

Effects of Homelessness on Children

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More than 4 walls and a roof, the word “home” evokes many emotions and images. For children, home should be a place of safety and security, a place of love and nurturance, where individuality, self-esteem, and confidence grow. Home is the place where children evolve into their best selves.

Although the data associated with homelessness are complicated by the various involved federal agencies using different definitions, the rate of homelessness among children in the United States must raise universal concern among pediatricians and other stakeholders in the welfare of our children and pose a call to action. A homeless person is reasonably defined as anyone who does not have stable housing and who, therefore, is living on the streets, in a shelter, in a mission or a single-room occupancy unit, or in an abandoned building or vehicle. In 2017, an average of 550,000 people in the United States, of whom 21% were children, were homeless on any given night according to the Department of Housing and Urban Development. By one estimate, 2.5 million American children, half of them younger than 6 years, experience homelessness each year. Among them are “runaways,” youths who left home either of their own volition or because their parents pushed them to leave. For many, irreconcilable conflicts or loss of contact with their families makes it impossible for them to return home. Many are victims of abuse or have spent time in foster care. Although the challenges of identifying these young people often lead to them being lost from the count of the homeless population, some estimates suggest that approximately 500,000 youth experience at least 1 week of undomiciled existence each year.

Children are homeless in every state, in every city, and in every county in the United States. We may not see them on our streets, but families with children are hidden away from sight in shelters, abandoned buildings, crowded in with family members or friends, living in their cars. Families that have experienced long periods without permanent housing face persistent instability, measured by frequent moves and continued flux because of economic hardship, unemployment, physical or mental health problems, addiction disorders, domestic violence, or childhood abuse ... a vicious cycle.

The causes of homelessness for families are myriad, with the most frequently cited reasons including a lack of affordable housing, unemployment, poverty, domestic violence, and the challenges of single parenting. Although childhood poverty rates in America have declined, approximately 25 million children live below federal standards for adequate income levels, with the highest rates found in single-parent homes led by Hispanic and black women: the rate of poverty among single-mother families is 5 times that of families with 2 parents. In addition, disasters such as hurricanes, tornadoes, flooding, and fires all lead to unexpected short-term homelessness that may persist, especially in families already living in tenuous economic conditions.

America's Youngest Outcasts: A Report Card on Child Homelessness. Bassuk EL, DeCandia CJ, Beach CA, Berman F. Waltham, MA: National Center on Family Homelessness, American Institutes for Research; 2014

The Lifelong Effects of Early Childhood Adversity and Toxic Stress. Shonkoff JP, Garner AS. *Pediatrics.* 2012;129(1):e232–e246

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Hidden in Plain Sight: Homeless Students in America's Public Schools. Ingram ES, Bridgeland M, Reed B, Atwell M. July 2016. Available at: <http://www.americaspromise.org/report/hidden-plain-sight>. Accessed July 30, 2018

The Mental and Physical Health of Homeless Youth: A Literature Review. Edidin JP, Ganim Z, Hunter SJ, Karnuk NS. *Child Psychiatry Hum Dev.* 2012;43(3):354–375

For unaccompanied youth, the chief factors underlying their homelessness include personal or family mental illness, substance abuse, and lack of affordable housing. Recently, more youth are made homeless when their families learn they belong to the LGBTQ community and disenfranchise them.

Children without a stable home are at risk for a host of adverse outcomes. Poverty, hunger, exposure to parental depression, or domestic violence may precede the loss of their home and contribute to the adverse outcomes seen in these displaced children. Homeless children are more likely to experience physical and behavioral health problems with less access to medical, mental health, and dental care.

More than a quarter of homeless children report having witnessed violence, and more than half have evidence of anxiety and depression. It is not uncommon for homeless children to be separated from their parents, some being placed in foster care and others left by their parents with relatives or friends. This separation may contribute to anxiety, depression, anger, conduct disorders, posttraumatic stress disorder, and poor school performance.

The ability of homeless children to meet their potential as individuals and contributing members of society is severely compromised. Inadequate shelter, insecurity, lack of services, and barriers to whatever services may be available all exacerbate the hunger and poor nutrition; the psychological, behavioral, and medical problems; and the educational failings and developmental delays that plague homeless children.

Environmental factors contribute to poor health outcomes. With the inadequacy of temporary shelter, homeless children are at increased risk for asthma, lead poisoning, and recurrent infections that can be particularly disabling in the context of poor nutrition, which also plays a role in lagging growth, poor dental hygiene, and educational and developmental delays. Despite the burden of their needs, homeless children generally lack access to consistent health care, and other resources and services vary from state to state and community to community: health insurance, the Supplemental Nutrition Assistance Program (SNAP), the Supplemental Nutrition Program for Women, Infants, and Children (WIC), and housing vouchers are not equally available in all parts of the United States. Compared with children living in stable homes, homeless children are more than twice as likely to have health problems and 3 times more likely to experience severe medical problems. They are more likely to miss meals and to worry about when they next

will eat. Their diets, low in nutritional quality and high in fat content, contribute to high rates of malnutrition, poor linear growth, and obesity.

The unrelenting stresses experienced by the parents of homeless children, most of whom are women on their own, often lead to depression, anxiety, posttraumatic stress disorder, and other disorders that result in ineffective parenting. The effect on the children, particularly young children, can be permanently damaging, leading to changes in brain architecture that affect cognitive skills and learning, as well as emotional self-regulation and social relationships.

Homeless children are more likely than their peers to experience abuse, witness and experience violence, and have emotional trauma. Their transience, with frequent moves that interfere with stable schooling, affects educational achievement, leading to significantly lower rates of literacy. Compared with low-income children in secure homes, homeless children perform more poorly on mathematics and reading achievement tests. Both low self-esteem and the lack of constancy that comes with frequent dislocations contribute to the unlikelihood of making lasting friendships and appropriate social adjustment as the child grows.

Children without a stable home are more than twice as likely as their peers to repeat a school grade, have high rates of absenteeism, be cited for behavioral issues, drop out of school, or be expelled or suspended. Of homeless adolescents who receive crisis services while in a homeless shelter, only approximately one-third attain a high school diploma or general equivalency diploma by 18 years of age.

Homeless youth who are on their own, having run away from home or having been left unaccompanied, differ from homeless children in families. They are more often exposed to violence and exploitation and are more likely to engage in high-risk sexual behaviors and drug use and to suffer from mood and anxiety disorders. Homeless adolescent girls are more likely to become pregnant than girls who reside with their families in stable homes.

Given the wide-ranging negative effects of homelessness on a child's overall health and potential, pediatricians should be prepared to help families mitigate these effects as much as possible. By being aware and integrating that awareness into their practices, by partnering with community-based services, and by actively advocating for families facing homelessness, pediatricians can help enhance the health and well-being of children affected by this major social failure.

To begin with, pediatricians should screen for the social and economic risk factors that lead to homelessness in an effort to intercede before families are displaced. Children known to be in shelters or transient living conditions should be screened for mental health problems with standardized screening questionnaires such as the Screen for Child Anxiety Related Disorders (SCARED); the Ages & Stages Questionnaire: Social-Emotional (ASQ-SE); and the Patient Health Questionnaire (PHQ)-2 and PHQ-9.

Whether in an office setting or an emergency department, pediatricians should take advantage of acute care visits for homeless children to provide needed comprehensive care, for example, to update immunizations while dealing with the acute problem rather than scheduling a separate follow-up appointment.

As pediatricians, we care and advocate for our individual patients, but as citizens, recognizing the social underpinnings of homelessness, we can effect change in our communities through advocacy, political action, and work through various organizations, such as the American Academy of Pediatrics.

Any society is measured by how it cares for its most vulnerable members. To support our most vulnerable children we need programs that strengthen their families: through economic advancement by enhancing education and job skills; with agencies that support single-parent

homes with subsidies for services such as after-school care; with early education available to every child. Social safety net programs (public assistance, WIC, SNAP, housing vouchers, and child care vouchers) enable young single parents to work while their children are in safe, positive environments. As always in pediatrics, prevention is preferable to treatment, and programs that address the social factors leading to homelessness can prevent the multitude of problems created for children who become homeless.

COMMENT: One hundred thousand or more children are homeless on any given night, and 2½ million children over the course of a year. This in “the land of the free,” where, ironically, we call ourselves “the *home* of the brave”! Shame on us. And now, as I’m writing this in June 2018, we are fracturing families, separating children from their refugee parents at our borders—more than 2,000 children during the past 2 weeks, many of them not old enough to understand what is happening to them. What can we say? Shame on us.

Yes, advocacy is fundamental to the role of the pediatrician.

– Henry M. Adam, MD
Associate Editor, *In Brief*

CME Quiz Correction

An error appeared in the print version of the quiz accompanying the August 2018 review “Pediatric Esophageal Disorders: Diagnosis and Treatment of Reflux and Eosinophilic Esophagitis” (Adamiak T, Plati KF. *Pediatr Rev.* 2018; 39(8):392–402; DOI: 10.1542/pir.2017-0266). Question 5, answer option E should read “Two-food elimination diet consisting of animal milk and gluten-containing cereals followed by a step up to 4- or 6-food elimination diet in nonresponders.” The online version of the quiz is correct, and a correction notice has been posted with the online version of the article. The journal regrets the error.

ANSWER KEY FOR OCTOBER 2018 PEDIATRICS IN REVIEW

Overall Approach to Trauma in the Emergency Department: 1. B; 2. C; 3. A; 4. E; 5. D.

Human and Animal Bites: 1. C; 2. C; 3. D; 4. D; 5. D.

Collagen Vascular Diseases: SLE, Dermatomyositis, Scleroderma, and MCTD: 1. A; 2. A; 3. C; 4. D; 5. A.

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