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Displaced Children:
Meeting the Health, Mental Health, and Educational Needs of Immigrant, Migrant, and Homeless Youth

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A permanent home and country is something many of us take for granted. Yet, a growing number of children of all ages are experiencing displacement, having been uprooted from their homes, communities, and sometimes, cultures. Whether due to immigration, migration, or homelessness, the impact of such displacement on children is generally detrimental and can have adverse effects on a child's safety, health, emotional state, behavior, and educational achievement.

This chapter explores the common needs of displaced children in the United States, focusing on three subgroups—children of immigrants, children from families of migrant farmworkers, and youth who are homeless, either with their families or on their own. Although these groups are not fully inclusive of all who experience residential instability and displacement (e.g., victims of natural disasters), together they illustrate the nature of the problem. Many of the challenges and needs of displaced children are common across age groups, but there are also differences between younger children and adolescents. A greater emphasis will be placed on issues of particular relevance for school-age children and adolescents. After providing background information on each of these groups, the shared and more specific needs of each group will be discussed followed by a set of recommendations for health care and service providers.

OVERVIEW OF ISSUES AND NEEDS

Immigrant and Refugee Children

Our nation is largely comprised of first-generation immigrants or their descendants. Immigrants

can be grouped into three distinct categories: (1) legal immigrants, (2) refugees, and (3) undocumented immigrants ("illegal aliens"). The U.S. Census Bureau estimates that, during the 1970s, approximately 4.3 million individuals were legally admitted into the United States; another 1.3 million crossed our borders illegally. This represents the largest wave of immigration, in absolute numbers, in our nation's history. Immigrants come from many different nations, but Mexico, the Philippines, and Vietnam supply close to three quarters of new arrivals to this country. Newcomers from Cambodia, Haiti, and several Central American countries (e.g., El Salvador, Guatemala, Honduras, and Nicaragua) are also represented in significant numbers. Most immigrants move to major metropolitan cities: Los Angeles and New York City are the immediate destination of 40% of immigrants, while another 20% reside in San Francisco, Chicago, Miami, Houston, and Washington, DC.[20] The number of immigrants aged 5–18 years who are now in the United States has been estimated at 2.1–2.7 million and another 100,000–300,000 undocumented immigrant children enter the U.S. each year.[21]

Little research has been conducted on immigrant and refugee children but their challenges are fairly apparent. Immigrant and refugee children must adjust to the loss of their homes and everything familiar to them.[2] Regardless of the circumstances and their developmental stage, most children will experience some grief about such losses. Children who leave their homelands and immigrate to this country must adapt to a new culture and many must learn a new language. Limited use of the English language is an obvious barrier that many immigrant children have to overcome. Children must adjust to differences in cultural norms as well and will sometimes do this faster than their parents, thereby setting up conflict. Fitting in with peers, while meeting parental expectations, is a common issue for adolescents but can be especially problematic for youths of first generation immigrants when their parents' views of how youths should look and behave are incongruent with the dominant culture. Immigrant children also may encounter racial tension and experience difficulties in identifying with other minority group members who do not share a similar heritage. For example, Jamaican and Haitian children who have moved to this country would not necessarily see themselves as "African-Americans." Similarly, youths from Southeastern Asian countries such as Vietnam, Cambodia, and Laos have heritages different from one another and from other Asian countries such as Japan, China, South Korea, and the Philippines.

Unfortunately, some immigrant and many refugee children have experienced the effects of trauma generated by exposure to extremely frightening circumstances including war, famine, and violence.[2] Global events such as war, political repression, and famine are scarcely felt by most of us, but they may have had profound effects for refugee children who may have experienced them first-hand. Recent crises in Bosnia, Somalia, Rwanda, Haiti, and Cuba highlight the many dangers still present in the world and some of the factors that propel families to move to a different land. The syndrome known as posttraumatic stress disorder (PTSD) can result from direct involvement and/or witnessing an acutely disturbing event that is outside the range of everyday experience. Its clinical manifestations include recurrent thoughts and images of the traumatic event(s), intense distress, avoidance of stimuli that could trigger memories or are associated with the event, and symptoms of increased arousal and vigilance including difficulties falling asleep, anger outbursts, problems in concentrating, and hypervigilance. Although it is beyond the scope of this chapter to review the literature on posttraumatic stress disorder in children, health care and other providers should be aware that refugee (and other displaced children) have an increased probability of suffering from this syndrome.[9]

Migrant Children

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Migrant Children

Migrant farmworkers provide a cheap but critical source of labor for American farmers who seasonally require large numbers of temporary workers to harvest their crops. These workers typically receive meager wages and benefits for their labor and live in makeshift and crowded housing arrangements. Predominantly Hispanic, many were born in Mexico or Central America. The majority of migrant farmworkers "shuttle" between their country of origin and the U.S. About one-third follow the crops in what is referred to as "streams." Three distinct migrant worker streams have been identified and include: (a) California, Oregon, and Washington states, (b) Texas and Colorado, and (c) Florida, Georgia, and the Carolinas.[11]

The number of migrant farmworkers is not known precisely, but the most reliable information is from The National Agricultural Workers Survey (NAWS) which estimated their size at 840,000 (42% of the approximately two million farmworkers). Of those, about 30% are parents accompanied by an average of two children. Based on the NAWS, the National Commission on Migrant Education estimated that, in 1990, about 587,000 children belonged to migrant farmworker families.[22] Some older children work in the fields alongside their parents while others are marginally supervised or left to fend for themselves during work hours.

Migrant farmworker families tend to experience residential instability in a slightly more elective and routinized manner, but with many of the same repercussions that affect other residentially unstable families. The hardships experienced by migrant farmworkers—long hours of difficult manual labor for low wages, unsafe working conditions, and meager housing—was first brought to national attention in 1960 by the television documentary "Harvest of Shame." In subsequent years, under the backdrop of President Johnson's War on Poverty, Congress legislated several programs intended to assist migrant farmworkers and their families in health, educational, and social service needs.

Studies of children of migrant farmworkers have documented higher rates of physical abuse,[17] poor health conditions and mortality,[28] mental health problems,[16] and academic problems[24] as compared to children in the general population. The National Commission on Migrant Education concluded that migrant children needed improved health care and nutrition and better methods for diagnosing speech and emotional disabilities.[22] The Commission noted that the mobility of many migrant children makes it difficult to conduct assessments and leads to interrupted services. In addition, frequent moving impedes school performance by making it more difficult to learn a curriculum and increases the likelihood of falling behind peers and eventually dropping out of school altogether. Some migrant youth who do manage to make it through high school are unable to obtain the diploma that they have rightfully earned. This is due to the fact that they have trouble documenting they have obtained the requisite number of credits needed to graduate across the multiple schools they have attended.

Homeless Children and Adolescents

Shelter providers and researchers have drawn a distinction between two different subgroups of homeless children and adolescents: (1) those who are homeless with one or both parents and any siblings, and (2) those who are homeless and unaccompanied by an adult. This latter group is older and commonly categorized as homeless or runaway youth while the former is typically younger. Research findings on the issues and needs of each of these two groups will be briefly reviewed.

HOMELESS CHILDREN WITH FAMILIES

The problem of homelessness for families emerged as a major social issue in the mid-1980s. Like research on migrant children, the first descriptive studies of homeless children in these families documented a range of emotional, health, and academic needs that were not being met.[1,6,19,23] Homeless families are the fastest growing segment of the homeless population and account for an estimated 43% of the total.[3] In most communities, homeless families tend to mirror the ethnic and racial composition of low-income families. The typical homeless family is comprised of a young single mother who has two children under the age of five years.[3,7] While this describes the norm, school-age children are common among homeless families as well. In 1989, the U.S. General Accounting Office estimated that at least 68,000 children (who are members of families) are homeless on any given night in this country with an additional 186,000 children precariously housed in doubled-up living arrangements.[13] More recently, the U.S. Department of Education estimated that 744,000 school-age children and adolescents are homeless in the course of a year.[30]

The shelter system in the United States has developed to the point that, in most communities, families who lose their homes are able to find temporary shelter.[31] Although homeless families can still be found "camping" or sleeping in cars, especially in warmer climates or during the summer, very few are literally unsheltered as is the case with some single homeless adults and unaccompanied adolescents. For children who become homeless with their families, residential instability generally takes the form of numerous moves prior to seeking emergency shelter which can include doubling-up to live for a while as secondary tenants with friends or relatives. A shelter stay that can range from several days to several months or longer is often followed by difficulties in achieving housing stability once a family has left the shelter.

The circumstances leading up to a family's loss of home as well as the subsequent change in routine can cause a child to become concerned about abandonment and safety. Often, a homeless child's biggest worry is for the well-being of his or her mother since she is perceived to be the child's primary "lifeline." This fear can be quite legitimate given the existing domestic and community violence and children's general inability to control the actions and fate of adults in their lives. Some homeless children manifest various disruptive externalizing behaviors in response to changes and strains in their lives while others may turn inward and become depressed and anxious. It is also not uncommon to see a child with both internalizing and externalizing problems. At the same time, there are also children and adolescents that appear more resilient and seem to weather the changes well. The variation in response may be related to the capacity of a child's support system to buffer the stress, the events surrounding the residential change, and the child's age.

For children under the age of five, the effect may be mostly indirect, that is, homelessness affects young children more by what it does to parents than by any direct influence on the child.[8] As children grow older and become more aware of what is happening around them, homelessness (and poverty in general) has greater direct effects on the emotional well-being of children. School-age children have a sense of the meaning of home and attachment to it that seems separate from their relationships with primary caregivers. For example, some homeless school-age children report low self-esteem and feelings of shame and embarrassment about not having a home. As a result, some of these children are secretive about their housing status. Residential change also uproots a child from social ties that he or she may have developed among friends, classmates, relatives, and other adults who live nearby.

Research conducted in the past several years, comparing homeless children to similarly poor but housed children in terms of exposure to major stressors and measures of mental health and behavioral s the two groups than was found i less of housing status, still eviden lation.[5,10,18] This appears to be the studies conducted in the 1980s f material resources and higher r but never homeless mothers, simi differences[7,14,18]

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UNACCOMPANIED HOMELESS

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* Homelessness can be likened to a a Darwinian-like struggle brought about b resource (e.g., affordable housing). Obtain ual or family at a competitive advantage in riencing homelessness.

of mental health and behavioral status, has revealed many more similarities between the two groups than was found in earlier research, although poor children, regardless of housing status, still evidence more problems than children in the general population.[5,10,18] This appears to be the case as well with these children's mothers; whereas studies conducted in the 1980s found that homeless mothers had fewer social and material resources and higher rates of individual dysfunction compared to poor but never homeless mothers, similar investigations in the 1990s have found far fewer differences[7,14,18]

Unfortunately, it does not appear that the plight of homeless families has improved over time; rather, a myriad of conditions affecting low-income families in general have worsened. Findings from a recently completed and comprehensive study of 220 homeless and 216 low-income housed (but never homeless) mothers and 627 of their children in Worcester, Massachusetts, bears this out.[5,7] Based on prior research, the study investigators had initially expected to find some pronounced psychosocial differences between these two groups of families but reached the conclusion that current housing status was a temporary and even somewhat superficial distinction between these low-income women. The majority of women in both groups survived on annual incomes of less than $10,000 and both groups were residentially unstable. An astounding 85–90% of both homeless and housed women had experienced physical and/or sexual abuse in their lifetime. Perhaps as a result, rates of stress-related mental disorders such as PTSD and major depression were almost identical between women in the two groups but were approximately three times that of the general female population. The most widespread and meaningful differences between the two groups were found in factors having mostly to do with monetary and social resources—mothers in the housed comparison group were much more likely in the past year to have had a housing subsidy, been a primary tenant, or been on AFDC (Aid to Families with Dependent Children) than homeless mothers.[7] Housing subsidies (in the form of Section 8 certificates or vouchers) are especially important for poor families and individuals as they can cover the majority of rent and free up income each month to meet other needs.* These results from Worcester, a city similar to many other mid-sized American cities, resemble recent findings on homeless and low-income women from other regions.[14,18,26] Taken together—and in the context of a growing climate of antipathy among policy-makers and the general public toward families on welfare—they bode poorly for the future well-being of poor families in this country.[4]

UNACCOMPANIED HOMELESS ADOLESCENTS

While the size of the runaway and unaccompanied homeless youth population in this country is not known with any precision, it is highly likely that on any given night unaccompanied homeless adolescents outnumber their counterparts who reside in shelters with their families. To address that need, shelters serving homeless adolescents were developed in recent years and can be found in all major and most mid-sized cities in America. (Homeless adolescents also can be found in most major cities in Europe, Asia, and especially Latin America; many of them endure an even harsher set of circumstances than do youths in this country.)

* Homelessness can be likened to a game of "musical chairs" in which winners and losers emerge from a Darwinian-like struggle brought about by a structural imbalance between the supply and demand for a vital resource (e.g., affordable housing). Obtaining something as valuable as a housing subsidy can put an individual or family at a competitive advantage in being able to afford housing and thus at much lesser risk for experiencing homelessness.

For some youths, life on the streets may seem like a safer setting than the homes from which they ran away. Other homeless youths are "system kids" having "graduated" from the foster care system at the age of 18 with no family to provide support and with limited work skills that would enable them to be self-sufficient. Studies have documented that exposure to sexual and/or physical abuse is quite common in the histories of runaway and homeless adolescents, with some surveys documenting abuse rates as high as 30–60% of the sample.[25] In some cases, running away from home may be more adaptive than not leaving. For those who do not return home after a short while, surviving on the streets is an extremely difficult process and living conditions are harsh. Some youths find themselves having to obtain money to meet basic survival needs by allowing themselves to be sexually exploited by predatory men. Mental health and substance abuse problems are high,[15] although drug use probably represents more a temporary escape from a grim reality than youthful experimentation. The probability of contracting HIV is markedly increased in this population given these high-risk behaviors.[27]

The needs of unaccompanied homeless adolescents, while comparable to children in homeless families, are often more complicated. The sequelae of recent and often traumatic abuse may lead to PTSD and other mental health problems, drug abuse, school failure, or criminal acts. In addition, homeless adolescents may have few independent living skills and no qualifications for finding a job. Without families to rely on for support, their best chance for improving their life circumstances is through involvement in an intensive (often residential) program that meets their basic needs as well as provides emotional support, teaches independent living skills, and works with them to identify job opportunities.

HELPING DISPLACED CHILDREN AND ADOLESCENTS

Residential instability, especially when it is forced upon an individual, can adversely affect even the most resilient among us by creating chronic sources of stress and making it more difficult to develop friendships and other supports that can serve as buffers. Change in both the physical and social surroundings can be disorienting. In a study based on a national survey of youth, Wood and colleagues[32] found that frequent family relocations (moves) were linked with both school failures and an exacerbation of behavioral problems. These associations held up even when competing explanatory factors such as poverty, race, and family structure were controlled in multivariate statistical analyses. This study is one of the clearest so far that documents the adverse consequences of frequent moves on the behavioral and academic functioning of children.

When children are exposed to events they cannot adequately process, either at a cognitive or emotional level, and without key individuals who may have once provided them with friendship or love, they are likely to be adversely affected. Health care and other service providers can help displaced youth by attending to a range of issues and needs that a child or adolescent may have. Services may be provided in traditional health care facilities, but are not limited to this type of setting. Schools are increasingly being seen as an important avenue to intervene on behalf of the children for reasons other than education.[29] Many communities nationwide have become aware of the utility of the school environment as a place for identifying health, mental health and other needs of youths and mobilizing effective and comprehensive interventions, especially for disadvantaged children. Schools are being asked to expand their mission and are being given the expertise, resources, and authority necessary to become a central locus for the delivery of these vital services. As a result, coalitions of agencies and institutions that combine human services and educational elements are emerging in communities. By empowering schools to take c better position to address the need:

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By empowering schools to take on this broader mandate, communities may be in a better position to address the needs of displaced and other high-risk children.

Regardless of where we work, the needs of displaced children and families are often many and complicated. In the remainder of this chapter, some ideas are offered regarding the types of program elements, services, and social policies that are likely to benefit displaced youths and families.

Providing Outreach and Establishing Rapport

Outreach is critical in fostering service utilization among displaced youths and families. If health care or school personnel wait for displaced families or homeless unaccompanied adolescents to approach them for help, the majority will remain unserved. Service providers need to go to where displaced families and individuals congregate and begin to forge a relationship with them. Many migrant, immigrant, and homeless families and youth may not be willing to access institutional services unless they have first developed rapport with service providers. Thus, before services can be provided or referrals made, a process of engagement needs to occur in order to reduce feelings of distrust or fear and to provide information and answer questions. The process of engaging individuals and families and encouraging them to participate in health, educational, or other service programs can be complicated and time-consuming. Trust is important to foster and often necessitates repetitive contacts, considerable patience, and sensitivity to a family's cultural heritage. Often, language barriers must be overcome as well. Trying to understand a family's priorities is critical since they may not converge with those seen by service providers. The importance of listening and determining a client's needs is essential to outreach workers, particularly by those who assist homeless unaccompanied adolescents and homeless single adults. They have found that they must first address a person's basic requirements—needs for food, shelter, and clothing before attempting to engage them in treatment for a mental health or substance abuse problem.

This lesson extends to homeless families who often have similar problems meeting basic needs and have practical barriers to obtaining services or treatment. The agenda of a health care provider may clash with that of a single mother who may readily acknowledge her child's health problems but may be facing the eviction of her family from their apartment or has no money or food stamps to buy groceries that week. Similarly, it can be very frustrating to health care providers to work with the parents of children who have chronic health care problems and who miss appointments. Yet, poor single parents can face significant barriers in seeking treatment for a child including transportation to a clinic, child care for siblings who stay behind, and work schedules. Sensitivity to these practical obstacles and efforts to address them will greatly help a health care provider to establish and maintain rapport with a disadvantaged family. "House calls" or outreach clinics should be considered to reduce practical barriers to treatment. Going into people's places of residence also allows a health care provider to evaluate firsthand the living conditions of their patients or clients and, thereby, to more fully appreciate their life circumstances and deliver services accordingly.

Providing Case Management

In most cities, the service system that has emerged to respond to the multiple needs of low-income families is fragmented, has long waiting lists, and is difficult to access. Families lack safe affordable housing, child care, transportation, and jobs that pay a livable wage. Dependable child care is necessary to enable parents to obtain needed services and to seek and maintain employment and stable housing. Low-income mothers' mental health and substance abuse difficulties are often undiagnosed and untreated and

typically linked to past and current experiences of violence. In order to respond to the complex and diverse needs of displaced individuals and families, some form of case management should be implemented. Case management has evolved in the social services professions to ensure quality care and to help clients negotiate a complex and often fragmented service and educational system. Case managers serve many diverse roles, such as service broker, counselor, ombudsman, and advocate; the overall objectives are to identify an individual's or a family's diverse needs, develop a coordinated service plan, link them to services, and provide adequate follow-up. Case managers thus facilitate comprehensive, coordinated, and continuous care which is often lacking for low-income persons in general and for those who are both poor and residentially unstable in particular. Ideally, caseloads would be small enough to ensure that sufficient attention can be given to linking families and youths to appropriate services. Intensive case management, where the family–case manager ratio is relatively low (e.g., 10:1), will better ensure a sufficient amount of family contacts and hours of service monthly.

Helping Children by Supporting Parents

As children look to their caregivers to help interpret what is taking place in the world around them, parents who lack adequate resources or who are beset by multiple difficulties themselves may not be of much assistance. Researchers have shown that young children can cope with major upheavals in their lives, including war and natural disasters, if they retain strong positive attachments to their families, and if parents are able to convey a sense of stability, coherence, and competence to their children.[12] When a parent is severely stressed and emotionally depleted, she or he will have little energy left to respond to the demands of a young child. Thus, understanding the pressures and problems faced by a mother and helping her to cope better, can be a critical first step in addressing the needs of an individual child. Here again, case management that includes linkage to services and benefits that address a family's basic needs may be critical to helping a family and enabling parent(s) to focus on their children's physical and mental health issues.

Creating Order, Stability, and Control in a Child's Life

Displaced children have been forced to cope with instability, impermanence, and often, lack of safety. Sometimes, they have been extremely stressed by unmanageable and catastrophic changes in their environment. The school and classroom environments represent an important social sphere in which displaced children have the opportunity to establish or reestablish a sense of belonging and permanence in their lives. Classrooms can be structured to ensure stability and constancy as much as possible. This can be accomplished by designing a program schedule that ensures the continuity of teachers and classmates, encourages friendships, and promotes a sense of safety. If possible, having the same teacher or at least the same classmates throughout the day will help children who need to establish a sense of stability and permanence. Of course, the process of moving displaces some children from the schools they were attending and requires that they be enrolled in a new school once they have relocated.

Some youths, especially older children and adolescents, may need emotional support and counseling to help them process and cope with events in their lives. To provide this, it is necessary to appreciate their experiences, perceptions, and strengths. While change and exposure to new stimuli and experiences can help children learn and develop skills, the problem for most youths who have been displaced is that change can be too rapid, is often uncontrollable, and can lead to undesirable consequences. Like most of us, children—when they experience having little control over their environments and destinies—may feel depressed an
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destinies—may feel depressed and anxious. In addition to the problems engendered by residential instability, the broader circumstances of poverty which all homeless, migrant and some immigrant children experience, expose many of them to stressors such as family and community violence and to squalid living environments. Youths may need assistance in understanding and processing their experiences, in learning to recognize and address the feelings that are engendered by adverse events in their lives, in being treated for the effects of trauma when necessary, and in evolving adaptive coping strategies that effectively marshal their inner and external resources to deal with stress.

Paradoxically, some low-income children who have experienced intermittent residential instability throughout their lives may be less affected by yet another residential move than the youths who have grown accustomed to living in one place and suddenly find themselves without a home or in unfamiliar surroundings. In other words, the type of youth who may be especially vulnerable to the adverse effects of sudden displacement is the one who has *not* experienced housing instability in the past. Such children can stand to lose the most in terms of leaving familiar surroundings and leaving their close friends if they are forced to move away.

Expanding Funding of Programs for Displaced Children

No amount of case management will solve the problem of inadequate services or lack of services; thus, adequate federal, state, and local funding of critical services is essential. For instance, treatment programs for mental health and substance abuse problems are underfunded and insufficient to meet the demands of both children and adults in most communities. Funds for special language programs, child care, or transportation are sometimes unavailable. Without these services, displaced children will be at increased risk of physical and mental health problems as well as at increased risk for school failure and drop-out. In short, a comprehensive and coordinated service system is needed, but is often lacking.

Various federal programs exist that provide private and public agencies as well as schools with funds for services specifically benefiting immigrant, migrant, and homeless children and adolescents. Most of these programs are administered either by the U.S. Department of Education (e.g., the Office of Migrant Education) or the U.S. Department of Health and Human Services (e.g., Refugee Mental Health Program within the National Institute of Mental Health; Runaway and Homeless Youth Program within the Administration for Children and Families). These programs provide important and sometimes vital services and educational programs for displaced youths.

While the needs of displaced children require an immediate response, preventive efforts are also critical. Programs that identify small problems and intervene early before they become more severe (i.e., secondary prevention) are part of the solution. Interventions that preclude the development of a problem altogether (i.e., primary prevention) are important to develop as well. Ultimately, a prevention-oriented service delivery system is more humane and cost-effective than a system that only waits for a disorder to appear before services are provided.

Supporting and Promoting Sensible and Compassionate Social Policies

Many of the adverse events that displaced children and youth have experienced should simply not have occurred in the first place. While services to ameliorate the adverse effects of poverty and acute stressors are needed, we, as a society, need to create the social, environmental, and family conditions that will allow children to grow up in a safe and prosperous setting.

Of the major social programs in this country that greatly affect the millions of poor and adolescents, the most prominent two are cash assistance to low-income parents of dependent children (i.e., "welfare") and medical care/health insurance in the form of Medicaid. In August 1996, the U.S. Congress passed The Personal Responsibility and Work Opportunity Act which instituted widespread reform and cut-backs in the current system of benefits and entitlements affecting this country's low-income families and legal immigrants. Federal aid to the poor, which in the past had largely been delivered through Aid to Families with Dependent Children (AFDC), was transformed into a block-grant program which is now administered by individual states. This effectively shifted much of the responsibility for the poor from the federal level to state and local governments and enabled Congress to freeze or cut federal spending for low-income families. The welfare reform legislation gave the states no minimum standards for cash assistance and wide discretionary power in terms of eligibility requirements and how federal block-grant funds could be spent.

A major concern with this large change in policy is that states now have a vested interest to "race to the bottom," that is, to provide as few services and to be as inhospitable as possible to those in need of public assistance, for to be relatively generous and compassionate means to risk attracting the poor from neighboring states.[4] While these changes will probably have little effect on those migrant farmworker families who have never been eligible for cash assistance in the first place (because they are not legal residents), legal immigrants in general are no longer eligible for many of the benefits that they could formerly receive. As of 1997, low-income families are beginning to experience the effects of welfare reform, including cuts in monthly cash assistance and the institution of work requirements in return for aid. These cut-backs and stricter policies are likely to further increase the risk of homelessness for many low-income families who were already struggling to remain stably housed.[4,5]

Unfortunately, some lawmakers and members of the public at large seem to have lost sight of the fact that cash assistance to needy families has been based, most fundamentally, on society's concern with the protection and well-being of dependent children. Efforts to promote "responsibility" among single parents through "get tough" welfare reform policies, risk harming the health, nutrition, and emotional well-being of millions of children and adolescents now living in poverty. Health care and service providers who work with poor and displaced youth will need to be more concerned than ever about the availability of public financial support for the programs they run and may need to educate policymakers and voters about the benefits of these services.

In the case of homeless families, our society may be inclined to want to view them (and homeless single adults) as a discrete and limited group because then only a modest expenditure of resources would be needed to address their needs. Unfortunately, empirical evidence does not support this; instead, the condition of homelessness for families with children appears to be more the extreme on a continuum of poverty and residential instability ("the tip of the iceberg") as opposed to a status bearing few commonalities to the plight of poor families more generally. Furthermore, as recent research attests, being poor and housed (but never homeless) cannot be equated with being residentially stable.

In the author's opinion, many of the issues that have been discussed in this chapter pertain to persons and families living in poverty. Health care and service providers should be concerned—not only for the well-being of homeless children (and adults)—but for persons of low-income more generally, as being poor but never homeless is no safe harbor from housing instability, exposure to violence in its many manifestations, and other major life stressors. Similarly, the needs of other displaced children and families should be recognized and addressed. Disassembling the social safety net for legal immigrants, refugees, and the litt
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immigrants, refugees, and the little that now exists for migrant farmworkers can help reduce the federal budget deficit, but at what ultimate human cost? The better we, as a society, can address and resolve the broader economic and social problems that emanate from conditions of poverty, the more we can meaningfully improve the health and well-being of displaced families and youth. Only then can our nation live up to its noble heritage as a sanctuary for the displaced of the world.

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