A PUBLICATION OF THE HCH CLINICIANS' NETWORK

HEALING HANDS

Vol. 14, No. 5 | October 2010

When the Bough Breaks . . . Families Experiencing Homelessness

Although the total number of homeless persons in America dropped slightly between 2008 and 2009, the number of homeless families increased for the second straight year, almost certainly related to the ongoing recession. The *2009 Status Report on Hunger and Homelessness* released by the U. S. Conference of Mayors cited the top three causes of family homelessness as being:

- A lack of affordable housing (74 percent)
- Poverty (52 percent)
- Unemployment (44 percent) and domestic violence (44 percent)[1]

The U. S. Department of Housing and Urban Development's *2009 Annual Homeless Assessment Report to Congress*, designed to measure the scope of homelessness across the country, found that of the nearly 1.56 million people who used an emergency shelter or a transitional housing program during 2009, about one-third (34.1 percent) were homeless as members of families rather than by themselves. HUD defines a *family* as a household that includes an adult 18 years of age or older *and* at least one child. In 2009, approximately 170,000 families were sheltered homeless, about a 30 percent increase since 2007. Furthermore, family homelessness became more severe in that it took the typical family longer to leave shelter: the median number of nights that family members stayed in an emergency shelter increased from 30 nights in 2008 to 36 nights in 2009.[2]

According to 2009 data[2], a typical homeless family consisted of a mother and two children, and the demographic profile of persons as part of a family differed considerably from that of homeless individuals by themselves in terms of gender, race, age, and veteran and disability status. These were the most common demographic characteristics of sheltered families:

- Adults are female (79.6 percent)—although adults were more likely in 2009 to be men (20.4 percent) than they were in 2007 (18.0 percent)
- More than half (55.2 percent) of these women are between age 18 and 30
- Over 60 percent are children under age 18
- The family identifies itself as belonging to a minority group (almost half are African-Americans)

According to HUD's report, homeless children are fairly young: over half (52.6 percent) are under age six; 32.5 percent are age six to 12; and 14.8 percent are age 13–17. One trend revealed in the 2009 data is that there are more two-parent families and male-headed families than there were in 2007. The increase may be attributed to the economic crisis that is making it hard for even one parent to find work.[2]

NOT A PRETTY PICTURE

These basic facts, however, underestimate the extent of the problem and belie the complexity of families who are experiencing homelessness. The data, for example, do not reflect the number of family members who are doubled-up with other friends or family; the number of "single" homeless women and men who are parents but do not have their children currently with them; families whose children are either grown or have been taken from them; those in shelters who have additional children living with an ex-partner or relatives; families staying in domestic violence shelters; or children who have different fathers and as a result, a different family network.[3] And then there are families that have to break up in order to be sheltered.

In a commentary appearing in the *American Journal of Orthopsychiatry*,[4] pediatric nurse practitioner **Betty Schulz** wrote: "Parenting under conditions of homelessness and poverty is extremely challenging. Many parents lack the resources to be supportive and these conditions exacerbate their difficulties."

In practice for almost two decades, Schulz described the changes in families she and her team have observed while working in Baltimore's urban emergency family shelters, transitional housing, and drop-in centers: "Over time, we have observed greater instability in families. Today it is common to see second- or third-generation family homelessness. In these cases, neither the parents nor the children have ever experienced the firm foundation of a stable home or a family that provides nurturing care, support, and protection. Our team is seeing more serious mental health and behavioral problems in even the youngest children, a direct consequence of family instability."[4]

SANDRA'S STORY

Sandra T., an attractive 50-year-old with four children, lives with her dog Max in a small apartment in Albuquerque. Sober for almost three years, Sandra continues to attend Alcoholics Anonymous meetings and "work the steps." Sandra described the challenges of parenting young

children while she experienced untreated posttraumatic stress disorder (PTSD), bipolar disorder **[see Table 1 for tips how to explain bipolar disorder to children]**, and crack addiction: "When I was depressed, I couldn't get out of bed, and when I was manic, I'd be out partying. I wasn't available for my kids—physically or emotionally."

Sexually abused by her father from a very young age, Sandra's earliest memory is of sneaking paregoric (a camphorated tincture of opium, available in some states without a prescription at that time) from the refrigerator at the age of four. Her search for refuge from her family life led her to begin drinking at the age of 12. Sandra's father, who also abused her two oldest children, suffered from alcoholism.

Given her own chaotic family situation while growing up, Sandra failed to recognize how unmanageable her and her young children's lives were. "I didn't know how to pay bills or to find a job. That's why we were evicted so often," she explained. "My son Scott drew a picture of a house with handles. When our case manager asked about the handles, Scott explained: 'That's so we can pick up the house and take it with us when we move so we won't be homeless anymore.'"

Sandra never experienced nor learned basic parenting skills in her own family. "I loved my kids and wanted to be a good mom, but I didn't have a clue how to raise my kids," she admits. Her advice to clinicians working in homeless health care: "Ask more questions, and listen for what's *not* being said." For example, she would tell her case manager that she wanted to be a good parent, but the case manager failed to recognize Sandra's need for life skills coaching and parenting classes. "At that time, I needed a structured environment and to be taught what to do, step-by-step." The parenting classes that were available were financially out of reach.

It took Sandra years to realize that her children "needed love, not just buying them things, but having their back, being there when there is a problem." Sandra says that her daughter, who also had problems with drug addiction, has forgiven her and accepts her as she is. Her eldest son Rick struggled with substance abuse, and as a result spent time in prison. Ethan, the middle son, is now in college studying theatre and film; Sandra describes her relationship with him as being "more like buddies than mom and son." She and Scott, the youngest, still have unresolved issues and are estranged. Sandra believes that Scott's behavioral problems and Asperger's syndrome—one of the milder autism spectrum disorders—are related to his lack of supportive parenting during the early, formative years of his life. She says Scott is "doing OK, but there is much sarcasm, hatred, anger and pain.

"I became tired of hurting myself and others," Sandra adds. "I went to parenting classes and started taking care of myself; if I can't care for myself, I can't care for a child." She continues working to build better, meaningful relationships with her children.

Sandra and her children are not alone nor are their experiences unique:

- Compared to the general female population, mothers who are homeless have three times the rate of PTSD (36 percent), and more than twice the rate of drug and alcohol abuse or dependence (41 percent)[5]
- A study in New York City found that five years after entering shelter, 44 percent of homeless mothers had become separated from one or more of their children, compared to 8 percent of mothers who were continuously housed[6]
- Based on state-level data, the National Center on Family Homelessness estimated that annually one in 50—over 1.5 million—children in America are homeless[7]
- Compared to children in the general population, homeless children experience more mental health and behavioral problems[6]
- Within a single year, most—97 percent—homeless children have moved;[7] residential moves are known stressful life events for both adults and children

Table 1. Explaining bipolar disorder to your child

- Figure out before you start which analogy or comparison you are going to use; for example, the weather, a pendulum, a roller coaster. You can use *The Rainbow Angels** to help.
- Be brief, but don't leave out important parts just because you are embarrassed!
- Invite questions.
- Emphasize what you are doing to get better.
- Don't complain, and never, ever blame anyone for your bipolar disorder.
- Always acknowledge the child's feelings as true and authentic; for example, never say, "Oh, you don't really feel like that."
- Help the child develop coping strategies for him or her self.
- Select another adult whom the child trusts to look after him or her if you become ill again and approach that person together.
- Be prepared to have many conversations about bipolar disorder over many years; life is a long story and everyone's understanding increases with time.

* A story to help explain bipolar disorder to young children; available at www.twotreesmedia.com

Source: Kelly, M. (2005). *Bipolar and the Art of Roller-coaster Riding*. Victoria, Australia: Two Trees Media.

PARENTING WITH MENTAL ILLNESS

It is critical that those working in homeless health care understand the mental health issues associated with homeless families so that interventions can be adapted to take into account factors leading to homelessness and any resulting effects on mental health. Based on HUD's 2009 point-in-time estimate, one-quarter of all sheltered persons (children and adults) who were homeless had a severe mental illness.[2] Familial mental illness—particularly maternal depression—can have a significant negative effect on children's development, and like mental illness in general, maternal depression is disproportionately represented in low-income households across all ethnicities.[8, 9] A study of sheltered homeless women in Worchester, Massachusetts, found that about 50 percent of homeless mothers have experienced a major depression since becoming homeless, and that 85 percent reported having a history of major depressive episodes.[10]

Maternal depression primarily affects parenting in two ways: impeding the development of healthy relationships and compromising the mother's ability to perform basic parental functions. The impact on children varies depending on the child's age, with maternal depression during infancy having a greater impact on the child's development than depression at later ages; the length and severity of the depression are also factors. Maternal depression is reported to have a stronger risk of child behavior problems than other studied risks including smoking, binge drinking, and emotional as well as physical domestic violence.[9]

"It's challenging for children to deal with a parent who has mental illness or a substance abuse problem," Schulz said in a recent interview. "Life is erratic with little consistency. The parent will experience extreme mood swings from one day to the next, sometimes nurturing, and sometimes aloof. The child may exhibit a behavior one day that goes unnoticed, and the next day, get a beating for the same behavior. Children don't understand these emotional swings and will back away, leading to poorer attachment."

The negative effects of maternal depression on a developing child can start during pregnancy, having been linked to poor birth outcomes (e.g., low birthweight, prematurity, and obstetric complications). Maternal depression while the child is in infancy is a predictor for increased cortisol levels in preschool ages, which are associated with anxiety, withdrawal, and decreased social competence. Additional concerns linked to maternal depression are that depressed mothers are less likely to:

- Breastfeed, and when they do breastfeed, they tend to do so for shorter time periods
- Follow guidelines for preventing SIDS (sudden infant death syndrome)
- Use age appropriate safety precautions such as car seats and socket covers
- Manage chronic conditions, such as asthma or disabilities, in their young children
- Carry out consistent routines[9]

THE IMPACT OF HOMELESSNESS & PARENTAL MENTAL ILLNESS ON EDUCATION

Homeless children face disadvantages related to their development, physical and mental health, and education. Maternal depression is a significant risk factor affecting children's well-being and school readiness. For example, maternal depression is linked to reduced language ability, which is key to early school success, and three-year-old children whose mothers were depressed in their infancy perform more poorly on cognitive and behavioral tasks.[8] Depressed mothers are less likely to read to their children or have fun with them, singing, playing and cuddling,[9] so that children who grow up without these advantages are already behind when they enter kindergarten.[8]

School can be a place of safety, structure, and opportunity for the impoverished or homeless child whose life is filled with uncertainty, loss, and deprivation.[11] "When a parent has a mental illness or substance abuse problem, the child who is trying to complete her education faces unique barriers," notes Policy Director **Barbara Duffield** with the National Association for the Education of Homeless Children and Youth. "Often these kids are the parent's caregiver, work to cover up for the parent, and the parent's mental illness can lead child protective services to break up the family instead of delivering services to keep the family intact. There is also a strong correlation between unaccompanied homeless youth and parental mental illness. As kids get older, they may find it more and more difficult to live with a parent who has mental illness, so they flee. Since child welfare is not always responsive to older children, they fall between the cracks."

CHALLENGES FOR CLINICIANS

"Parents' mood swings test clinicians, too," says Schulz. "Today the parent may think the clinician's recommendation is a good idea and the following day, she may not be able to focus on what you are trying to teach her. You can't force the client to assimilate information when they are unreceptive; you must wait for the teachable moment. This is especially difficult for the clinician who is untrained in mental illness, unless another clinician with this expertise is working with you."

Stephanie A. Savard, LICSW, MSW, vice-president of New Hampshire-based Families in Transition, says, "It's a challenge for our clinicians to educate these women about their illnesses so that they can understand that they are not just being a bad parent. It's key for the client suffering from depression to understand that the fact that she can't get out of bed is a symptom of depression, or that her short temper is a symptom of PTSD. We also teach children about the parent's mental illness, so they don't blame themselves for their parent's behavior." In addition, research has suggested that educating parents about the effects of their depression on their children may stimulate reluctant mothers to seek treatment.[9]

Of particular concern to both clinicians and their patients is how to treat mental illness during pregnancy: stay on mood-stabilizing medications, which carry risks of causing birth defects, or discontinue the medications and face the possibility of relapse. These complicated treatment decisions are well beyond the scope of this newsletter, and any specific advice is in danger of quickly being out of date. Here is a sample of current guidelines and recommendations that clinicians may wish to consult:

- In 2010, the American Psychiatric Association (APA) updated its practice guideline for the treatment of major depressive disorder. These evidence-based recommendations include options for treating mild to moderate cases of depression during pregnancy; APA plans to develop a separate guideline for bipolar disorders.[12]
- "Guidance for Preconception Care of Women with Psychiatric Disorders," includes counseling and care guidelines for women with depression and anxiety disorders, bipolar disorder, and schizophrenia.[13]
- "The Management of Depression During Pregnancy: A Report from the APA and The American College of Obstetricians and Gynecologists," offers recommendations for the treatment of women with depression during pregnancy based on an extensive review of existing research.[14]
- The article "Prescribing Psychotropic Medications During Pregnancy and Lactation: Principles and Guidelines"[15] appearing in the *Journal of Psychosocial Nursing and Mental Health Services* contains specific recommendations.

BARRIERS TO CARE

Much is known about how to treat depression in women, but more research is needed on treatment strategies for homeless and other impoverished women. In general, depression is responsive to combinations of medication, peer-to-peer support groups, and traditional cognitive and interpersonal treatment strategies. Barriers to treatment include lack of mental health insurance coverage and too few appropriately trained providers. Other limitations are that most interventions for depression do not address the adult as a parent—nor do interventions include strategies to prevent or repair damage to the parent–child relationship. Furthermore, the women's perception of mental illness and what treatment might mean for them and their family makes many women reluctant to seek treatment.[9]

WHAT CAN HELP MOTHERS WITH OR AT-RISK FOR DEPRESSION & THEIR CHILDREN?

Rapid re-housing. "First and foremost, homeless families need housing and wrap-around services, including mental health care, nutritional support, and education," advocates **Dana Gamble, LCSW**, Children's Medical Services program director in Santa Barbara, California. "Families will also benefit from better integration of services across agencies—especially the integration of physical and behavioral health care."

Early detection & treatment. Some states and communities use standardized, validated screening instruments to identify women during pregnancy or with young children who are experiencing depression. The screening should be available where the mothers are, and a referral and follow-up system should be in place before implementing screening. Here are suggestions for validated screening tools used to detect maternal depression:[9]

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screen (PPDS)
- Beck Depression Inventory–II (BDI–II)
- Center for Epidemiological Studies–Depression Scale (CES–D)

ACOG recommends a simple two question psychosocial screening of pregnant women at least once per trimester (or three times during prenatal care):

1. Over the past two weeks, have you ever felt down, depressed, or hopeless?
2. Over the past two weeks, have you felt little interest or pleasure in doing things?

If this preliminary screen indicates possible depression, there should be additional screening.[9]

Targeted interventions to reduce depression & improve early parenting. One strategy is to incorporate interventions designed to prevent or reduce depression and its consequences for young children into early childhood programs such as home-visiting and Early Head Start. Home-visiting programs may be part of Healthy Start, Early Head Start, or stand-alone programs.[9] In general, home visitors focus on parents, encouraging and training them to relate to and help their children, and home-visits provide an avenue to address maternal depression.[8] "Home-visitors" often serve homeless clients who are doubled-up or living in shelters.

Table 2. Practice recommendations that support homeless parents & families

- Involve parents who are homeless in decision making & treatment planning for themselves & their families.
- Collaboratively develop tailored service interventions to support parents & children as they exit homelessness.
- Ensure that individuals & families are asked about family members & children who may not currently be living with them. Explore strategies for reconnecting with family members when appropriate.
- Assist parents with parenting skills that support the growth & development of their children while living in transient situations.
- Conduct training on parenting skills for staff working with families who are homeless.
- Provide fathers who are homeless with opportunities for parenting education & gender-specific supportive services.
- Provide family planning support to young mothers in the homeless service system.
- Provide time & space for parents & children in shelters to play together constructively.
- Conduct assessments & interventions that explore the occurrence & impact of violence among the broader family system, not only related to family members in shelter.
- Create substance use treatment services that allow parents to participate with their children.

Source: Paquette, K., & Bassuk, E. L. (2009).[3]

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Research has shown that as parenting improves, symptoms of maternal depression may lift, and that parent education has been effective in improving parenting and reducing child problem behavior.[16]

"New health reform legislation (Subtitle IV–Maternal and Child Health Services)[17] addresses home-visiting by requiring statewide needs assessments, evaluating the quality and capacity of existing home-visiting programs as well as the state's capacity to provide substance abuse treatment and counseling," reports National Health Care for the Homeless Council Policy Director **Barbara DiPietro, PhD**

"The U. S. Department of Health and Human Services may make grants for early childhood home-visitation programs that lead to quantifiable, measurable improvement in benchmark areas (e.g., reduction in family violence, improvement in school and community coordination and referrals, improvement in family self-sufficiency, etc.). An independent expert advisory panel will examine the outcomes of home-visiting and other early childhood development initiatives."

PUTTING EVIDENCE INTO PRACTICE: PROTECTIVE FACTORS

Families in Transition (FIT) serves homeless families in Manchester and Concord, New Hampshire. FIT's integrated family-centered care includes permanent and supportive housing, a therapeutic childcare center, family advocacy, and case management. Catholic Medical Center's Mobile Community Health Team Project, a Health Care for the Homeless grantee, provides primary medical care and additional services onsite. On average, FIT serves 160–170 individuals at any one time, and collaborates closely with schools, child protective services, and other community agencies. FIT also runs a small program for single fathers, Spruce Street, a five-unit apartment house providing transitional housing for 18–24 months.

FIT received a half-million dollar grant from the Robert Wood Johnson Foundation and another half-million in local matching grants to establish The Family Place, which has the capacity to serve 40–50 families. "As we

Table 3. The Five Protective Factors

The Center for the Study of Social Policy researched & identified these five protective factors, which are conditions in the family that reduce the likelihood of child abuse & neglect

- Parental resilience: The ability to cope & bounce back from all types of challenges
- Social connections: Friends, family members, neighbors & other community members who provide emotional support & concrete assistance to parents
- Knowledge of parenting & child development: Accurate information about raising young children & appropriate expectations for their behavior
- Concrete support in times of need: Financial security to cover day-to-day expenses & unexpected costs that come up occasionally, access to formal supports like TANF & Medicaid & informal support from social networks
- Children's social & emotional development: A child's ability to interact positively with others & communicate his or her emotions effectively

The *Strengthening Families & Communities: 2010 Resource Guide*—available free from the website below—features detailed information about the protective factors & tips for incorporating them into practice; strategies to help build community awareness & partnerships; information about child maltreatment & tip sheets on parenting topics for use with caregivers.

Source: Child Welfare Information Gateway | www.childwelfare.gov

designed our program," Savard explains, "we asked ourselves how we could best help these kids, and what we could give families to help mitigate developmental delays, prevent child abuse and neglect, decrease school drop-out rates, and ultimately break the cycle of homelessness. We designed a positive, strengths-based model and our multi-focus program serves primarily homeless families with co-occurring disorders—mental illness and substance abuse. Our goal is to increase the protective factors[18] in the lives of these homeless children." **[See Table 3]**

"For example, research has shown that increased family involvement is a protective factor, so we encourage families to gather at least once a day for a meal," Savard continues. "Our families are primarily single mothers with two children. One thing that almost all of these women have in common is a history of trauma—either sexual or physical abuse or domestic violence."

According to the National Child Traumatic Stress Network, over 90 percent of sheltered and low-income mothers have experienced severe physical and sexual assault during their lifetime, and about two-thirds of homeless mothers have histories of domestic violence. Furthermore, homelessness puts families into situations where they are at increased risk of traumatic experiences including witnessing violence, assault, or abrupt separation. Stresses associated with homelessness and living in

Photo courtesy of Families in Transition

The Family Mill provides safe and affordable housing for both families and individuals.

shelters can interfere with recovery and exacerbate the consequences of trauma. These factors—along with the loss of community, possessions, privacy, routines, and security—often result in a damaging, costly cycle to both the individuals and their communities.[19]

Community-based shelters—such as those operated by FIT—are the primary refuge for thousands of homeless families across America. Shelters and other programs have the opportunity to become trauma-informed, address specific trauma symptoms, and create safe, nonthreatening, and supportive environments to help families exposed to trauma and speed their return to community life.[19] ■ **[Editor's note: The December issue of *Healing Hands* will focus on trauma-informed care.]**

Table 4. Practice recommendations for housing & homelessness programs

- Train & support staff to promote supportive parenting
- Promote structured parent–child activities in shelters; teach parents how to play with their children & encourage positive relationships & bonding
- Promote better access to behavioral health services
- Keep family members together to avoid separation & further trauma; promote family reunification
- Encourage school attendance; encourage parents to attend school meetings, communicate with teachers regularly & help children with homework
- Provide daycare that promotes the parent–child bond
- Provide Housing First for families with intense supportive services, including case management & access to services that promote supportive parenting practices & teach basic life skills such as budgeting, shopping, cleaning & cooking

Source: Adapted from Schulz, B. (2009).[4]

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Healing Hands

Healing Hands is published bimonthly by the National Health Care for the Homeless Council | www.nhchc.org

Brenda Proffitt, MHA, writer | Lily Catalano, communications coordinator | MGroup, layout & design

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