



POLICY STATEMENT

Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity

abstract

FREE

Child health and housing security are closely intertwined, and children without homes are more likely to suffer from chronic disease, hunger, and malnutrition than are children with homes. Homeless children and youth often have significant psychosocial development issues, and their education is frequently interrupted. Given the overall effects that homelessness can have on a child's health and potential, it is important for pediatricians to recognize the factors that lead to homelessness, understand the ways that homelessness and its causes can lead to poor health outcomes, and when possible, help children and families mitigate some of the effects of homelessness. Through practice change, partnership with community resources, awareness, and advocacy, pediatricians can help optimize the health and well-being of children affected by homelessness. *Pediatrics* 2013;131:1206–1210

INTRODUCTION

An estimated 1.6 million children, or nearly 1 in 45 American children, experienced homelessness in 2010.¹ Although a national economic downturn and an increase in housing foreclosures contribute to family homelessness, additional adversity and risk factors often contribute to this complex problem. Children affected by homelessness may experience a variety of challenges to their health because of difficulty accessing health care, inadequate nutrition, education interruptions, trauma, and family dynamics. By recognizing these challenges, pediatricians can help improve the care of these children in practices and communities.

DEFINING AND MEASURING HOMELESSNESS

The US Department of Education defines a homeless individual as “(A) an individual who lacks a fixed, regular, and adequate nighttime residence . . . and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as

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KEY WORDS

homelessness, housing insecurity, children, adolescents, pediatrician, health, poverty, toxic stress

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www.pediatrics.org/cgi/doi/10.1542/peds.2013-0645

doi:10.1542/peds.2013-0645

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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a regular sleeping accommodation for human beings ...; (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii)."²

Measuring the homeless population is difficult, and there are no definitive counts of homeless persons in the United States. The US Census Bureau does not currently attempt to estimate the total homeless population; however, the US Department of Housing and Urban Development collects data on shelter usage and makes point-in-time estimates of homelessness. The 2011 Annual Homeless Assessment Report to Congress estimates that approximately 1.5 million homeless people used an emergency shelter or transitional housing during 2010–2011, and on a single night in January 2011, 636 017 people were homeless. From 2007 to 2011, the number of children in shelters increased by 1.9% and families with children comprised 35.8% of the total sheltered population in 2011. In addition, from 2007 to 2011, the number of families that moved from stable housing arrangements to the shelter system increased by 38.5%.³ These estimates did not include homeless persons who were unsheltered or living temporarily with other families. The incidence of homelessness in the United States in a given year is thought to be much higher.

RISK FACTORS

Although all populations experience homelessness, some populations are disproportionately affected. Major risk factors for homelessness among parents include unemployment, substance abuse, mental illness, previous

military service, and a previous history of domestic violence or physical or sexual abuse.⁴ An analysis of homelessness in a national cohort of US adolescents revealed that poor family relationship quality, school adjustment problems, and victimization during adolescence were each independent predictors of homelessness in adulthood.⁵ Among homeless youth, a sexual orientation other than heterosexual and a history of foster care placement and school expulsion are all potential predictors of homelessness as well.^{6,7} Racial and ethnic minorities are significantly overrepresented in the sheltered homeless population. In 2011, 71.9% of sheltered families were racial minorities.³ Recognition of these risk factors is an important part of understanding and supporting homeless children and families.

Homeless children and families often experience a number of negative exposures and life events that create a cumulative risk for poor health outcomes. For example, children who live in poverty, are exposed to violence, or experience food insecurity also have poor health care service attainment, increased emergency department utilization, and overall poor health outcomes, independent of housing status.^{8,9} However, these risks can be additionally compounded by homelessness. A series of studies on adverse childhood experiences has shown that multiple toxic stressors that begin in childhood can have long-term adverse effects on a child's neurobiological make-up, cognitive ability, mental health, and ability to manage stressors as an adult.^{10,11} It is therefore important to understand and address these stressors both separately and in totality.

HEALTH EFFECTS OF HOMELESSNESS

Homelessness and housing insecurity negatively impact child health and

development in many ways. Homeless children have shown higher rates of acute and chronic health problems than low-income children with homes. Cross-sectional surveys conducted in the 1990s reveal increased rates of multiple infectious, respiratory, gastrointestinal, and dermatologic diseases and otitis media, diarrhea, bronchitis, scabies, lice, and dental caries.^{12,13} Both the prevalence and severity of asthma are markedly increased among homeless children, and homeless children suffer from higher rates of accidents and injuries than low-income children with homes.^{12,14} In an evaluation completed in a school-based health center, homeless children were 2.5 times more likely to have health problems and 3 times more likely to have severe health problems than children with homes.¹⁵ Children without a stable home are more likely to skip meals, worry about the availability of food, and consume foods with low nutritional quality and high fat content.^{16,17} As a result, they suffer from high rates of malnutrition, stunting, and obesity.^{8,18} Homeless children are at an increased risk of abuse, exposure to violence, and psychological trauma. Emotional distress, developmental delays, and decreased academic achievement are all more common in this population.^{19–21} Speech and language deficits lead to significantly decreased literacy rates in school-aged children.^{19,21} Homeless children may experience frequent moves that interrupt their education and impact school performance. In a study in elementary school students, homeless children scored lower on math and reading achievement tests than low-income students living in homes.²¹ A study in homeless adolescents who received crisis services at a homeless shelter revealed just 34% of those students attained a high school diploma or general equivalency diploma (GED) by 18 years of age.²²

Unaccompanied homeless and runaway youth differ from homeless children in families. They are more often separated from their families and more frequently exposed to violence and exploitation. Unaccompanied homeless youth are more likely to engage in high-risk sexual behaviors, have teenage pregnancies, engage in drug use, experience mood and anxiety disorders, and face violence than youth with homes.^{23,24}

ACCESS TO HOUSING

Homeless families face many barriers to accessing appropriate housing. In the 2012 Hunger and Homelessness Survey conducted by the US Conference of Mayors, 64% of the surveyed cities reported that shelters turn away families with children experiencing homelessness because of lack of available beds.²⁵ Access to shelters is challenging in urban settings and rural communities. Although homeless families are more likely to be sheltered than individuals, age and gender restrictions in many shelters often lead to family separations. Homeless mothers are also more likely than housed mothers to have their children separated from them by the child welfare system.²⁶

ACCESS TO HEALTH CARE

Children and families in unstable housing often receive fragmented health care and rely on the emergency department as a primary source of care.²⁷ Some of the barriers that prevent homeless children and families from accessing optimal care include the following:

- difficulty obtaining affordable, accessible, and coordinated health care services;
- frequent and unpredictable changes in living circumstances that prevent timely presentation for care, follow-up,

and communications with health care providers;

- inadequate access to storage places for medication and medical supplies; and
- potential exposure to violence or fear of violence that limits freedom.

Despite these barriers, pediatricians can support homeless children. By partnering with community resources and making changes in practice, pediatricians have the opportunity to help families establish a stable source of quality health care, improve family dynamics, and obtain housing and needed services. Addressing these barriers has been shown to have a positive effect on the health outcomes of those who have experienced homelessness.^{21,22,28,29}

RECOMMENDATIONS

The following recommendations address how pediatricians can help improve the health of homeless children through practice strategies.

1. Pediatricians should help homeless children increase access to health care services by promoting and, when possible, facilitating Medicaid enrollment to eligible children and families.
2. Pediatricians should familiarize themselves with best practices for care of homeless populations and the management of chronic diseases in homeless populations.
3. Pediatricians should optimize acute care visits to best resolve patient concerns and provide comprehensive care when possible. For example, pediatricians can update immunizations if a patient is significantly behind rather than having him or her schedule a separate appointment.
4. Pediatricians should seek to identify the issues of homelessness and housing insecurity in their patient

populations. Pediatricians can use methods such as routine screening on intake and making note of frequent address changes or a history of scattered care provision.

5. Pediatricians should seek to identify underlying causes of homelessness in specific families and help facilitate connection to appropriate resources. This may include asking sensitive questions about unemployment, intimate partner violence, substance abuse, and sexual and gender identity issues. Supporting families to address these difficult issues in addition to their housing needs is critical to improving child health and development.
6. Pediatricians should partner with families to develop care plans that acknowledge barriers posed by homelessness. This can involve a variety of innovations, such as making a communications plan that takes into consideration patient access to telephone and mail services, assisting with transportation through vouchers, offering more flexible office visit scheduling, and prescribing the most affordable treatments available. Pediatricians can also learn about the availability of mobile health services in communities to facilitate care that is convenient for homeless children and families.
7. Pediatricians should become familiar with government and community-based services that assist families with unmet social and economic needs. These include such programs as Temporary Assistance for Needy Families (TANF), Special Nutrition Assistance for Nutrition (SNAP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Medical-legal partnerships and local departments of health

and human services are also helpful resources.

8. Pediatricians should support and assist in the development of shelter-based care, including partnering with mental health, dental, and other health programs when possible.
9. Pediatricians can learn about the causes and prevalence of homelessness in their communities. The State Report Card on Child Homelessness (www.homelesschildrenameric.org) issued by the National Coalition on Family Homelessness (www.familyhomelessness.org) is one of many good resources.

Pediatricians and the American Academy of Pediatrics can advocate for the needs of homeless children and families in the following ways:

1. Support local, state, and federal policies that lead to increased availability of low-income, transitional, and permanent housing.
2. Support policies and programs, such as the "Homelessness Prevention and Rapid Re-Housing Program," that aim to quickly place families in stable, permanent housing rather than a continuum of emergency and temporary housing. Permanent housing has been demonstrated to be more cost-effective and more stabilizing for families, who can be exposed to significant trauma while experiencing homelessness.
3. Support violence protection policies such as the Family Violence Prevention and Services Act and Child Abuse Prevention and Treatment Act, which provide substantial funding for shelter in addition to social services and legal aid for victims of family violence.
4. Support creative approaches to providing stable health insurance to homeless and unemployed populations, and promote strategies that enable homeless families to enroll and maintain health coverage without requiring a permanent address.
5. Support policies to eliminate any barriers for children without addresses to enroll in school.
6. Support local, state, and federal policies that provide child care vouchers for homeless families.
7. Support reformation of the foster care system to allow longer time in foster care, increased resources for maintaining families when children are aging out of foster care, and greater resources toward training/supporting foster children as they transition into independent adulthood.

Homelessness is a complex issue that presents a number of challenges for children and families. Pediatricians can support all children who are impacted, by implementing practice-level strategies and engaging in advocacy to promote their health and well-being.

LEAD AUTHOR

Melissa A. Briggs, MD, MPH

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Pediatrics 2013;131;1206

DOI: 10.1542/peds.2013-0645 originally published online May 27, 2013;

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COUNCIL ON COMMUNITY PEDIATRICS

Pediatrics 2013;131;1206

DOI: 10.1542/peds.2013-0645 originally published online May 27, 2013;

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