Health Needs of Homeless Children and Families

Committee on Community Health Services

ABSTRACT. The intent of this statement is to substantiate the existence of homelessness in virtually every community, illustrate the pervasive health and psychosocial problems facing the growing population of children who are homeless, and encourage practitioners to include homeless children in their health care delivery practices, social services, and advocacy efforts. The recommendations will guide practitioners in taking actions to diminish the severe negative impact that living in temporary shelters has on the health and well-being of developing children. In this statement the American Academy of Pediatrics reaffirms its stance that homeless children need permanent dwellings in order to thrive.

An increasing number of children and families in virtually all communities in the United States are either homeless or living in tenuous situations that put them at a profoundly high risk of losing their homes, a most basic human necessity.

Families with children are the fastest growing subgroup of the homeless population nationally and represent more than half of the homeless population in many cities. Lack of a permanent dwelling deprives children of one of the most basic necessities for proper growth and development and poses unique risks for homeless children that compromise their health status. Pediatricians are encouraged to be aware of this growing population of children and include them in their health care delivery practices, social services, and advocacy efforts.

BACKGROUND

The term homeless, as defined by the Department of Housing and Urban Development (HUD), includes those who are homeless, i.e., living on the streets or in shelters, and those who are at risk of being homeless. Included in the latter group are those who find themselves in: 1) precarious arrangements attempting to stay in conventional housing, including the increasing number of children living in poverty or in single-parent families, those who are recent immigrants, and those caught in the complicated web of urban decay and conflicting housing and social policies; 2) the process of termination of a stay in an institutional setting; or 3) situations in which they have insufficient prospects or resources.

Each year an estimated 2.5 to 3 million people lack access to a conventional dwelling or residence, and it is estimated that families with children account for up to 43% of the homeless population. Although there is disagreement concerning the exact number of homeless persons, there is consensus that the numbers are large and continuing to grow. In 1994, requests for emergency shelter increased in 30 major cities by an average of 13%, with 9 of 10 of the cities reporting an increase in requests from families. In 87% of those cities, emergency shelters may have to turn away homeless families with children because of limited resources; 73% of the surveyed cities identified homeless families with children as a group for whom shelter and other services were particularly lacking. There were 1900 shelters counted by HUD in 1984; by 1988, there were 5400 shelters. In 1984, 21% of the homeless requiring emergency shelter were families; that percentage increased to 40% in 1988.

Several societal problems contribute to the increasing rate of homelessness among American families, including lack of affordable housing; decreases in availability of rent subsidies; unemployment, especially among those who have held only marginal jobs; personal crises such as divorce and domestic violence; cutbacks in public welfare programs; substance abuse; deinstitutionalization of the mentally ill; and increasing rates of poverty. Although traditionally the homeless population has predominantly been made up of single adults, today families with children account for up to 43% of the homeless population. In some cities, children account for an average of 60% of homeless family members (e.g., San Antonio, TX; St Louis, MO; Minneapolis, MN; and Kansas City, MO), and in New York, NY, and Trenton, NJ, children are estimated to account for as much as 75% of homeless family members. Of the 30 cities surveyed by the US Conference of Mayors, 27 (90%) reported increases of families with children among the homeless population.

Most homeless children are temporarily housed with their families in shelters and missions operated by religious organizations and public agencies. However, in many cities, public agencies contract with private hotels to provide temporary housing to homeless people. A 1990 study of public shelter use in New York, NY, and Philadelphia, PA, showed a disproportionate impact of homelessness on minorities, especially black families. In both cities about 7% of black children had spent time in a public shelter between 1990 and 1992, in contrast to less than 1% of white children.

Whereas maternal education is a potent predictor of children's poverty in the United States, and home-
HEALTH AND OTHER PROBLEMS ASSOCIATED WITH HOMELESSNESS

Common acute problems in homeless children include upper respiratory tract infections, scabies, lice, tooth decay, ear infections, skin infections, diaper rash, and conjunctivitis. In addition, the incidence of trauma-related injuries, developmental delays, and chronic disease, e.g., sinusitis, anemia, asthma, bowel dysfunction, eczema, visual deficits, and neurologic deficits is notably higher for homeless children than for others.

In a Los Angeles study, it was found that homeless families were more likely to use emergency services for preventive and sick care than were domiciled poor families. Moreover, access to care is a formidable barrier for such families. It is estimated that 30% to 50% of the nation’s 220,000 to 280,000 school-age homeless children do not attend school. Of those in school, sporadic attendance, grade repetition, and below-average performance (designated as having special needs) are common. The rate of developmental problems is two to three times higher in homeless children than in poor children who are not homeless.

Although iron deficiency anemia is found to be two to three times more common in homeless children than in children who are not homeless, the most prevalent nutritional problem appears to be obesity. Since refrigeration storage and cooking facilities are not available, fast-food restaurants and convenience stores are often the most common sources for food for homeless individuals. As a result, their diets often contain an excessive amount of carbohydrates and fats. Hunger is another common problem, with a significant number of homeless children lacking sufficient caloric intake.

Access to health care, particularly preventive health care, is impaired for homeless families. Health becomes a lower priority as parents struggle to meet the family’s daily demands for food and shelter. Families are so often relocating that there is no opportunity to develop an ongoing relationship with a health care provider. When there is an acute problem, hospital emergency rooms, visiting public health nurses, and clinics usually are relied on to provide episodic and fragmented care. Continuity of care is nonexistent and care is rarely comprehensive, resulting in high rates of underimmunization and other unmet health needs.

Living in a shelter not only separates families from their usual sources of support in the community but also imposes severe hardships in carrying out daily sustenance activities. Despite the fact that families with children are the fastest growing segment of the homeless population, 53% of shelters in 30 major surveyed cities often cannot house families together. Rarely are homeless families housed in their originating neighborhoods. Schooling for children is therefore interrupted and often the family is separated from social networks and institutional support systems, such as day care and health care. Within temporary living situations, refrigeration storage, cooking facilities, opportunities for privacy, bathrooms, quiet quarters for reading and studying, storage space, telephones, and appropriate bedding may be unavailable. Sanitation, safety, and stability are often lacking. These impediments create unique health and social problems for homeless children.

Because young people living on the street often resort to “survival” sex (exchanging sexual activity for shelter, food, protection, or drugs), they are at significant risk of HIV infection, as well as other sexually transmitted diseases. Moreover, the incidence of pregnancy, alcohol and drug abuse, mental illness, and poor nutrition in this population is very high.

RECOMMENDATIONS

The American Academy of Pediatrics recognizes the severe negative impact that living in temporary shelters can have on the health and well-being of a developing child. The Academy recommends the following actions:

1. Pediatricians should be aware that homelessness is a pervasive societal problem and that children need permanent dwellings. They should be knowledgeable about the existence of homelessness in their own communities and are encouraged to become involved in local relief and advocacy programs. Pediatricians need to be supportive of collaborative efforts on behalf of homeless children.

2. Pediatricians should be involved in the development of national guidelines regarding health and safety standards for temporary residences that house children and families that can be distributed to all states, local governments, and agencies involved with issues of homelessness.

3. Pediatricians should educate social service agencies about the medical problems for which homeless children are at risk, and they should work with these agencies to develop comprehensive systems of care and to strive to ensure that every homeless child and family has a medical home.

4. Comprehensive and coordinated services should be integral to all efforts on behalf of homeless children and families; this is especially critical for children with chronic illnesses and mental health problems.
5. Pediatricians should encourage federal, state, and local governments to support and provide adequate funding for comprehensive homeless prevention programs (including mental health and dental care) to ensure a continuum of care for homeless children and their families.

6. Pediatricians should encourage federal, state, and local governments to appropriate sufficient monies to fund primary health care grants for the provision of comprehensive health care for all homeless people, with a focus on continuity of preventive care.

7. Pediatricians should encourage Congress to fund additional mental health grants for community-based organizations that serve homeless children.

8. As welfare and health care reform move forward, pediatricians should ensure that monitoring systems be devised that will track potentially untoward, as well as positive, effects of these reform initiatives.

Committee on Community Health Services, 1995 to 1996
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