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Homelessness

TUTOR NOTES

Case Materials:

- Tutor's Guide
- Case
- Slide Set
- References
- Evaluation Tools
  - Tutor's evaluation/prior to presentation
  - Tutor's evaluation/post presentation
  - Student evaluations

Teaching Objectives

1)To describe the population of homeless children in terms of demographics, living conditions, circumstances of homelessness or rootlessness, social correlates.

2)To understand barriers homeless families face in accessing needed services.

3)To understand the medical and developmental consequences of homelessness.

4)To describe innovative health care delivery systems used for this high-risk population.

Overview of Homeless Case:

Nationwide estimates of the number of homeless persons vary considerably, ranging from 400,000 to 3 million. These numbers are probably underestimates, as they reflect only those families who are using the shelter system. Year to year variability also arises as cities change their eligibility requirements for accessing shelter. However, despite difficulties in counting the actual numbers of homeless persons, there is consensus that the number is large and increasing yearly.

Supported by a grant from *The Maternal and Child Health Bureau*.

Introduction

Families with children are the fastest growing homeless population. In New York City, the incidence of family homelessness increased by 32% between 1988 and 1992 (3). In several studies in multiple cities (1, 3-7), homeless families with children represent up to 35% of all homeless persons. Approximately 3% were unaccompanied minors. Most homeless families were headed by a single female parent. More than half the homeless children were less than five years old and about 70% were minorities. Over 50% of mothers reported a history of significant physical or mental illness or substance abuse. In some series, over 80% of mothers report a history of domestic violence or sexual abuse.

Many families have been rootless, living "doubled up" with a series of friends and family for several months before becoming "homeless". On entering the shelter system, families have been moved 3 times more compared to housed poor children (5). Once in the system, families may be housed in group shelters, welfare "motels", or temporary transitional apartments. Most families are placed in shelters far from their original neighborhood, disrupting ties to education and health services as well as to social supports. Lengths of stays vary considerably, but tend to range between 9 and 15 months (5).

Societal changes that have contributed to the rise in homelessness include a rise in the number of children living in poverty, the lack of affordable housing, and a decline in rent subsidies. Other antecedents of homelessness for many families include a history of domestic violence, substance abuse or mental illness.

Guiding questions for discussion

1) How does homelessness affect the health of children?

2) What effect does homelessness have on the behavior and development of children? What services are available to address these needs?

3) What are some of the barriers to effective service delivery to homeless families?

4) How might you design a clinic to help address these problems?

Guiding Questions

1. How does homelessness effect the health of children?

Many of the health problems of homeless children result from significant barriers to accessing primary and preventative care. On entering the shelter system, many families are placed in shelters far from their usual sources of health care, educational services and social services. Daily struggles to obtain basic necessities such as food, money, transportation and permanent shelter force them to prioritize needs. Preventative health care is often a lower priority in their struggles to meet basic needs. Lack of health insurance and transportation may also be barriers to accessing care. Even with health insurance and an identified primary care provider, studies show that homeless children are less likely to receive timely well child care (8). These children used the Emergency Department two to three times as frequently as housed poor children. Other environmental conditions that pose hazards to health include overcrowding, exposure to environmental tobacco smoke, poor facilities for food preparation, and exposure to communicable diseases.

Not surprisingly, homeless children have an overall poorer health status than housed poor children (8,9). Homeless mothers are twice as likely to report their children to be in fair or poor health. Immunization and health screening delays are pervasive in all populations of homeless children, reaching levels of 70 % immunization delay for 2 year old in New York City (6,10). Studies of homeless children also show slightly higher levels of many of same illness affecting all children living in poverty, including otitis media, asthma, anemia, and gastroenteritis (8,9,11). However, in homeless children, these illnesses are more likely to go untreated or to be treated episodically in Emergency departments. In addition to poorly controlled asthma and chronic middle ear disease, homeless children have high rate of other chronic illness.

In the 1998 Worcester Family research Project (8), researchers evaluated the extent to which homelessness as well as other risk factors contributed to the poorer health status of homeless children. After controlling for potential confounding factors between a large group of homeless and housed poor children, homelessness remained an independent predictor of poor health status. Mother's emotional distress was the other independent predictor of acute illness symptoms and higher Emergency department usage.

Nutritional issues are another major area of concern for homeless children. Compared to poor housed children, families of homeless children report significantly more times per month when they have been unable to provide food for their children (11). Although this results in failure to thrive for some homeless children, obesity and specific nutritional deficiencies are the most commonly reported problems. Due to inadequate cooking and refrigeration facilities and lack of local shopping facilities, homeless families frequently eat in fast food and convenience stores. The type of high fat diet provided places homeless children at risk for obesity, hypercholesterolemia, and vitamin and iron deficiency. Estimates of obesity in homeless children range from 12 to 35 % (9, 11). Nineteen percent of homeless children in New York City have iron deficiency (10).

2) What effect does homelessness have on the behavior and development of children? What services are available to address these needs?

Homelessness may have profound effects on the development and behavior of children. As a group, homeless children experience significantly more stressful life events as compared to housed low-income children (4). Family problems such as domestic violence, substance abuse and maternal mental illness place homeless children at higher risk. Up to 40% of homeless children in the Worchester series had undergone care and protection investigation (4). Other family stresses, a sub-optimal living and playing environment, and higher rates of illness all created more challenges to healthy development.

On entry into the shelter system, homeless children have rates of developmental delay similar to housed poor children. However, some studies report that after months of homelessness, children have significantly higher rates of developmental delay and behavior problems. In a Boston study, over half of all homeless children had at least one delay noted on screening with the Denver Developmental Screening Test (12). Many studies report that rates of developmental delay in homeless children are two to three times higher than in housed poor children. Language development is the most commonly reported delay. Not surprisingly, older children have higher rates of school problems, due to developmental issues as well as absenteeism. In one study, nearly one-third of school age homeless children had repeated a grade (11). Seventeen percent reported missing more than 3 weeks of school in the preceding three-month period. Other studies show greater behavioral problems, including higher scores on scales of anxiety, depression and aggression (12).

This finding emphasizes the importance of family-oriented interventions that address the needs of both the children and their mothers (4). Clinicians providing care to homeless children should screen carefully for developmental and behavioral concerns in the children as well as for physical and mental health issues in the mother. As issues are identified, homeless families should be referred promptly to intervention programs including intervention, head start, special needs classes, substance abuse programs and counseling.

Part II

3) What are some of the barriers to effective service delivery to homeless families?

4) How might you design a clinic to help address these problems?

This case illustrates many of the barriers to effective service delivery to homeless families. When entering the shelter system, homeless families are often placed far from their original neighborhood, severing ties to community, educational, and health services as well as to their social and family support systems. Once in the shelter system, efforts to establish new ties may be hampered by lack of transportation, insurance and money. Further, the enormous effort required to meet basic needs such as food and searches for new housing may further limit homeless families abilities to access new social, health and educational services. As illustrated in this case, homeless families may need to go through this process several times a year as they move to new shelter sites or temporary transitional housing.

Providing comprehensive primary health care is clearly challenging in this setting. However, in many areas, health care providers have developed innovative approaches to providing continuity and comprehensive health care. In some areas, assistance with transportation helps homeless families continue to receive health care through their primary physician. When this is not possible, other clinicians have moved the site of medical care to the families. For instance, in New York City, Montpelier Medical Center provides health care to homeless families using an extensive system of mobiles medical vans (13,14). Clinicians on these vans provide primary as well as episodic care. Other areas have established clinic sites at the homeless shelter or welfare motel (3). Centralized and/or computerized medical records and case managers allow clinicians to follow families as they move through the system (15).

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Part 1

David is a 6-year old boy who, for the past month, has been living in a hotel for homeless families with his 29-year old mother, Sara, and his three-month old twin sisters. It is the eighth place that David has moved to in the last twelve months. Up to a year ago, he and his mother had been living in an apartment with his father, but she left with David to escape battering. Since that time, throughout a pregnancy and the birth of the twins, the family has lived in several temporary shelters as well as briefly with friends.

The hotel is located on a busy highway 25 miles from the city where David was born. There are no kitchen facilities except for a microwave and small refrigerator shared by the 30 others in the hotel. David and his family have one room and a bathroom to themselves. The nearest local community with restaurants and stores is an affluent suburb a 20-minute bus ride away. Their primary care clinic is now over three bus trips away, which is an hour's ride into the city,

David's mother decided to bring her son to your office a month ago, asking that you complete a physical report so that David could enroll in the local school. You are a pediatrician and your practice is not far from the hotel.

The history reveals that David has been generally healthy but, because of the frequent moves over the last two years, has received only intermittent care from a number of different providers. His last health supervision visit was over two years ago. His mother did not have copies of his immunizations or medical records.

You perform a physical exam, which is normal except for a weight at the fifth percentile and height at the twenty-fifth. David's mother signed several releases so that you could obtain his records. You planted a PPD, screened for anemia, and asked David's mother to keep a diet history and return for follow-up in one month.

Two months later David is back for his follow-up visit. His past records have arrived and show that he is in need of several immunizations. You give him a DPT, polio, and MMR. You also note that he has lost weight over the last two months and is now less that the fifth percentile. After reviewing his diet history, you realize that his mother has not been giving him breakfast or lunch because they were provided at school. She tells you she doesn't have enough money for all their needs and asks for your help in getting services.

Supported by a grant from *The Maternal and Child Health Bureau*.

Part 2

You next see David three months later. You note that David's weight has improved. His mother tells you that the social worker you had referred at the last visit has helped them apply for food stamps and welfare. Even the school bus driver pitched in, bringing bagels for David for the morning ride.

At this visit, David's mother is concerned about his troubles at school. His teachers, for example, have moved him from first grade back into kindergarten. You do a Denver developmental screening (DDST) which shows that David has good gross motor skills but may have weaknesses in other areas. He can copy squares and triangles but is unable to draw a figure of a person. He knows some but not all of his colors. He is just beginning to learn letters. He can count to 10 but not beyond. On assessment of language using the DDST, David also appears to be slightly delayed.

After discussing your concerns with David's teacher, the school performs an evaluation that confirms your suspicions of a significant developmental delay. Arrangements are made for David to receive special educational services.

Approximately one month later, you are upset when Sara informs you that David was suspended from school. You call his teacher, and she tells you he saw a plastic knife in her desk drawer, removed it and started running around the class yelling, "Don't you hurt me". The teachers and parents of students in the class were very concerned about the possibility of future violent behavior. David was held out of school temporarily while the school administration and parents planned to meet to choose an appropriate course.

You attend the meeting to discuss David's issues. The conclusion of the group is that David is not likely to truly become violent and he is allowed to return to the classroom. However, the incident has pushed various issues to the forefront and David's teachers and principal arrange for special educational, behavior counseling and nutritional services for him. Over the next several months, David's developmental and behavioral problems improve and he gains weight. You are pleased with his progress in all areas and with the members of the school community for rallying to provide necessary services.

In December, the principal calls the your clinic near the hotel to say that David has not been in school for a week and he wonders why. When you check the list of hotel residents, you find that department of welfare has moved David and his family to temporary housing two hours away.

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Module Evaluation

For presenters to fill out before teaching the class

A. I consider myself

1.A nationally known expert on this topic	**2**. A locally known expert on this topic	**3**. Very knowledgeable on this topic	**4**. to have learned about this topic to teach it	**5**. **Not sure**

B. I spent approximately _____ minutes preparing for teaching this topic.

C. Of the time I spent preparing to teach this topic, I used material provided to me as part of the Serving the Underserved Curriculum

1. 100% of the time
2. 75-99%of the time
3. 50-74% of the time
4. 25-49% of the time
5. <25% of the time

D. How appropriate were the educational objectives?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

E. How appropriate were the tutor notes?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

F. How appropriate were the references?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

G. If your answer to any of the above questions (except A) was 3, 4 or 5, please comment.

Please feel free to write further comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.

*This material was adapted from that created by Janet Hafler, Ed.D.

Module Evaluation

(For Presenters to use after the teaching session)

Presenter:_____

Your responses will help us refine and develop this case.

A. Please rate the overall quality of this material as a stimulus for learning.

1. Excellent **2. Good** **3. Average** **4. Poor** **5. Not sure**

B. Please rate the classes participation in the learning

1. Excellent **2. Good** **3. Average** **4. Poor** **5. Not sure**

C. How comfortable were you with case based teaching

		Not at All				Very Much
1.	**Prior to this teaching session**	**1**	**2**	**3**	**4**	**5**
2.	**During the teaching session**	**1**	**2**	**3**	**4**	**5**
3.	**After the teaching session**	**1**	**2**	**3**	**4**	**5**

D. Please list how long you spent on this topic, and how the time was devided

Total Time _____ **minutes**

Time spent on case discussion _____ **minutes**

Please describe how you spent the rest of the time

E. Please Rate each of the following

		Poor				Excellent
1.	**The Educational Objectives**	**1**	**2**	**3**	**4**	**5**
2.	**The Case Vignette**	**1**	**2**	**3**	**4**	**5**
3.	**The Tutor Guide, including guiding questions**	**1**	**2**	**3**	**4**	**5**
4.	**Reference List**	**1**	**2**	**3**	**4**	**5**
5.	**Handouts**	**1**	**2**	**3**	**4**	**5**
6.	**Audiovisual Materials**	**1**	**2**	**3**	**4**	**5**

If you answered 1-3 on any of the above, please comment further

F What were the cases strengths

1.
2.
3.

G What were the cases weaknesses

1.
2.
3.

H What is the single most important thing that you learned from the case discussion?

I Case Evaluations

1. Do you think facts or data should be added? **1. Yes** **2. No**
If **yes**, what should be added?

2 Do you think facts or data should be deleted? **1. Yes** **2. No**
If **yes**, what should be deleted?

J. Tutor notes evaluation

1. Did you use the **tutor notes**? **1. Yes** **2. No**
If **no**, why not?

2. What were the **tutor notes** strengths?
1.
2.
3.

3. What were the **tutor notes** weaknesses?
1.
2.
3.

4. How would you suggest improving the t**utor notes**?

5. Do you think facts or data should be added to the **tutor notes**? **1. Yes** **2. No**
If **yes**, what should be added?

6. Do you think facts or data should be deleted from the tutor notes? **1. Yes** **2. No**
If **yes**, what should be deleted?

K Slide Evaluation

1. Did you use any of the **slides**? **1. Yes** **2. No**
If yes, which ones

2. How would you suggest improving the **slides**?

3. Do you think more slides would be useful? **1. Yes** **2. No**
If **yes**, what should be added?

4. Do you think there are slides that will never be useful? **1. Yes** **2. No**
If **yes**, what should be deleted?

L Did you use any other materials **1. Yes** **2. No**
If **yes**, what other materials?

If supplied by the Serving the Underserved Project, how would you improve the material

M. What did you as a teacher learn about this topic?

#1
#2
#3

Please feel free to write any further comments on the back of this form

Thank you for taking the time to fill out this evaluation.

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Module Evaluation

Presenter:_____

Your responses will help us refine and develop this educational material. The person completing this form is:

PGY1 PGY2 PGY3 Fellow Faculty Other_____

A. What is the single most important thing you learned from the case discussion today.

B. Please rate the overall quality of this case as a stimulus for learning.
1. Excellent **2. Good** **3. Average** **4. Fair** **5. Poor**

C. The facilitator

		Not at All				Very Much
1.	**Encourages student direction of teaching**	**1**	**2**	**3**	**4**	**5**
2.	**Stimulated interest in the subject matter**	**1**	**2**	**3**	**4**	**5**
3.	**Encouraged Group Participation**	**1**	**2**	**3**	**4**	**5**

D. I consider the facilitator

1.A nationally known expert on this topic	**2**. A locally known expert on this topic	**3**. Very knowledgeable on this topic	**4**. a teacher who learned about this topic to teach it	**5**. **Not sure**

E. Please rate each of the following components of the teaching session (N/A for not applicable)

		Poor		Good		Excellent	
1.	**Case Vignette**	**1**	**2**	**3**	**4**	**5**	**N/A**
2.	**Case Based/Learner Centered Format**	**1**	**2**	**3**	**4**	**5**	**N/A**
3.	**Handouts/Supplemental Materials**	**1**	**2**	**3**	**4**	**5**	**N/A**
4.	**Teacher/Facilitator**	**1**	**2**	**3**	**4**	**5**	**N/A**

F. Do you think information should be added? **1. Yes** **2. No** **3. Not Sure**
If **yes**, what should be added?

G. Do you think information should be deleted? **1. Yes** **2. No** **3. Not Sure**
If **yes**, what should be deleted?

H. Comments

Please feel free to write any comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.
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