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# The Impact of Homelessness on Children

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*This article reviews and critiques community-based research on the effects of homelessness on children. Homeless children confront serious threats to their ability to succeed and their future well-being. Of particular concern are health problems, hunger, poor nutrition, developmental delays, anxiety, depression, behavioral problems, and educational underachievement. Factors that may mediate the observed outcomes include inadequate shelter conditions, instability in residences and shelters, inadequate services, and barriers to accessing services that are available. Public policy initiatives are needed to meet the needs of homeless children.*

Research on the impact of homelessness on children indicates that homeless children (generally identified as those in emergency shelter facilities with their families) confront serious threats to their well-being. Of particular concern are health problems, hunger and poor nutrition, developmental delays, psychological problems, and educational underachievement. This article examines the problems faced by homeless children in each of these areas. Where possible, we describe the extent to which homeless children are at a disadvantage, relative not only to the population at large but to other poor children. That is, we attempt to understand to what extent problems are associated with homelessness per se and to what extent they are linked with extreme poverty.

A second task of this article is to understand how homelessness leads to the outcomes we document and to identify which conditions in the lives of homeless children lead to particular adverse effects. As Molnar and Rubin (1991) pointed out, homelessness is a composite of many conditions and events, such as poverty, changes in residence, schools, and services, loss of possessions, disruptions in social networks, and exposure to extreme hardship. Effects of homelessness on children may be mediated by any of these ecological conditions and by their effects on parents and the family system. Research on homeless children, however, has not generally examined mediating mechanisms. We focus on mechanisms that can be influenced by social policy, namely, inadequate shelter conditions, instability of shelters and residences, lack of adequate services, and barriers to accessing available services. A final section describes linkages among outcomes and discusses implications for public policy.

## Health Problems

Studies have consistently found that homeless children experience elevated levels of acute and chronic health

problems. Risk for health problems begins before birth. Chavkin, Kristal, Seabron, and Guigli (1987) compared the reproductive experience of 401 homeless women in welfare hotels in New York City with that of 13,249 women in public housing and with all live births in New York City during the same time period. Significantly more of the homeless women (16%, compared with 11% of women in public housing and 7% of all women) had low birth-weight babies. Infant mortality was also extraordinarily high: 25 deaths per 1,000 live births among the homeless women, compared with 17 per 1,000 for housed poor women and 12 per 1,000 for women citywide.

Wright (1987, 1990, 1991) examined the medical records of 1,028 homeless children under 15 years of age who were treated in the Robert Wood Johnson Health Care for the Homeless programs in 16 cities. He compared the occurrence of various diseases and disorders among homeless children with rates reported in the National Ambulatory Medical Care Survey for U.S. ambulatory patients ages 15 and under. All of the disorders studied were more common among homeless children, often occurring at double the rate observed in the general pediatric caseload. The most common disorders among homeless children were upper respiratory infections (42% vs. 22% in the national sample), minor skin ailments (20% vs. 5% in the national sample), ear disorders (18% vs. 12% in the national sample), chronic physical disorders (15% vs. 9% in the national sample), and gastrointestinal disorders (15% vs. 4% in the national sample). Infestational ailments, although less common than other disorders among homeless children (7%), occurred at more than 35 times the rate of those in the national sample. The Health Care for the Homeless and National Ambulatory Medical Care Survey samples differ along several dimensions. Members of the homeless sample are more likely to be poor, members of minority groups, and urban dwellers. Also, both surveys assess prevalence among those who use health services rather than among the general population. Al-

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though one might expect homeless families to wait until problems become serious before seeking treatment (leading to higher prevalence rates for many disorders), differences in utilization patterns are unlikely to account for the high prevalences observed. As Wright (1987) concluded, "Among the many good reasons to do something about homelessness is . . . that homelessness makes people ill; in the extreme case, it is a fatal condition" (p. 80).

Alperstein and Arnstein (1988) and Alperstein, Rappaport, and Flanigan (1988) made several comparisons between the health of homeless children in New York City and that of poor housed children receiving health care there. Using clinic records, they found that 27% of 265 homeless children under the age of 5 who were living in a "welfare" hotel were late in getting necessary immunizations, compared with 8% of 100 poor children attending the same outpatient clinic. Twice as many homeless children (4%) as members of the population of 1,072 children whose blood was tested that year by the clinic (2%), had elevated lead levels in the blood. (The comparison group may have included some homeless children.) Rates of hospital admission among a larger sample of 2,500 homeless children under the age of 18 were almost twice as high as for 6,000 children of the same age living in the same area (11.6 vs. 7.5 per thousand, respectively).

Bernstein, Alperstein, and Fierman (1988) compared the clinic charts of 90 homeless children aged 6 months to 12 years with those of a matched cohort of housed children whose family incomes were below the federal poverty level. Nearly one half (48%) of the homeless children under age 2 were delayed in their immunizations, compared with 16% of the housed children. Fifty percent of the homeless children, compared with 25% of the housed group, had iron deficiencies, which may be related to other unmeasured nutritional deficiencies. Most of these studies are based on families who use health care services, so that differential patterns in the use of services could account for some of the differences in health status.

Other studies that are based on self-reported health status or that lack comparison groups paint a consistent picture. Homeless children's health problems include immunization delays, asthma, ear infections, overall poor health, diarrhea, and anemia (Dehavenon & Benker, 1989; Miller & Lin, 1988; New York City Department of Health, 1986; Paone & Kay, 1988; Rafferty & Rollins, 1989; Redlener, 1989; Roth & Fox, 1988; Wright, 1990, 1991; but not Wood, Valdez, Hayashi, & Shen, 1990a).

Both inadequate emergency shelter conditions and lack of adequate preventive and curative health services are prime mechanisms by which homelessness leads to poor health. A third factor, poor nutrition, is discussed in the next section.

The conditions in many private and public shelters place children at risk of lead poisoning and other environmental hazards. Congregate living environments in many shelters present optimal conditions for the transmission of infectious and communicable diseases such as upper respiratory infections, skin disorders, and diarrhea.

These conditions include close proximity of beds, use of bathrooms by many people, inadequate facilities to change and bathe infants, unsanitary conditions, and noise and light that disrupt sleep (cf. Citizens Committee for Children, 1988; Gross & Rosenberg, 1987; Jahiel, 1987). According to the New York City Department of Health (1986), "There appears to be no basis for concluding that congregate family shelters can be operated in compliance with basic principles of public health" (p. 5). Regulations in 50% of cities require families to leave shelters during daytime hours (U.S. Conference of Mayors, 1989). This policy means that children are exposed to the elements, and it makes daytime naps for preschoolers and adequate care of sick children impossible.

Another important mediator of health problems is the lack of adequate primary and preventive health care services. Research has demonstrated that poor children have less access to quality health care than do middle-class children (Newacheck & Starfield, 1988); children who are both poor and homeless are at an even greater disadvantage. Access to timely and consistent health care is compromised by extreme poverty, removal from community ties, frequent disruptions in family life, and lack of health insurance (Angel & Worobey, 1988; Rafferty & Rollins, 1989; Roth & Fox, 1988).

The scarcity of adequate health care for homeless children begins with the paucity of prenatal care available to their mothers. Chavkin et al. (1987) found that 40% of 401 homeless women received no prenatal care compared with 14.5% of public housing residents and 9% of all women in New York who gave birth during the same period. This may help to explain the higher risk of negative birth outcomes, previously described, for homeless women.

As noted earlier, most research focuses on homeless children in emergency shelters because they are easier to study and identify. Many health problems may predate shelter entry, including crowding in doubled-up situations, as well as exposure and lack of sanitary facilities in public places.

### **Hunger and Poor Nutrition**

In their survey of 26 cities, the U.S. Conference of Mayors (1987) described a variety of negative effects of homelessness on physical and emotional well-being. The factors mentioned most frequently by city officials were lack of food and poor nutrition. The struggle to maintain an adequate and nutritionally balanced diet while living in a welfare hotel was described by Simpson, Kilduff, and Blewett (1984), who surveyed 40 heads of families (representing 194 people). Overall, 92% had no refrigerator in the hotel room, no family had a stove, 80% reported eating less food and food of lesser quality than they previously had, and 67% said they "felt hungrier" since moving to the hotel. Similarly, Wood et al. (1990a) compared the dietary intake and episodes of hunger among 192 homeless and 194 stably housed poor children in Los Angeles. Homeless children were significantly more likely to have gone hungry during the prior month (23% vs.

4%, respectively); more than one fifth (21% vs. 7%, respectively) did not have enough to eat because of lack of money.

Dehavenon and Benker (1989) found that nonpregnant adults in 202 families requesting shelter in New York City reported eating only once per day over the previous three days, on average; pregnant women ate twice per day. Although children were reported to have eaten three times per day, suggesting that adults gave up food for them, it appears unlikely that the children's food intake was adequate, given the bleak nutritional picture for their families. Among those in the shelter system for at least a week, nonpregnant women lost a median of eight pounds; of 98 pregnant women, 22% reported losing weight during their pregnancy and an additional 8% reported no weight gain. Nine of 26 families reported stretching infants' formula with water.

Anecdotal observations of homeless children in day care settings also suggest that they are hungry. Molnar (1988) reported that some homeless children threw tantrums until they were fed. Grant (1989) noted that most "ate enthusiastically, asking for second helpings" but "nearly all lacked previous experience in eating at a table and sharing food family-style" (p. 30). Many had not used utensils or cups.

Inadequate benefits and difficulties in accessing food and entitlements are the major mediators of hunger and poor nutrition. The vast majority of homeless families are headed by women who rely on Aid to Families with Dependent Children (AFDC) as their primary source of income (Bassuk & Rosenberg, 1988; Rafferty & Rollins, 1989). However, benefit levels have been described as "woefully inadequate" (National Coalition for the Homeless, 1988) and a main cause of hunger (U.S. Conference of Mayors, 1989).

The difficulties homeless families have in trying to manage on benefits that generally fall below 70% of the federal poverty line (Community Food Resource Center, 1989) are frequently compounded by failure to receive benefits to which they are entitled, erroneous case closings, and benefit reductions (National Coalition for the Homeless, 1988). The U.S. House of Representatives Select Committee on Hunger (1987) surveyed 2,112 individuals in emergency shelters in New York City in 1987 and found that 49% of those who were eligible for food stamps were not receiving them. In addition, more than 50% of all New York City residents who were eligible for the federally funded Special Supplemental Food Program for Women, Infants, and Children (WIC) in 1988 did not receive benefits (New York State Department of Health, 1988). Among New York City families with a pregnant mother or a newborn, only 44% of 385 families seeking shelter were receiving WIC benefits, compared with 60% of 83 families randomly sampled from the public assistance caseload (Knickman & Weitzman, 1989).

Homeless families are also more likely than housed families to have had their welfare (AFDC) cases closed and benefits reduced. In one study conducted in California, 43% of 196 homeless families reported losing or being

removed from the welfare rolls during the past year, often contributing to their loss of housing. In contrast, 23% of 194 stably housed poor families had *ever* lost their AFDC benefits (Wood, Valdez, Hayashi, & Shen, 1990b). In addition, homeless families were less likely to be receiving food stamps or WIC (62% vs. 81%, respectively).

Families with limited resources are often left with no other alternative than emergency food assistance facilities. However, in almost 20 of 27 cities surveyed, emergency food programs reported that they turned away people in need because of lack of resources. Emergency food programs in 17 of the cities reported being unable to provide adequate quantities of food (U.S. Conference of Mayors, 1989).

### Developmental Delays

Molnar (1988) documented observational and teachers' anecdotal accounts of distressing behaviors of homeless preschoolers aged 2½ to 5 years. The behaviors most frequently mentioned include short attention span, withdrawal, aggression, speech delays, sleep disorders, "regressive" toddlerlike behaviors, inappropriate social interaction with adults, immature peer interaction contrasted with strong sibling relationships, and immature motor behavior.

Whitman and her colleagues (Whitman, 1987; Whitman, Accardo, Boyert, & Kendagor, 1990) observed severe language disabilities and impaired cognitive ability among 88 children living in a dormitory style shelter for homeless families in St. Louis. Overall, 35% of these children scored at or below the borderline/slow-learner range on the Slosson Intelligence Test (Jensen & Armstrong, 1985), and 67% were delayed in their capacity to use and produce language as judged by the Peabody Picture Vocabulary Test (Dunn & Dunn, 1981).

Using the Denver Developmental Screening Test (DDST; Frankenburg, Goldstein, & Camp, 1971), Bassuk and her colleagues (Bassuk & Rosenberg, 1988; Bassuk & Rubin, 1987; Bassuk, Rubin, & Lauriat, 1986) assessed the development of 81 children (age 5 or younger) living in family shelters in Massachusetts. Overall, 36% of the children demonstrated language delays, 34% could not complete the personal and social developmental tasks, 18% lacked gross motor skills, and 15% lacked fine motor coordination. Almost one half (47%) manifested at least one developmental lag, 33% had two or more, and 14% failed in all four areas. A subgroup of the sample (those sheltered in the Boston area) was subsequently compared with poor housed children. When compared with 75 housed preschoolers, the 48 homeless preschoolers tested were significantly more likely to manifest at least one developmental lag (54% vs. 16%, respectively), to lack personal and social development (42% vs. 3%, respectively), to demonstrate language delays (42% vs. 13%, respectively), to lack gross motor skills (17% vs. 4%, respectively), and to lack fine motor skills (15% vs. 1%, respectively; Bassuk & Rosenberg, 1988, 1990).

In contrast, more recent studies of homeless children in Ohio, Los Angeles, Philadelphia, and New York City,

have not found such severe developmental problems. Wagner and Menke (1990), also using the DDST to assess 162 homeless children age 5 or younger in Ohio, found that 23% demonstrated language delays, 12% could not complete the personal and social developmental tasks, and 17% lacked gross motor skills. However, twice as many children in this sample lacked fine motor coordination as in the Boston sample (30% vs. 15%, respectively). Although Wagner and Menke (1990) had no comparison group, overall, their homeless children were more similar to the homeless than to the housed children in Bassuk and Rosenberg's (1988) study. Of the Ohio children, 44% manifested at least one developmental lag and 24% had two or more.

Wood et al. (1990b) studied developmental lags (as assessed by the DDST) in a sample of preschoolers in Los Angeles. Although overall performance was worse than in the general child population, only 15% manifested at least one delay and 9% had two or more. The most common delay was language (13%), then fine motor coordination (11%), gross motor coordination (6%), and personal-social development (5%).

Rescorla, Parker, and Stolley (1991) compared the cognitive ability of 40 homeless children between the ages of 3 and 5 with 20 housed children of the same age awaiting treatment at a pediatric clinic in Philadelphia. Significant delays were found for receptive vocabulary as assessed by the Peabody Picture Vocabulary Test (*M* score of 68 for homeless children vs. 78 for housed children) and visual motor development as assessed by the Beery (1989) Developmental Test of Visual Motor Integration (82 vs. 90, respectively). However, no differences were found for vocabulary (using the Stanford-Binet [Thorndike, Hagen, & Sattler, 1986]), visual motor development (using the Draw-a-Person clinical technique [Harris, 1963]), or developmental ability (using the Cubes Test [Yale Child Study Center, 1986]).

When they assessed speech, language, cognition, perception, and gross and fine motor coordination using the Early Screening Inventory (Meisels & Wiske, 1988), Molnar and Rath (1990) found no significant differences between 84 homeless and 76 poor housed children between the ages of 3 and 5. Children in both groups scored poorly. Note that the only significant difference to emerge in this New York City sample was between children who did and those who did not receive day care services.

Although many of the instruments used to assess development have not been standardized for poor and minority children, the strong differences between homeless and comparison samples in several studies suggests that the problems are significant. In fact, problems may be underestimated because the commonly used DDST is a conservative screening instrument and because families in some studies had been in shelters for only short periods of time.

The poor performance of both homeless and comparison samples suggests that poverty may be a key mediator of developmental problems. Other influential mediating factors include inadequate shelter conditions, lack

of access to quality day care services, instability in child care arrangements, and effects of homelessness on parents.

Media accounts detail the brutal and shocking conditions in welfare hotels and in other shelters for homeless families (Kozol, 1988). Berezin (1988) described how restrictive physical environments in emergency shelters make physical exploration virtually impossible: "There is little opportunity for the kind of exploration and interactive play that we know lay the foundation for healthy physical, emotional, and cognitive growth" (p. 3).

Despite the abundance of literature documenting the importance of high quality day care services for social and intellectual stimulation (Consortium for Longitudinal Studies, 1983; Haskins, 1989; Phillips, McCartney, & Scarr, 1987; Scarr & Weinberg, 1986), there is a paucity of such programs for homeless children (Berezin, 1988; Molnar, 1988). In New York City, for example, the percentage of homeless children reported to be enrolled in early childhood programs ranges from 15% (Vanderbourg & Christofides, 1986) to 20% (Molnar, 1988). Similarly, 15% of 40 homeless preschoolers in Philadelphia were enrolled in early childhood programs, in contrast to 65% of the 20 housed children in the comparison group (Rescorla et al., 1991).

Instability in shelter placements and other disruptions in child care and schooling may also impede children's development. For example, stability in child care arrangements for domiciled children is related to competent play with peers and toys in day care settings and to academic competence in first grade (Howes, 1988; Howes & Stewart, 1987). Finally, Molnar and Rubin (1991) extrapolate from research on poverty to posit that effects of homelessness on children's development and psychological functioning (reviewed next) are mediated by parental distress and its effect on parenting behaviors.

## Psychological Problems

Psychological problems identified most often among homeless children include depression, anxiety, and behavioral problems. Bassuk and her colleagues (Bassuk & Rubin, 1987; Bassuk et al., 1986) studied 156 children from 82 families sheltered in Massachusetts. On the Children's Depression Inventory (CDI; Kovacs, 1983), 54% of the 44 homeless children over the age of 5 scored above the cutoff score of 9, indicating a need for mental health evaluation; 31% were clinically depressed. In fact, the mean score of 10.4 was higher than the mean for six of eight clinical comparison groups studied during the development of the test. In a subsequent comparison of a subgroup of this sample, 16 of 31 children (52%) sheltered in Boston scored in the clinical range, compared with 16 of 33 (48%) housed poor children. Although mean scores for the children who were homeless were higher than were those for the housed group (10.3 vs. 8.3, respectively), the difference was not significant (Bassuk & Rosenberg, 1990). The 50 school-aged children's average score on the Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985) was 14.4, and 30% scored in the clinical range (a *T* score of 60 or higher), indicating a need for

mental health evaluation. In a subsequent comparison of a subgroup of this sample, 9 of 29 children (31%) sheltered in Boston scored in the clinical range compared with 3 out of 34 (9%) housed children ( $p = .06$ ). No mean scores are presented (Bassuk & Rosenberg, 1990).

Two other studies also used the CDI to assess depression. Wagner and Menke (1990) found that 50% of 76 homeless children between the ages of 7 and 12 years manifested a need for mental health evaluation, and 35% were clinically depressed; boys scored slightly higher than did girls (11.3 vs. 10.3, respectively). Masten (1990) found that 159 homeless children and 62 poor housed children ages 8–17 years did not differ significantly from each other (9.45 vs. 8.13, respectively) or from normative levels either in mean scores or in the proportion of children in the clinical range.

Several studies have examined parents' reports of their children's behavior using the Achenbach Behavior Problem Checklist (CBCL; Achenbach & Edelbrock, 1981, 1983). Overall, mean differences between homeless and poor housed children are somewhat elusive, but more homeless children tend to score in the clinical range. Wood, Hayashi, Schlossman, and Valdez (1989) found no differences between 194 homeless and 193 stably housed poor children on the Behavior Problems Scale (adapted from the CBCL). Mean scores were quite similar, and only a minority of both groups displayed a significant number of behavior problems, primarily aggressive behaviors. Similarly, Masten (1990) found no difference in mean scores of 159 homeless children between the ages of 8 and 17 years and 62 housed children, although both groups had mean scores above normative levels. Also, the means for the externalizing subscale (reflecting acting-out behavior problems) were significantly higher for the homeless sample, and significantly more homeless children scored in the clinical range on both internalizing (reflecting emotional problems like anxiety and depression) and externalizing.

Rescorla et al. (1991) found marginally significant differences on the CBCL between 43 homeless and 25 housed children between the ages of 6 and 12 years. More homeless school-age children (30%) than housed children (16%) had scores above 65; however, differences between the proportions of extreme scores were significant only for externalization (35% vs. 12%, respectively). Finally, Bassuk and Rosenberg (1990) found that a greater proportion of 31 homeless children between the ages of 6 and 16 years exceeded the cutoff point than did a comparison group of 54 housed children (39% vs. 26%, respectively). However, this difference was not significant.

Only two studies have used the CBCL among preschool children. Rescorla et al. (1991) found that their sample of 40 preschoolers between the ages of 3 and 5 scored significantly higher than did the comparison group of 20 housed children of the same age, and 20% of the homeless children (vs. 5% of the housed children) had scores in the clinical range. Molnar and Rath (1990) found no mean differences on the CBCL between 84 homeless and 76 poor housed children between the ages of 3 and

5 years; neither group differed from a nonclinical, normative group. However, once again, significantly more homeless children than housed comparison peers scored above the clinical cutoff point (33% vs. 11%, respectively).

Other, primarily descriptive, studies of behavioral problems also yield inconsistent findings. Bassuk and Rosenberg (1988) found that 55 homeless preschool children scored significantly higher ( $M = 5.6$ ) on the Simmons Behavior Checklist (Reinherz & Gracey, 1982) than did both a sample of 17 "normal" children ( $M = 1.9$ ) and a sample of 17 "disturbed" children ( $M = 2.3$ ). When compared with the housed normal children, the homeless children had poorer attention, more trouble sleeping, delayed speech, and were more likely to exhibit aggressive behaviors, shyness, and withdrawal. The only area in which homeless children scored significantly lower than both comparison groups was in being less afraid of new things. Note that a subsequent analysis compared a subgroup of this sample ( $n = 21$ ) with 33 permanently housed poor children and found no significant differences on any of the aforementioned measures (Bassuk & Rosenberg, 1990).

A study of 83 families sheltered in New York City (Citizen's Committee for Children, 1988) revealed that 66% of parents had observed adverse behavioral changes in their children since becoming homeless. Among the most frequent changes were increased acting out, fighting, restlessness, depression, and moodiness. Molnar, Rath, and Klein (1991) cited parent reports of withdrawal, exaggerated fears, disobedience, and destructiveness.

In sum, several studies show that homeless children are more likely than are housed poor children or normative groups to have clinical levels of depression, anxiety, or behavior problems. Research findings, however, have not been entirely consistent. Possible explanations include small sample sizes and the lack of adequate comparison groups in some studies. In addition, several researchers suggest that other methodological issues need to be considered. For example, Cohen and Schwab-Stone (1990) noted the inadequacy of available instruments to assess the mental health of children generally, and additional limitations in making valid assessments of homeless children (e.g., lack of appropriate places to carry out interviews, families' greater involvement in problems connected to daily living than to the interview). The fact that families are often in an acutely stressful situation may temporarily inflate children's scores on measures of depression and anxiety. Molnar and Rubin (1991) also discussed how the chaotic life arrangements of homeless families are not conducive to lengthy interviews. They also address the limitations of assessment instruments in ethnic minority groups and suggest the use of multiple informants.

Finally, the fact that both homeless and poor housed children perform poorly, relative to normative samples, in more recent studies also implicates poverty, as well as specific conditions of homelessness, in the development of psychological problems. In fact, many of the risk factors previously discussed also prevail in extremely poor fam-

ilies. Homeless families, however, are even more likely to be deprived of some essential requirements for child rearing. These include adequate health care, nutrition, housing, employment, and status for parenthood (Bronfenbrenner, 1986).

In addition, the emergency shelter needs of families frequently go unmet. For example, 21 of 27 cities turn away homeless families because of a lack of resources (U.S. Conference of Mayors, 1989). Birmingham, Alabama, for example, turns away 25% of the families requesting emergency shelter each day (National Coalition for the Homeless, 1989a). In other cases in which shelter is available, fathers and older boys are separated from their families. Overall, 17 of the cities reported being unable to keep homeless families intact in emergency shelters.

For families who manage to obtain emergency shelter, other obstacles prevail. Unsafe, chaotic, unpredictable shelter placements are not conducive to normal psychological development. Rafferty and Rollins (1989) found that families in New York City shelters were routinely bounced from one facility to another, compounding stress for children already struggling to master their environments. According to Neiman (1988), the resiliency literature indicates that children are not particularly at risk from any single stressor, but when two stressors occur together, the risk quadruples. Thus, she argued, if even a portion of the multiple stressors that plague homeless families were substantially alleviated, the psychological risk for children would be greatly reduced.

Finally, homeless parents often encounter difficulties balancing their own physical, social, and personal needs and those of their children. The loss of control over their environment and their lives place them at increased risk for learned helplessness and depression. Drawing on Maslow's hierarchy of needs, Eddowes and Hranitz (1989) suggested that deprivation of basic needs and lack of security often lead to mistrust, apathy, and despair in homeless parents. Maternal depression, in turn, places children at increased risk for depressive disorders, behavior problems, anxiety, attention problems, insecure attachment, and social incompetence (cf. Dodge, 1990; Rutter, 1990).

### **Educational Underachievement**

Little research has focused on the educational achievement of homeless children. What has been undertaken, however, indicates that homeless children score poorly on standardized reading and mathematics tests and are often required to repeat a grade.

Rafferty and Rollins (1989) examined the educational records of the entire population of 9,659 homeless school-age children identified by the New York City Board of Education between September 1987 and May 1988. Of the 3,805 homeless children in Grades 3 through 10 who took the Degrees of Reading Power test in the spring of 1988, 42% scored at or above grade level, compared with 68% citywide. Although these findings may reflect effects of poverty as well as homelessness, findings in the

three school districts that served the greatest numbers of homeless children (45% of the total) were consistent. The percentages of homeless children scoring at or above grade level were 36%, 40%, and 41%, compared with 57%, 74%, and 68% for all children. Furthermore, of the 73 schools composing these three school districts, only 1 school had a lower proportion of students reading at or above grade level than did the overall proportion for homeless children attending schools in that district.

Results were similar for the Metropolitan Achievement Test in mathematics, which 4,203 homeless children in Grades 2 through 8 took in the spring of 1988. Homeless students were less than half as likely to score at or above grade level as were all students both citywide (28% vs. 57%, respectively) and in the three districts with the most homeless children (22%, 24%, and 23% vs. 48%, 70%, and 60%, respectively).

Several other studies have found that homeless children are more likely than are housed poor children to have repeated grades (Masten, 1990: 38% vs. 24%, respectively; Wood et al., 1989: 30% vs. 18%, respectively) or to be currently repeating a grade (Rafferty & Rollins, 1989: 15% vs. 7%, respectively). Other studies without comparison groups also found high rates of grade retention (Dumpson & Dinkins, 1987: 50%; Maza & Hall, 1988: 30%). In contrast, Rescorla et al. (1991) found similar retention rates among homeless and housed children (35% vs. 32%, respectively). The excessive rate of hold-overs among homeless children will, no doubt, have long-term repercussions. Students who are overage for their grade are more likely than are others to drop out of school, get into trouble with the law, learn less the following year, and develop negative self-concepts (Hess, 1987).

Several factors appear to mediate the educational underachievement of homeless children. These include poor school attendance, lack of adequate educational services, inadequate shelter conditions, and shelter instability.

Government estimates of the number of homeless school-aged children who do not regularly attend school range from 15% (U.S. General Accounting Office, 1989) to 30% (U.S. Department of Education, 1989). In contrast, the National Coalition for the Homeless (1987a) estimated that 57% of homeless school-aged children do not regularly attend school. Two additional studies have evaluated the school attendance of homeless children. Homeless students in Los Angeles (Wood et al., 1989) missed more days in the prior three months than did poor housed children (8–9 vs. 5–6, respectively), and were more likely to have missed more than one week of school (42% vs. 22%, respectively). For housed children, the primary reason for absence was illness; for homeless children, it was family transience. In a New York City study of 6,142 homeless students (Rafferty & Rollins, 1989), homeless high school students had the poorest rate of attendance (51% vs. 84% citywide), followed by junior high school students (64% vs. 86% citywide) and children in elementary schools (74% vs. 89% citywide).

Many homeless children experience difficulty obtaining and maintaining access to a free public education.

Major barriers include residency requirements, guardianship requirements, special education requirements, inability to obtain school records, transportation problems, lack of clothing and supplies, inadequate health care services, and lack of day care for teenage parents (Center for Law and Education, 1987; National Coalition for the Homeless, 1987a; Rafferty, 1991; U.S. Department of Education, 1990).

School is especially crucial for homeless children because it may instill a sense of stability that they otherwise lack (National Coalition for the Homeless, 1987a). Given the disruptions associated with homelessness and the excessive number of school transfers, homeless children may also need remedial educational services to address academic deficits, preschool enrichment services to prevent academic failure, psychological support services to respond to emotional problems, and greater sensitivity from school personnel who often stigmatize them (cf. Edowes & Hranitz, 1989; Gewirtzman & Fodor, 1987; Horowitz, Springer, & Kose, 1988; National Association of State Coordinators for the Education of Homeless Children and Youth, 1990). Despite these needs, homeless children are likely to lose educational services with the onset of homelessness. Of 97 children who were receiving remedial assistance, bilingual services, or gifted and talented programs in New York City prior to their loss of permanent housing, only 54% continued to receive them while they were homeless (Rafferty & Rollins, 1989).

Environmental conditions within emergency shelters are hardly conducive to education. In addition, families entering the emergency shelter system are often placed in temporary facilities without consideration of the educational needs of the children or the impact of their being moved to unfamiliar and often distant communities. For example, 71% of 277 homeless families interviewed by Rafferty and Rollins (1989) were in temporary shelter facilities in a different borough than that of their last permanent home. Bouncing families from one facility to another compounded the disruptions in their lives and in their children's schooling. Overall, 66% of families had been in at least two shelters, 29% in at least four, and 10% in seven or more. The resulting school transitions significantly hindered children's continuity of education and disrupted their social relationships with classmates and friends.

### **Conclusion and Social Policy Implications**

Homeless children confront abject poverty and experience a constellation of risks that have a devastating impact on their well-being. The research reviewed here links homelessness among children to hunger and poor nutrition, health problems and lack of health and mental health care, developmental delays, psychological problems, and academic underachievement. These consequences of homelessness often compound one another as well. When young children's nutritional needs are not met, growth is affected (Jahiel, 1987), physical health deteriorates (Acker, Fierman, & Dreyer, 1987), mental health is adversely affected (Winick, 1985), behavioral problems in-

crease (Lazoff, 1989), the ability to concentrate is compromised (Jahiel, 1987), and academic performance suffers (Galler, 1984).

The paucity of prenatal care available to homeless women places unborn homeless children at risk of low birth weight (Buescher et al., 1988), subsequent health problems and chronic diseases (Hack, Caron, Rivers, & Fanaroff, 1983), cognitive and developmental problems (Resnick, Armstrong, & Carter, 1988), and academic problems (Russell & Williams, 1988). Delays in language development, motor skills, cognitive ability, and personal and social development place children at risk for academic failure (Molnar, 1988). Health problems are associated with psychological problems, classroom performance, and dropout rates (Needleman, Gunnoe, & Leviton, 1979; Needleman, Schell, Bellinger, Leviton, & Allred, 1990). Anxiety, depression, and behavioral problems engendered by destructive psychological environments interfere with one's capacity to learn (Jahiel, 1987). Thus, the risks we have identified may snowball to seriously compromise the future of homeless children.

Any list of solutions to homelessness must begin with decent, permanent, and affordable housing (National Alliance to End Homelessness, 1988; National Coalition for the Homeless, 1987b; Partnership for the Homeless, 1989; U.S. Conference of Mayors, 1988). National policy must focus both on rehousing those who are currently homeless and on preventing additional homelessness (National Coalition for the Homeless, 1989b). However, although affordable permanent housing is the fundamental issue of homelessness, it is not the sole need of homeless families with children. The research we have surveyed suggests that homeless families also have special needs in the areas of adequate shelter facilities, stability, and adequate services without barriers to access.

At the very least, homeless children and their families need access to safe, clean emergency shelters for transitional use while they are without homes. Shelters must provide privacy so that children are not exposed to communicable diseases, control over light and noise so that children can sleep and do homework, and enough space so that young children can explore their environments. Shelters must provide nutritious meals, or they must have refrigeration and cooking facilities so that families can prepare nutritious meals.

Emergency shelter placements must be designed to create stability, not chaos, in children's lives. Families and their children should not be required to leave shelters during the day or to move from shelter to shelter (or back to the street) because of administrative convenience or arbitrary limits on length of stay. Families must be accommodated as families and not be forced to separate in order to obtain shelter. To minimize disruptions in schools and services, shelters should be in the neighborhoods from which families came or in the neighborhoods in which they will be housed permanently.

In the realm of services, homeless families need adequate health care, including prenatal, mental health, pediatric, and preventive care, and they need continuity of



care. Children need day care and early intervention programs (to prevent the onset of developmental delays), after-school programs, and the same or better standard of public education received by other children. Children should continue to receive the bilingual, special education, or gifted and talented services they obtained previously. They should have the option of continuing at the schools they attended before becoming homeless. By maintaining stability for children and offering new services to help them cope with the trauma of homelessness, schools can play an important role in tertiary prevention and in preventing residual damage from homelessness.

Our poorest families with children, inside or outside of shelter, also need adequate levels of benefits to meet basic needs—a public assistance grant at least at the federal poverty level, food stamps, the WIC program—and the assurance of receiving, without interruption, benefits to which they are entitled. More adequate and continuous benefits, along with an increase in the supply of affordable housing, would prevent many families from ever becoming homeless.

Recent studies have emphasized similarities, rather than differences, between homeless and poor housed children on measures of development and psychological problems. Both groups are at high risk. Even in health and education, where homeless children clearly fare worse than do their housed peers, the profile of both groups is grim. These findings indicate the need for a public policy agenda that addresses poverty among children, in addition to providing housing, stability, and services for those who are homeless.

In conclusion, an entire generation of children faces truly unacceptable risks that jeopardize their future potential. In the long run, the monetary costs of neglecting children's needs are likely to substantially exceed the costs of combating poverty and homelessness. The human costs will be much more tragic. Our cities and our nation must develop an appropriate and effective response.

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