

## Homeless Shelters, Permanent/Supportive Housing, and Transitional Housing

By Abigail H. Gewirtz



### Case Scenarios and Analyses

#### Scenarios

*From a homeless shelter.* Tamara and her three children (ages 4, 7, and 10) came to a homeless shelter from the home they had shared for 6 months with Jason, Tamara's boyfriend. Jason lost his lease on the apartment and left a note for Tamara saying that he was moving out of State to "start over." Their relationship had not been easy, but Jason had promised

Tamara earlier that he would do what he could to maintain the lease so that the children could have some permanence. Tamara and her children have moved from place to place since her oldest child, Jamaica, was born when Tamara was 16. They had lived on and off with Tamara's mother, but the apartment became too crowded, so Tamara and her children were often homeless. They stayed in homeless shelters for several months at a time. During the last stay, the children witnessed several assaults in the vicinity of the shelter. Right before they moved in with Jason, they witnessed the stabbing of a man outside the shelter. Both the shelter and Jason's apartment are in a high-crime, inner-city neighborhood. Jamaica is in fifth grade but has many unexcused absences this school year. She reports that she skips school to be with her mom because she is scared of "what happens outside" and worried about her family's safety. Jamaica and her siblings sleep in their mom's bed at the shelter. Jamaica has frequent nightmares about fighting and killing, is scared to go outdoors, and startles easily, especially around men. She cannot forget the incidents she has seen, particularly the stabbing: "I keep seeing blood, and the man looking surprised and angry, and then falling down; I can't get him out of my mind." Tayz, Tamara's 7-year-old son, is doing well in second grade. Tawonda, the youngest, is enrolled in

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### The Safe Start Center Series on Children Exposed to Violence

Each Issue Brief in the series explains the importance of addressing exposure to violence to ensure the well-being of children from birth to age 18 in all systems that interact with vulnerable children and families. Through the use of literature reviews, case scenarios, and analyses of data, the Issue Briefs translate lessons learned from research and program practices into actions that can effectively prevent or reduce the negative impact of exposure to violence.

Issue Brief #6 translates emerging research and program practice into action steps for providers to design and implement programs that meet the needs of children who are exposed to violence and living in homeless shelters or supportive or transitional housing. The risks and vulnerabilities of these children and their families are similar to those that are found in domestic violence agencies. The goal of Issue Brief #6 is to build the capacity of housing and homelessness services providers to offer sensitive, timely, and appropriate interventions that enhance children's safety, promote their resilience, and ensure their well-being. Issue Brief #5 addresses interventions for staff and advocates in domestic violence agencies. (For a complete list of Issue Briefs, see the box on page 8.)



Head Start but has a hard time leaving her mom and, as a result, rarely makes it to preschool. Tamara gets very irritable with her because “I never get a break.”

*From supportive housing.* Jane lives in a permanent supportive housing apartment with her two children, Jennifer and James, ages 12 and 10. Three months earlier, Jane had been hospitalized for addiction to multiple substances. Her children were in foster placement for several months. They have been placed in foster care three times in their lives—separated on two occasions and together on one occasion—and have occasionally lived with Jane’s mother over the past 2 years. Before her substance abuse treatment, Jane would leave the children alone for nights at a time, while she was using or dealing drugs. She also dealt drugs from their apartment, and the children witnessed several fights between Jane’s male “associates.” Jane suspects that Jennifer was sexually abused by one of the men. When Jane completed treatment and found housing, child protective services (CPS) reunited her with her children. Although she is glad to have them back, Jane feels overwhelmed. She suspects that Jennifer may be sexually active, and her daughter talks of wanting to have a baby. Jennifer also reports being extremely fearful of many things, including the dark, animals, and noises that remind her of the fights she witnessed. She finds it hard to talk to friends about her problems, and discussions with her mom often turn into arguments. Jennifer has not visited a doctor since she was 10. Her brother, James, often gets into fights with other children at school.

*From transitional housing.* Katie resides in a transitional housing apartment for teenage mothers. At 17, she is the mother of a 2-year-old. Katie ran away from an abusive home at 15. When she moved to the city, she was lured into prostitution by an older man. He became her pimp and the father of her child. He was physically and mentally abusive to her throughout her pregnancy. She found out about a nonprofit organization that provides housing and help for teenage mothers and, with the help of a friend, escaped with her child. Although she is glad to be out of the abusive relationship, she reports that her child’s father cared for the child and that she has little confidence in her parenting skills. She is impatient with her son and herself. Although she reports that the toddler was never abused, she worries that she might abuse him because her parents were abusive to her and her siblings. When observed with her baby, Katie appears at times loving and at other times irritable and intrusive. For example, when Dan cries, she sometimes shouts, “Why are you crying? Are you mad at

me, just like your dad? You look like him too. Just shut up!” At other times, she holds him tenderly, smiling and playing with him. Sometimes, Katie appears distracted, not paying attention to, or even hearing, Dan’s distress or positive attempts to get her attention.

### Analyses

*Opportunities for intervention in a homeless shelter.* When the family arrives at the shelter, it is assigned an advocate who immediately works with Tamara to ensure that the children have transportation to continue attending school. Tamara agrees to participate in a family intake session that includes standardized assessments. These assessments reveal that Tamara suffers from depression. The family is enrolled in Medicaid, and Tamara is referred for therapy and case management services. Jamaica exhibits clinically significant symptoms of anxiety and posttraumatic stress disorder (PTSD) and is referred to a children’s mental health clinic that provides services at the shelter. All three children are invited to participate in afterschool programs at the shelter. The shelter advocate coordinates services and secures transitional housing for the family. As the family prepares to move into transitional housing, Tamara reports feeling positive about the family’s future. Tawonda begins looking forward to her Head Start sessions. Jamaica is working with her therapist who plans to continue visiting her in the family’s new housing.

*Opportunities for intervention in supportive housing.* The supportive housing intake process includes an assessment of the family’s strengths and needs using standardized self-report questionnaires completed by each family member, a family and parent interview, and reports from the children’s teachers. Jane reports being highly motivated to improve her parenting skills and to get help for her children, noting that “this might be my last chance to get them back on track.” Jane’s case manager meets with the family twice to discuss the results of the needs assessment. Together, the family creates a plan. The plan includes (1) participation in a parent training intervention and continuing substance abuse treatment for Jane; (2) trauma-focused cognitive-behavioral therapy for Jennifer, who reports clinically significant symptoms for PTSD; and (3) school-based monitoring and mentoring of both children by the family case manager.

*Opportunities for intervention in transitional housing.* Katie’s advocate in the transitional housing program meets regularly with her, and they develop a good relationship. Katie receives legal services to achieve emancipation and enrolls in a high school for teenage

mothers that provides onsite day care for her toddler. Although classes at school help Katie understand the basics of child development and what to expect from her child, she still struggles with parenting him. Specifically, she talks about how he increasingly reminds her of his dad and reports that Dan is defiant and angry with her. Further evaluation of Dan's development and of the parent-child relationship reveals that, although Dan is developing normally, there are problems related to parent-child attachment. Katie and Dan are referred for parent-child psychotherapy. Their therapist visits them weekly. Several months into the therapy, the therapist reports that Katie is more sensitive and responsive to Dan's needs and that Dan appears more secure in his mother's presence. Katie reports that she understands and enjoys Dan more and is less preoccupied with how he reminds her of his dad.

## Impact of Exposure to Violence on Children

A recent review found that children who are homeless are much more likely than other children to be exposed to all types of violence, including community violence, domestic violence, and child abuse (Anooshian, 2005). In addition, these children are exposed to high rates of related stressors (e.g., losing a home, changing schools frequently, hunger and malnutrition, lack of basic supplies) (Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993). These related risks may sensitize children, making them even more vulnerable to mental health problems such as depression, anxiety, and PTSD when exposed to traumatic events. The crisis or crises precipitating a family's arrival at a homeless shelter can exacerbate existing emotional and behavioral difficulties among children.

Although safe and stable housing is critical to children's recovery and healthy functioning, housing alone is likely to be insufficient. Studies have found that formerly homeless children in stable housing continue to suffer from high rates of mental health problems (Vostanis, Grattan, & Cumella, 1998). Criteria for entry into many housing programs include caregiver mental illness and/or substance use disorder in addition to homelessness. Not surprisingly, significant mental health needs have been documented among families residing in supportive and transitional housing (Gewirtz, Hart-Shegos, & Medhanie, 2008). In supportive and transitional housing, educational, behavioral, and emotional problems among children were associated

with exposure to traumatic stressors and parental mental illness (Gewirtz et al., 2008).

## Signs and Symptoms of Exposure to Violence

Symptoms of children experiencing traumatic stress vary by developmental stage and often manifest differently from adult symptoms. Identifying symptoms and signs of traumatic stress is often most easily done by comparing the children's behavior with the behavior that is typical for other children of the same age. For example, in very young children, typical developmental tasks include walking, talking, and interest in exploring the world. In traumatized young children, attachment difficulties may be evident, with children showing extreme fear of strangers and unwillingness to separate from parents. Or they may exhibit the opposite behavior, being overly affectionate with strangers and ready to attach to just about anybody. Elementary school children, for whom play and the peer groups are critical, may show extreme anxiety, report nightmares or flashbacks, or avoid certain situations that remind them of their traumatic experience. These children may play differently from other children, re-experiencing or attempting to resolve elements of the traumatic event with play activity that is repetitive rather than spontaneous; repetitive activity is common in children who have experienced traumatic stress, whereas spontaneous activity is the type of play that is typical of developing children.

Children of all ages may have temper tantrums or act out aggressively, attempting to demonstrate that they are in control of an uncontrollable situation. Children may also show elements of adult PTSD symptoms, including avoidance of traumatic reminders and exaggerated startle reactions. In teens, impulsive and aggressive behavior may be common. Sometimes, symptoms of PTSD among children are similar to adult symptoms and include hypervigilance, avoidance, intrusive memories, flashbacks, or recurrent nightmares.

## Working With Families Who Live in Homeless Shelters or Supportive or Transitional Housing

The experience of homelessness extends far beyond lacking a home. Homeless families experience many other homelessness-related stressors and are more likely than other families to be exposed to traumatic events.

The impact of homelessness is pervasive. Homeless children are sick more often than other children and have more emotional and behavioral problems than their peers.

Homeless families' limited mobility and lack of resources mean that they have less access to health-care, school-based, and social services. Thus, efforts to coordinate or integrate the work of systems serving homeless families (e.g., housing, child welfare, income maintenance, education, health/mental health) can offer powerful ways to increase access to care for homeless children and their families.

Interventions for homeless families must acknowledge the barriers families face in engaging in services and should focus on engagement as a critical component of services. Engagement efforts might include concrete strategies for recruitment and retention (e.g., providing meals and child care during sessions, compensation for participation, travel reimbursement, cell phone stipends or phone cards, episodic program benefits such as holiday gift programs) and interventions to enhance engagement such as motivational interviewing.

### **Evidence-Based Practices for Working With Children Exposed to Violence in Housing Agencies and Shelters**

#### **Intervention to build the resilience of vulnerable families**

Single-site transitional or supportive housing provides a unique opportunity to support children's healthy development by implementing comprehensive health promotion or illness prevention programming. An example of this type of program is the *Early Risers Skills for Success Prevention Program*, which has been tailored for families in supportive housing (Gewirtz & August, 2008). Early Risers is a comprehensive, developmentally focused, competence-enhancement program for elementary school children who are at high risk for early emerging behavior problems and substance use. The program is delivered by family advocates and includes afterschool, summer camp, and school-based services, in addition to case management and parenting/family components.

### **Interventions for children who have been exposed to violence**

A few trauma-focused interventions have been tested with homeless and formerly homeless families. However, the following interventions have been successful with at-risk groups that share many of the risks of homeless families:

- *Trauma-focused cognitive-behavioral therapy* for children (Cohen, Mannarino, & Deblinger, 2006) has been evaluated with children living with their mothers in domestic violence shelters.
- *Child-parent psychotherapy* (Lieberman & Van Horn, 2008) has been found to be a promising intervention for vulnerable traumatized families. Both this intervention and the trauma-focused intervention above aim at reducing children's distress or internalizing their symptoms related to trauma exposure. However, studies have also shown high rates of externalizing or acting-out behaviors among homeless and formerly homeless children. Parent training interventions have significant utility among homeless and formerly homeless families, and these two interventions have been specifically developed or adapted for families in or leaving shelters.
- *Project SUPPORT* (Jouriles et al., 2001) is a home-based intervention for mothers and children leaving battered women's shelters. The intervention combines parent training and advocacy for families, providing in-home sessions over several months.
- *Parenting Through Change* (Forgatch & DeGarmo, 1999) is a 14-week group-based parent training intervention that has been adapted and implemented successfully in battered women's shelters and supportive housing agencies. Trauma-focused parent coaching extends the work of Parenting Through Change by providing a parent training intervention that focuses specifically on bolstering emotion regulation and parenting skills among traumatized parents of children exposed to violent trauma.

### **Building the Infrastructure**

The length of stay in a shelter affects the types of services that can be offered to traumatized children and families. However, policies can be implemented to facilitate screening and services for children:

- Create formal intake processes that will begin within 72 hours of entering a shelter or within a week of entering housing. Intake should include standardized screening of children's exposure to violent events and for PTSD or other anxiety symptoms, in addition to a general strengths and needs assessment.
- Develop a network of community-based licensed providers or agencies to provide easily accessible (e.g., home-based) mental health and related services (e.g., parenting interventions) for families and children.
- Increase the awareness of all providers of the multiple needs (e.g., children's mental health) of homeless children and families. Raising awareness can be done through education opportunities, cross-trainings, and open houses.
- In longer term or permanent housing, allow case management staff members to function as coordinators of services provided by entities working with the family (e.g., providers of mental health, CPS, or domestic violence services).
- Increase the skills and expertise of housing case managers, advocates, and other housing staff members in working with children and families exposed to violence. For example, provide information on healthy child development, children's mental health, identifying traumatized children, tools for working with families in crisis, and child welfare requirements (see Mandated Reporting box).
- Offer training opportunities to client services staff members (i.e., advocates and case managers) to develop their skills to engage families, such as strategies that include reflective listening and conflict resolution techniques.

## Special Considerations That May Arise in Implementing Promising Practices

Shelters are public places. Parenting in shelters in which people come and go 24 hours a day 7 days a week is enormously stressful for parents. Shelter advocates (and other staff members) who are trained to understand families' stressors and strengths are better able to preempt crises and react calmly and swiftly as crises arise. (Information about psychological first aid can be found in Issue Brief #3 for school personnel.)

Families entering shelters may be in acute crisis and unable to fully participate in services or give informed consent for services. Consideration of the family's functioning is important in anticipating whether an offer of intervention will be perceived as helpful and valuable or intrusive and burdensome. However, experience suggests that even residents in short-term or emergency shelters can benefit from participating in best-practice interventions. For example, 90 percent of participants in a parent training group intervention offered in an emergency shelter completed the 14-week group, even though all but one of the participants had left the shelter by the time the group intervention ended (Gewirtz & Taylor, 2009).

In all housing environments, but particularly longer term housing, families may be suspicious of service options that include home visits. A discovery of housing infractions (e.g., an extra person or a pet residing in an apartment) during a home visit may result in a family's eviction. This situation creates potential barriers to service engagement if residents perceive that they could lose their housing by admitting to difficulties (e.g., relapse, maltreatment, others living in the house).

Homelessness policies meant for single adults but implemented in settings where families reside may cause

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### Mandated Reporting

Many children experiencing crises or violence are also at risk for child abuse and neglect. All States have child welfare systems that receive and respond to reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home.

Domestic violence does not equal child abuse and neglect, and therefore not all cases of domestic violence must be reported to child protective services. When responding to families affected by domestic violence, it is critically important for practitioners to consider simultaneously the safety of the child and the safety of any adult victim.

State-by-State information on reporting requirements can be found at [www.childwelfare.gov/systemwide/laws\\_policies/state](http://www.childwelfare.gov/systemwide/laws_policies/state).

unintended negative consequences for children. For example, approaches that tolerate use of drugs among residents may inadvertently increase children's exposure to associated stressors (e.g., drug dealing, community violence).

Child maltreatment reporting requirements and failure-to-protect statutes that affect families in shelters are similar to those that address domestic violence (see Mandated Reporting box). However, the stakes are higher in shelters because housing is often tied to a child's well-being and future placement. If a child is removed (even for a short time), the family will likely lose its housing. Conversely, family reunification may be delayed pending a parent's ability to access stable housing. Housing entities must have strong and ongoing relationships with CPS authorities so that (1) families have support from housing agency staff to help them through the reunification process and (2) advance planning can address the risks of subsequent exposure to violence that may lead to child removal and loss of housing. For example, safety planning might include ways for parents to ask for help in parenting or for respite care when stress increases and maltreatment is a concern, without triggering an automatic CPS referral by housing staff.

Many shelter or housing agencies are small, grassroots agencies with high staff turnover and few resources for ensuring high standards for training and supervision of staff. Collaborating with similar agencies for education, training, and supervision offers economies of scale. One example is that of a group of supportive housing agencies that collaborated and partnered with a local university to develop monthly staff trainings on child and family mental health (Gewirtz, 2007). The partnership is facilitated by an agency that raises funds for the trainings and other activities, and the training series is recorded and available on DVD for all staff members who cannot attend a particular session. Training includes trauma-related topics such as childhood PTSD, staff burnout, and dealing with grieving families.

### Additional Information/Resources

#### Resources for screening and assessment of trauma/exposure to violence

The Measures Review Database of the National Child Traumatic Services Network provides information on tools that measure children's experiences of trauma, their reactions to it, and other mental health and trauma-related issues. Visit [www.nctsn.net/org/nccts/nav.do?pid=ctr\\_tool\\_searchMeasures](http://www.nctsn.net/org/nccts/nav.do?pid=ctr_tool_searchMeasures).

The screening and assessment section under construction on the Safe Start Center Web site will provide information on articles and tools to screen and assess exposure to violence. Visit [www.safestartcenter.org](http://www.safestartcenter.org).

#### Web sites with information on evidence-based interventions

Ambit Network: [www.ambitnetwork.org](http://www.ambitnetwork.org)

California Evidence-Based Clearinghouse for Child Welfare: [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

Guide to Community Preventive Services: [www.thecommunityguide.org](http://www.thecommunityguide.org)

Hollywood Homeless Youth Partnership: [www.hhyp.org](http://www.hhyp.org)

National Center on Family Homelessness: [www.familyhomelessness.org](http://www.familyhomelessness.org)

National Child Traumatic Stress Network: [www.nctsn.org](http://www.nctsn.org)

National Implementation Research Network: [www.fpg.unc.edu/~nirn](http://www.fpg.unc.edu/~nirn)

Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide: [ojjdp.ncjrs.org/Programs/mpg.html](http://ojjdp.ncjrs.org/Programs/mpg.html)

Promising Practices Network on Children, Families and Communities: [www.promisingpractices.net](http://www.promisingpractices.net)

Psychological First Aid for Families Experiencing Homelessness: [66.92.43.14/ucla/PFA\\_Families\\_homelessness.pdf](http://66.92.43.14/ucla/PFA_Families_homelessness.pdf)

Psychological First Aid for Youth Experiencing Homelessness: [66.92.43.14/duke/pfa\\_homeless\\_youth.pdf](http://66.92.43.14/duke/pfa_homeless_youth.pdf)

Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices: [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)

Safe Start Evidence-based Guide on Children Exposed to Violence, the OJJDP Model Programs Guide: [www.safestartcenter.org](http://www.safestartcenter.org) (under construction)

Trauma-Focused Cognitive-Behavioral Therapy: [tfcbt.musc.edu](http://tfcbt.musc.edu)

### References

Anooshian, L. J. (2005). Violence and aggression in the lives of homeless children: A review. *Aggression and Violent Behavior, 10*(2), 129–152.

Cohen, J., Mannarino, A., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

Forgatch, M. S., & DeGarmo, D. S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology, 67*, 711–724.

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## Moving From Evidence to Action

### The Safe Start Center Series on Children Exposed to Violence

#### Core Concepts

*Definition of exposure to violence.* The Issue Briefs in the series use the definition of exposure to violence of the Safe Start initiative: “direct and indirect exposure to violence in [the] home, school, and community.”

*Impact of exposure to violence.* Children react to exposure to violence in different ways, and many children demonstrate remarkable resilience. However, children’s exposure to violence has been associated with difficulties with attachment, regressive behavior, anxiety and depression, aggression and conduct problems, dating violence, delinquency, and involvement with child welfare and juvenile justice systems. There is a strong likelihood that exposure to violence will affect children’s capacity for partnering and parenting later in life, continuing the cycle of violence into the next generation.

*Risk and protective factors.* The impact of children’s exposure to violence is influenced both by risk factors that increase the likelihood of a disruption in the developmental trajectories and by protective factors in the environment. These risk and protective factors depend on a child’s age and developmental level and the type and intensity of challenges present in the environment. The presence of supportive adults and/or nurturing environments provide a powerful buffer to children from the more intense stress or anxiety that may occur when children are exposed to violence.

*Effective interventions.* Research has documented the effectiveness of the following strategies to address the needs of vulnerable children and families—including children exposed to violence:

- Participation in *high-quality early care and education programs* can enhance physical, cognitive, and social development and promote readiness and capacity to succeed in school.
- *Early identification of and intervention with high-risk children* by early education programs and schools, pediatric and mental health programs, child welfare systems, and court and law enforcement agencies can prevent threats to healthy development by detecting and addressing emerging problems.
- For children and families already exposed to violence, *intensive intervention programs* delivered in the home and in the community can improve outcomes for children well into their adult years and can generate benefits to society that far exceed program costs.
- Outcomes improve when highly skilled practitioners provide *intensive, trauma-focused psychotherapeutic interventions* to stop the negative chain reaction following exposure to traumatic stressors (e.g., child abuse and neglect, homelessness, severe maternal depression, domestic violence). Treatment is an essential component of successful adjustments to exposure to violence, especially for children who have frequent exposures and who have complicated courses of recovery.

#### Guiding Principles To Support Best Practices

- **Safety** of the non-offending parent and of the children **must be paramount and addressed concurrently** in cases involving domestic violence.
- Children **must be understood in the context** of their individual traits, families, and communities (**a socio-ecological approach**).
- Responsibility for a child’s well-being must be owned by parents, community agencies, and public systems together—**addressing children’s exposure to violence is everyone’s responsibility**.
- Agencies must **work together in coordinated manner** to expand and enhance service delivery.
- Policies, programs, and services must be **developmentally appropriate and culturally responsive** and offered in the family’s preferred language.
- Programs and services need to be **evaluated rigorously** for effectiveness—efficacy is key. We must commit to **learning about what works**.

Gewirtz, A. H. (2007). Promoting children's mental health in family supportive housing: A community-university partnership for formerly homeless children and families. *Journal of Primary Prevention*, 28(3-4), 359-374.

Gewirtz, A. H., & August, G. J. (2008). Incorporating multifaceted mental health prevention services in community sectors-of-care. *Clinical Child and Family Psychology Review*, 11(1-2), 1-11.

Gewirtz, A. H., Hart-Shegos, E., & Medhanie, A. (2008). Psychosocial status of children and families in supportive housing. *American Behavioral Scientist*, 51(6), 810-823.

Gewirtz, A. H., & Taylor, T. (2009). Participation of homeless and abused women in a parent training program: Science and practice converge in a battered women's shelter. In M. F. Hindsworth & T. B. Lang (Eds.), *Community participation and empowerment*. Hauppauge, NY: Nova Science Publishers.

Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank, P. R., Stephens, N., et al. (2001). *Child-parent psychotherapy*. Washington, DC: Zero to Three Press. Retrieved December 3, 2009, from [http://www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/Child\\_Parent\\_Psychotherapy\\_CPP\\_fact\\_sheet\\_3-20-07.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/Child_Parent_Psychotherapy_CPP_fact_sheet_3-20-07.pdf)

Lieberman, A., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York: Guilford Press.

Masten, A. S., Miliotis, D., Graham-Bermann, S. A., Ramirez, M., & Neemann, J. (1993). Children in homeless families: Risks to mental health and development. *Journal of Consulting and Clinical Psychology*, 61, 335-343.

Vostanis, P., Grattan, E., & Cumella, S. (1998). Mental health problems of homeless children and families: Longitudinal study. *British Medical Journal*, 316(7135), 899-902.

### **Moving From Evidence to Action** **The Safe Start Center Series on Children Exposed to Violence**

The goal of the series is to build the capacity of practitioners in a variety of different fields to offer sensitive, timely, and appropriate interventions that enhance children's safety, promote their resilience, and ensure their well-being.

**Issue Brief #1: Understanding Children's Exposure to Violence**

**Issue Brief #2: Pediatric Care Settings**

**Issue Brief #3: Schools**

**Issue Brief #4: Child Welfare Systems**

**Issue Brief #5: Domestic Violence Agencies and Shelters**

**Issue Brief #6: Homeless Shelters, Permanent/Supportive Housing, and Transitional Housing**

**Issue Brief #7: Fatherhood Programs**

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Points of view or opinions expressed in this document are those of the author and do not necessarily represent the official position or policies of the Office of Juvenile Justice and Delinquency Prevention or the U.S. Department of Justice.

### **Safe Start Initiative**

The Safe Start initiative is funded by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. The goal of the initiative is to increase the knowledge of and promote community investment in evidence-based strategies for preventing and reducing the impact of children's exposure to violence. Eleven demonstration sites were funded from 2000 to 2006 to create a comprehensive service delivery system to improve the accessibility, delivery, and quality of services for children exposed to violence at any point of entry. A national evaluation broadened understanding of how communities can successfully implement a comprehensive system of care with policy and practice interventions to minimize the negative consequences of exposure to violence.

Fifteen Promising Approaches pilot sites, funded in 2005, are focusing on implementing and measuring developmentally appropriate services for children exposed to violence within the context of the systems that serve them. A national evaluation of these sites will analyze the impact of specific intervention strategies on outcomes for children and families.

The Safe Start Center is a resource center designed to support the Safe Start initiative on a national level and to broaden the scope of knowledge and resources for responding to the needs of children exposed to violence and their families. For more information on the Safe Start initiative and Safe Start Center, visit [www.safestartcenter.org](http://www.safestartcenter.org).

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