Case Report

Emotional and Cognitive Impact of Chronic Homelessness on a Child

Health Care for the Homeless Clinicians' Network
National Health Care for the Homeless Council
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"Homelessness is severe trauma. It stays with you the rest of your life. In the two years I was homeless, the main thing that was reinforced within me was that I was not worthwhile, that I did not belong, not only to the community, but maybe even to humankind."
-Zenobia Embrey-Nimmer (Friedman 2000)

Initially thought to be a problem associated with individuals with addiction and mental illness, the face of homelessness has changed over the past thirty years. Homeless families now comprise more than one-third of the entire homeless population (National Center on Family Homelessness 2008). Within these families experiencing homelessness, 42 percent of the children are under age six, a crucial time for development of educational, cognitive, social and emotional skills (Guarino 2010).

For this reason, the focus of this case report is on the effects of chronic homelessness on the cognitive and emotional development of children ages zero to five. The long-term effects of infant and early childhood chronic homelessness are not fully understood. This case report describes the experience of one child and may help to illuminate the unique challenges in providing health care services to a family experiencing chronic homelessness and specific interventions to prevent long-term damage to the cognitive and emotional functioning of homeless children.

ABOUT THE PATIENT

John is a seven-year-old African American male who has been homeless on and off for his entire life. He is the subject of this case report. John's mother is a 29-year-old African American female who started residing in shelters after dropping out of college when she was pregnant with John. When John was three months old, he and his mother were referred to the Pediatric Outreach Program at Health Care for the Homeless (HCH) in Baltimore. The family was first seen by an HCH social worker due to a report of physical abuse to the local Department of Social Services by shelter staff. Even though the report was not substantiated, John's mother was referred to a local parenting support group.

The social worker's initial interview with John's mother identified a young, first-time single parent with limited family support who had previously resided in two other shelters. John's mother experienced a normal pregnancy and delivery with standard medical care and no complications. John was feeding on baby formula, voiding and sleeping normally. At six months old, John was enrolled in the therapeutic infant nursery that was housed in the same shelter. He was seen regularly by the HCH pediatric nurse practitioner (PNP) for acute issues, such as facial and diaper rashes as well as upper respiratory infections. His physical and cognitive development was within normal limits during this period.

When John was ten months old, he and his mother moved into a transitional housing program. He continued to be followed by the outreach PNP (who had seen him at the shelter), providing regular acute medical care for illnesses such as ear infections, upper respiratory infections and eczema. She also provided medical case management, which included linkages to his primary health care provider (PCP) for ongoing preventive and well child medical care. At age two, his PCP diagnosed him with asthma.
When John was two and a half years old, his mother gave birth to a baby girl. Shortly afterwards, his mother had an episode of post-partum depression and started to receive mental health treatment. Although John seemed to be adjusting well to this life change, the PNP started to note that his speech was not meeting the standard developmental milestones.

After John's mother gained employment, his family left the transitional housing program and moved to fair market housing. Five months later, John's family was evicted when his mother, who was again pregnant, lost employment. John and his family then returned to living in a shelter.

At three years and eight months old, John was referred to a preschool for homeless children where he was diagnosed with receptive and expressive language delay and started to receive speech services. At the same time, the PNP who had worked with John's family during his previous homeless episode continued to follow John for his asthma.

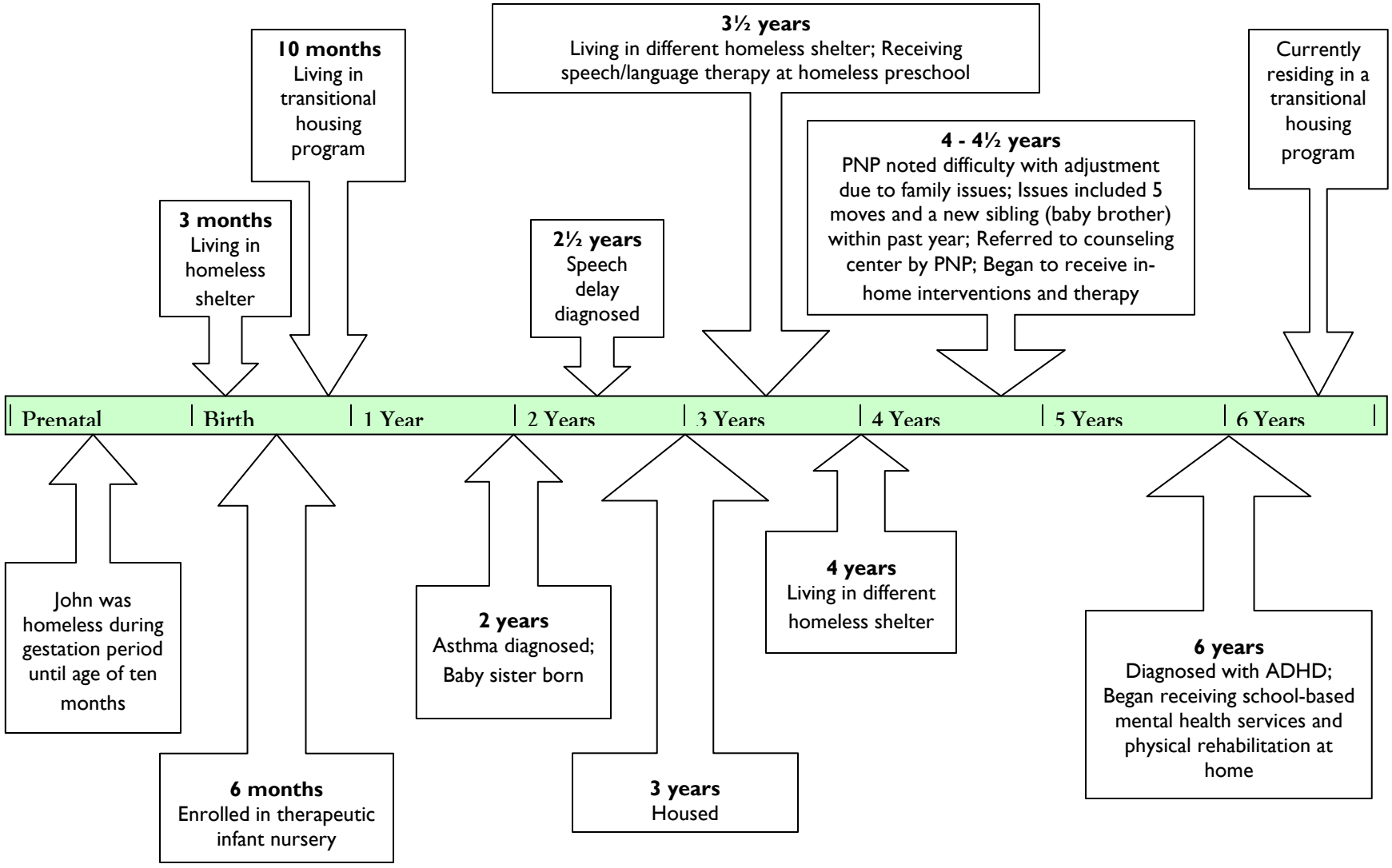
After doubling-up with other family members, John returned to a shelter at age four and was seen by another PNP on outreach who noted "difficulty with adjustment due to several family issues in past year" (five moves and a new sibling). John was referred to a counseling center by the PNP due to tantrums, mood swings, withdrawal and trauma from recurrent homelessness. He started to receive weekly, in-home therapy while his mother attended a parenting class at the shelter.

Around that time, John and his family moved from the shelter to another transitional housing facility, where he remained for over two years. The HCH PNP and social worker again worked with John and his family to initiate supportive services and mental health services for his mother. They also engaged the transitional housing case manager and children's program coordinator in providing support. John continued to receive speech services until the age of six.

John was also diagnosed with attention deficit hyperactivity disorder. He continued to have behavior problems and his mother initiated mental health services at John's school, where he received therapy for several months. The school provider referred John to a Psychiatric Rehabilitation Program (PRP) where he could receive services at home. Within the last six months before writing, John and his mother were seen both by a community mental health provider and the counseling center that had treated him when he was four years old.

Figure 1 on the next page highlights John's episodes of homelessness and the onset of his various diagnoses—medical, developmental and behavioral.

Figure I. John's episodes of homelessness and the onset of medical, developmental and mental health problems



Speech and Language/Communication Delay

John attended a therapeutic preschool for homeless children at age three for 42 weeks during one of his episodes of recurrent homelessness. The therapeutic preschool utilized a nurturing and language-based approach with its homeless children ages three to five years old. The program also had a maximum of 18 children (a high teacher-student ratio), transportation and in-house speech and mental health services.

A review of John's file reflected a delay in both receptive and expressive speech development. Initial testing using the Preschool Language Scale-4 upon entry to the preschool program placed John in the two-year and three-month range (1st percentile) for receptive language and in the two-year and seven-month range (7th percentile) for expressive language (Zimmerman 2005). John's total language score (receptive and expressive language) was in the two-year four-month old range (1st percentile). John was three years old at the initial testing period. The tester summarized her findings as follows:

- John's receptive and expressive language skills are "significantly delayed in comparison to his chronological age."
- These delays may negatively affect his performance in the classroom by interfering with following directions, understanding vocabulary and concepts and communicating in an effective manner, specifically in classroom participation and social situations.

The objectives for John's speech and language treatment plan included:

- "To improve receptive/expressive vocabulary skills (everyday categories, curriculum related units)."
- "To increase the use of utterance of response, comment appropriately."
- "To improve ability to answer basic questions (where and what doing?)."

The service delivery model included:

- Individual speech therapy two times per week for ten to fifteen minutes to address the targeted goals.
- Interventions throughout his daily routine two mornings per week to facilitate language and social skills.

Monthly follow-up by the speech and language provider indicated steady improvement in John's receptive and expressive language during his time in the program. Additionally, the preschool program developed its own language assessment, which they administered five times over the course of John's stay in the program (upon entry and at one to two month intervals), each time reflecting steady improvement in John's language. Upon transitioning John to the public school system for kindergarten, the preschool referred John to speech and language services to work on his articulation.

Academic Achievement

Report cards obtained for John over the past year indicated satisfactory academic performance and behavior. The primary issue for John was regular attendance, with 22 absences by the second quarter (half were excused). Teacher comments reflected John's ability to improve with regular school attendance.

Mental Health

John started to receive early behavior intervention services through a full-day therapeutic nursery when he was three months old. Data from the therapeutic nursery shows that John was exceeding in most areas of development (gross motor, fine motor and language) when he entered the program. He continued to develop within normal limits until he exited the program at age ten months old.

Although John received mental health treatment on and off since the age of four, the authors were unable to obtain the records for this report.

DISCUSSION

John and his family resided in a variety of shelter settings throughout his young life. These settings ranged from dormitory-style (many individuals and families sharing the same sleeping, bathing and eating space) to shelters that provide families with individual rooms to transitional housing programs that provide families with their own apartment. Each of these living situations can be classified as some form of homelessness, which the authors define as lack of stable and/or potentially permanent housing. In a study comparing three different living standards for children, overcrowded and moldy living situations presented a number of health risks but did not have the long-term effects that homelessness did on children (Harker 2007). Over two-fifths of the children who were homeless continued to suffer from mental health and developmental issues more than a year after being housed. The children who were homeless were also three times more likely than their housed peers to demonstrate anxiety and depression. Many of these children continued to lag in their language development even after being housed. Those that were homeless within the first year of life had an increased rate of these problems. Homeless children are also likely to be aggressive as older children. John has a history of mental health and developmental issues, but it remains to be seen if they will be long-term or resolve after being housed.

Many of John's domicile settings have been shelters. While shelters try to help residents establish routines by offering meals and programs (i.e. parenting and life skills trainings) at designated times, shelter life also provides many challenges for parents with young children:

- Limited access to kitchen facilities for food preparation
- Lack of safe places for children to play with parents or one another
- Lack of storage space for personal belongings (i.e., clothes, toys, books)
- Increased noise due to the volume of residents
- Limited support to care for children (some shelters discourage socializing among residents or prohibit shared child care)
- Pressure on families to keep their children quiet

These challenges can result in stress for parents as they try to meet the demands of the child and adhere to the shelter rules. A majority of parents of homeless children is diagnosed with mental health and substance abuse disorders, and these parents who enter shelters may find shelter rules particularly stressful and difficult to follow (Gerwitz 2008). John's mother received mental health treatment and the state of her mental health surely played a role in his development.

In addition, shelter stays are often time-limited and families typically do not have an opportunity to adjust as they are immediately pressured to look for another place to reside. Lee's (2010) study of the mental health needs of homeless mothers and children showed the mothers in supportive housing had increased psychological stress, less than optimal parenting practices and increased relational frustration.

Although every member of the HCH Pediatric Team was involved with John's family, there appeared to be some gaps in services and missed opportunities for interventions. In complex cases such as John's, it might have been beneficial for the team members to hold periodic case conferences to discuss and develop treatment plans that could have better addressed John's developmental and emotional needs. Periodic case conferences might have also provided a system of checks and balances to ensure that treatment services and referrals were effective and successful.

Early childhood education programs may have benefitted a child like John. Even though John's PNP identified speech delay at age two and a half, services were not initiated until he entered the therapeutic nursery a year later. Perhaps if the PNP had communicated with the primary care provider (PCP) or made a

referral to an intervention service earlier, John might not have exhibited the same severity of speech delay a year later. Early intervention is a form of prevention. Early intervention programs have documented gains in behavioral, social and academic outcomes and are associated with a decrease in mental health disorders and risk taking behaviors later in life (Lee 2010).

Homeless children have high rates of exposure to trauma. Forty-two percent of homeless children are under the age of six and one-fourth of homeless children have been separated from their families (Guarino 2010). These children have faced the loss of their home and feelings of safety and security. This population is also at higher risk of experiencing abuse, neglect, witnessing domestic or community violence and entering foster care. More than one-third of homeless children have been involved in a child protection investigation. This complex trauma impacts both the child's and parent's ability to function in a healthy manner, threatening the physical and emotional well-being of both parties. Complex trauma is defined as prolonged and persistent traumatic experiences occurring during critical periods of development and resulting in long-term functioning difficulties.

Prior to the past decade, experts on homelessness in children believed that the most damaging time for children to experience homelessness was after the age of five. The belief was that younger children do not remember early life experiences and, subsequently, are not affected by the homelessness. However, with the emergence of research around trauma in children, experts are now aware that sustained periods of complex trauma, including chronic homelessness, have adverse effects on the developing brain of young children (Gaurino 2010, van der Kolk 2009).

The complex trauma John suffered may serve to explain why he exhibited speech and language delay as well as behavior problems before the age of six. Research has demonstrated that ongoing trauma during the critical years, when attachment is forming, can alter the brain's structure and result in a variety of mental health and behavioral disorders. The next edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, (scheduled for publication/distribution in 2013) is looking at a new diagnosis for children with sustained trauma during the attachment years, namely *Developmental Trauma Disorder* (Smith 2011). John's behavioral issues may have been averted if John and his mother had received mental health support (preferably in home/shelter) prior to the birth of his first sibling.

John's homelessness affected his education. Although his academic reports revealed satisfactory performance, his attendance rate was low and his teachers reported that he could have performed better with regular attendance. Research has indicated that homelessness and family poverty are strong predictors of a negative educational outcome. Children from these families are more likely to experience behavioral problems and lack adequate social skills, thereby affecting their educational outcomes (Rouse 2009).

The program director at the preschool that John attended is a social worker with over thirty years experience with underserved and homeless children. This program director has found (through experience and evidence-based practice) that language and communication are predictors of future academic and social success. If children are unable to understand language and communicate with others, they will fall behind academically and be unable to identify and express feelings—key components to managing a social situation. Children who do not master speech and language during the critical years of zero and five will have a difficult time catching up to their peers.

Parks' review of cognition showed that homeless children have greater delays in receptive and expressive language and three times the cognitive and developmental problems of their housed peers (2007). In addition, those with intact functioning in early childhood still had delays in motor and receptive language

in preschool and poorer scholastic achievement at school age. The study also suggested that the duration of homelessness may be related to difficulties in cognition, implying that homeless intervention programs need to target cognition early. Early intervention programs like Jumpstart (http://www.jstart.org), Head Start (http://www.acf.hhs.gov/programs/ohs/), Healthy Start (http://www.nationalhealthystart.org/) and the homeless preschool that John attended put forth efforts to present some stability and opportunities for improving cognitive development.

In this example, John started to experience the effects of homelessness prenatally. After birth, John seemed to be developing normally but eventually started to show effects of prolonged stress and trauma with speech delay and behavioral issues. It is evident from the preschool records that John showed improvement in speech and language skills during his attendance at that program. Although John received mental health services over the past three years, services have been intermittent due to a variety of factors including changes in providers, transportation, and his mother's mental health state and challenges raising three children. Although John's academic progress is within the average range, his attendance has been a chronic issue. One constant in John's life is that his family's homelessness has not been resolved.

IMPLICATIONS FOR PRACTICE

The following are suggestions for minimizing the negative developmental impact of homelessness on children:

Minimize length of homelessness by identifying safe and affordable housing as soon as possible. Early efforts to keep young children out of shelters and homelessness can prevent and minimize the trauma of homelessness. A community-based approach for preventing homelessness might be most effective. Yu (2007) showed that homeless children suffered disruptive behavior disorders as a result of homelessness and suggested that efforts be directed "toward eradicating homelessness itself." Prevention initiatives should involve advocacy with local, state and federal government.

Build relationships with the homeless families. Each HCH provider was able to develop a relationship and follow-up with John's family by having different members of the care team assigned to local shelters. Maintaining contact with John's family in this way and removing barriers to care was important for intervening on multiple levels.

Advocate for child-friendly shelter environments. This type of advocacy may need to occur at the macro-level by asking government agencies that provide funding for shelters to develop standards that help create child-friendly and trauma-informed environments. Suggestions include (1) training shelter staff on the effects of homelessness on the developing child and best practices for interacting positively with children and parents, (2) setting aside space for a play area so that parents and children have time together and (3) developing a network of organizations that serve children to provide programs for families utilizing the shelter system.

Work closely with each child's primary care provider. Recommend increased follow-up and encourage frequent developmental screening. Act as a bridge to ensure that referrals to early intervention services do occur by keeping communication open.

Establish early intervention programs within and outside of the shelter. Establish therapeutic daycares and preschools that support the emotional and educational needs of children who come into shelters or homelessness. Enroll young children in these programs as soon as possible to prevent potential negative health outcomes. Work to identify and remove barriers that might prevent children from accessing these services. Develop groups and programs within the shelter setting to help parents practice skills that foster emotional and educational growth. Provide educational workshops and supportive networks for parents to learn about developmental processes and age-appropriate activities. (For example, provide a space for parents to read with their children, or have reading time as part of a structured program within the shelter.)

Health care providers for families experiencing homelessness should screen often for developmental delays and refer early for developmental interventions. Modeling behaviors to enhance parent-child interaction and providing books and other developmentally appropriate toys may also be beneficial. MacGillivray (2010) suggests that all adults should take the time to read in front of children to serve as positive models. Simple things like reading a cereal box or street signs while walking with your child can improve literacy and language skills.

Integrate services to enhance the parent's mental and cognitive health and the parent-child bond. The therapeutic nursery that John attended is one example of a program that provided daycare and had mental health staff to work with parents and children on attachment. The literature shows

a link between maternal and child verbal cognitive abilities and indicates the importance of the "provision of educational and skills trainings programs for mothers" (Yu 2007). Developing this type of support is another way to provide support to the family that may prevent mental, behavioral and cognitive issues with both parents and children.

Identify the family's support system and build on it. As the saying goes, it takes a village to raise a child. For young children in homeless situations, that village needs to be large and stable. Identify individuals in the family's life that can be of assistance, organizations that can provide appropriate services to the family and techniques to enhance communication between these villagers to best support the family.

Developing a community-wide initiative to improve medical, mental health and social services for families and children might help to prevent and treat the adverse effects of homelessness.

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