandate does not apply to federally funded home visiting programs or to other early childhood education providers. Prioritizing the enrollment of children experiencing homelessness is important given that they tend to lag behind their low-income stably housed peers in the domains of social–emotional and cognitive development and that they are generally less likely to participate in early childhood education programs (McCoy-Roth et al., 2012). One study found that homeless or highly mobile children who particated in Head Start made significant gains relative to their low-income but stably housed peers on measures of social–emotional development but fell further behind on measures of cognitive development (Institute for Children, Poverty, and Homelessness, 2013).

Screen Pregnant Youth and Young Parents for Homelessness and Housing Instability

Identifying pregnant young women who are homeless or at risk for homelessness is important because doing so can reduce their risk for poor birth outcomes and their child's risk for poor health and delayed development (Sandel et al., 2018b). Research has also demonstrated the value of screening for housing instability in settings where families with young children are served. In a study of nearly 1,000 families with a child enrolled in Head Start or Early Head Start, 53% of families were identified on the Quick Risks and Assets for Family Triage—Early Childhood as having significant to severe barriers to housing, such as living in transitional housing or a shelter, among other issues (Farrell, Kull, & Ferguson, 2018); nearly all were referred to housing resources, such as eviction prevention or rental assistance programs, and many were referred to other necessary family support services.

Develop the Capacity of Homeless Service Providers to Serve Young Parents Who Are Homeless, Regardless of Their Age, Gender, or Marital Status

A survey of homeless service providers administered as part of VoYC found significant gaps in the availability of services for young parents who are homeless, particularly if those parents are minors or live in rural areas (Dworsky et al., 2018). Most programs for homeless families do not serve minor parents, and many programs for homeless youth do not serve youth who are parenting.

Increase Partnerships Between Homeless Service Providers and Other Systems That Can Address the Developmental Needs of Young Children and Their Parents

Communities can promote partnerships by engaging the early childhood and early intervention systems in their Continuums of Care, encouraging homeless service providers to refer young parents and their children to early childhood or early intervention programs, and co-locating services in shelters or other housing programs. Better coordination of services and more intensive case management could also reduce barriers that otherwise limit access to services (McCoy-Roth et al., 2012).

Conclusion

Family homelessness has profound developmental consequences for both young parents and their children, including long-term effects on health and well-being. More research is needed on interventions that address the multifaceted needs of this population so that effective programs for young parents and their children experiencing homelessness can be identified. In the meantime, there are practical steps that communities can take to reduce the harmful consequences of homelessness for young parents and their children.

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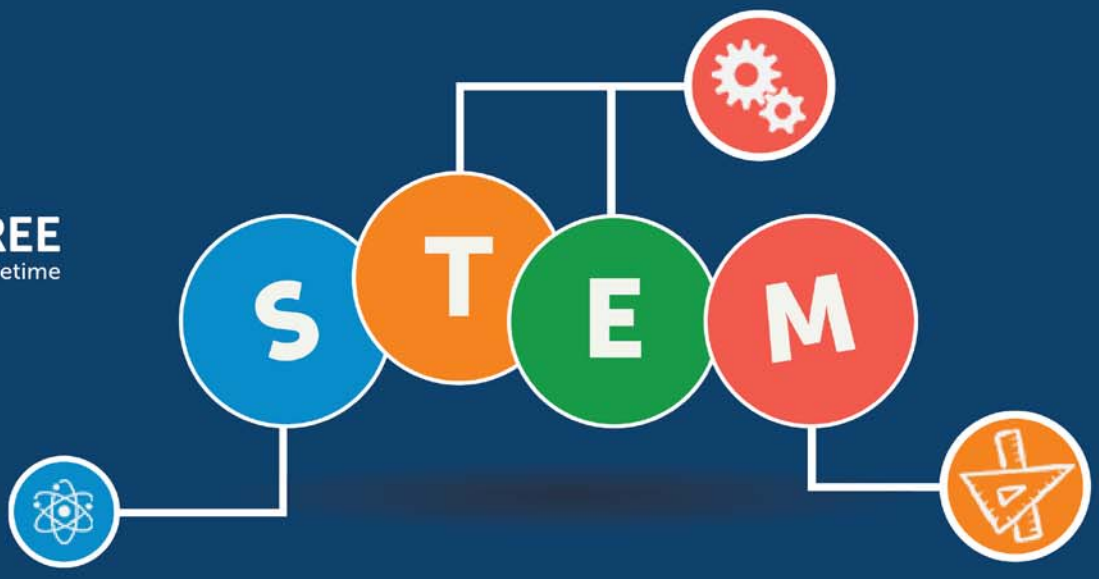

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