THE Children's Health FUND

Health Care for New York's Homeless Children and Families: Models that Work

A Children's Health Fund Issue Brief

May 2003

Background:

A trend that began in 1998 has led to the largest number of homeless New Yorkers in the City's history. Two factors are largely responsible. First, there is the drastic reduction of affordable housing for low- and middle-income families resulting from the previous administration's housing development policy. Second, the economic downturn of 2000, exacerbated by 9/11, has the nation, state, and city facing their most severe fiscal crises since World War II. The current administration came into office faced with a burgeoning crisis in homelessness and, to its credit, has confronted the situation with a determination to find a humane solution to end people "making their home on the street."

In June 2002, the Department of Homeless Services (DHS) issued The Second Decade of Reform, the first-ever strategic plan for preventing and reducing homelessness and ensuring the quality of homeless services. Its focus is to find permanent housing for homeless families more quickly, and to evaluate current programs for efficiency and accountability. However, one of the assumptions challenged by the administration is whether the package of social services provided in the shelters, originally intended to support homeless people's struggle for stability, instead fosters dependency rather than encouraging responsibility.

Since its founding in 1987, the Children's Health Fund (CHF), in conjunction with the New York Children's Health Project (NYCHP), has been providing health care to children and families in the New York City shelter system. The same year, the first federal law aimed at alleviating and ameliorating the effects of homelessness, the Stewart B. McKinney Homeless Assistance Act, was enacted. The McKinney Act included the Health Care for the Homeless Program (HCH).

The Children's Health Fund believes that good health care is part of the foundation which enables children to achieve their full potential and make a productive contribution to society. For children and their parents, health problems should be prioritized and appropriately addressed through accessible and comprehensive care. There are successful models for delivering health services to homeless people. We believe the City can profit from the lessons learned in HCH programs; we can adapt, improve and expand health services to help homeless families transition successfully to independence and self-reliance.

Health Services for Homeless Children and Families:

HCH programs offer comprehensive primary care services, often including substance abuse treatment, behavioral and mental health services, and oral health care. A 2002 survey by the National Association of Community Health Centers (NACHC) indicates high patient satisfaction, quality care, and "barrier free" access to health services.

Poor children have less access to health care and greater unmet needs. Publicly insured children are 50 percent more likely than privately insured children to not have their health needs met[1]. Children frequently enter shelters with unresolved health care needs, a result of either inadequate health care or because their health care has been interrupted by the circumstances preceding homelessness.

Clinical experience indicates that providing comprehensive primary care and ancillary services helps families, and especially children, practice good health and develop good health behaviors. The NACHC survey reports 82 percent of homeless people kept referral appointments, a figure borne out by CHF's ***Referral Management Initiative***. In addition, HCH programs can help families recover from the trauma that accompanies displacement and homelessness.

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[1] Newacheck P, Hughes D, Hung Y, Wong S, Stoddard J. The Unmet Health Needs of America's Children. Pediatrics, vol. 105, no. 4, April 2000.

Pediatricians caring for homeless children know to delve more fully into the child's health history to uncover unattended issues. Given the average length of stay in the shelter, delaying care could result in losing critical time frames in a child's development. A third of the children are under two years of age, and 50 percent are five or younger. It is well known that environment and experiences in the first years of life have lasting effects: brain development, social development, physical well being, readiness for school, and ultimately, a child's success in life are all linked to these critical first years of life.

One out of four new NYCHP patients requires at least one specialty referral. Ophthalmology accounts for the greatest percentage of these referrals. With restricted visual acuity, children will not succeed in school or be able to participate in the play activities that build the skills necessary for intellectual and social development. Most children require nothing more than corrective glasses. Children with developmental delays are identified as early as possible: failure to identify developmental delays within this window of opportunity can mean that speech-language and cognitive skills will be negatively impacted. Referrals for cardiology, neurology and surgery are often for conditions previously identified which have become severe and urgent without the medical continuity that comes with a stable living environment. Despite the extraordinary incidence rate of asthma in the shelter population, with appropriate primary care there are seldom referrals to pulmonologists. NYCHP providers have developed individualized asthma treatment interventions that keep children out of the emergency room and in the schoolroom.

Approximately 80 percent of children under five years seen by the NYCHP receive at least one of their scheduled immunizations. Varicella (chicken pox) immunizations have become especially important for children living in congregate settings.

More than half the mothers in the shelter system are victims of domestic violence.[2] Most are coping with the stresses that accompany homelessness, or long-term mental health issues, making it difficult to provide the parental guidance to help their children effectively manage the disruption from a home setting and stigma attached to being homeless. These women and children are often in need of specialized mental health services. The sooner the mental health intervention is made, the more likely it is that future crises can be averted. For some, short-term intervention and psychotropic medication by HCH mental health teams are successful. Those requiring more intensive services are confronted by a mental health infrastructure that is woefully inadequate. Few clinics can accept new clients, and those that can have waiting lists of four to six months.

Policy Implications and Recommendations:

Given the prevalence of unrecognized or unresolved health and mental health issues in homeless families, shelter caseworkers should encourage utilization of specialized on-site clinics when the family believes they would encounter difficulties in accessing their customary provider. Families should be made aware that providers are available for both Medicaid and uninsured clients, and there is no stigma attached to using available health resources. By doing so, shelter caseworkers can pave the way for preventive care and family stability.

Once a family is out of the shelter system, they may find permanent housing located in unfamiliar, low-income communities, which are often medically underserved. It takes time to develop personal support networks, important resources for making medical decisions. Resources should be made available to enable HCH to create transitional programs to help clients locate appropriate medical resources in their new community, which will ensure continuity of care.

Mental health resources for children must be improved. Although New York State implemented a strategic plan for improving mental health services, the mental health infrastructure is

[2] Homelessness in New York City: The Basic Facts. Coalition for the Homeless, February 2003.

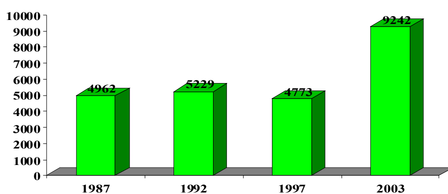
inadequate for those desperately needing to access services. Capacity is far below identified needs. Caps on the number of units of services should be removed or increased and hurdles to organizations seeking new licensure should be eased. The State and City should work constructively with community-based organizations to develop new resources for a growing homeless population.

Homelessness in New York City – A Timeline:

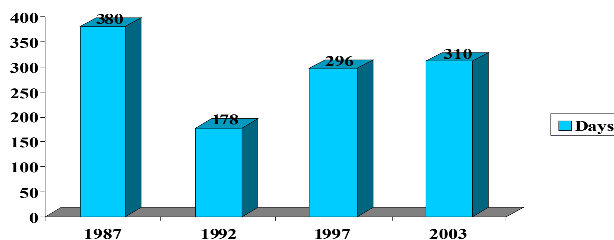
Before 1990, less than half the shelter population in New York City consisted of families. Today, children and families comprise 79 percent of those living in shelters. Eighty-five percent of these families are headed by a single mother.

- ***June 1987:*** 4,962 families were living in temporary housing, including 11,972 children. The average length of stay was 12.68 months.
- ***June 1992:*** 5,229 families were living in temporary housing, of which 3,579 were housed in Tier II shelters. There were 9,076 children and the average length of stay was 178 days.
- ***June 1997:*** 4,773 families were living in temporary housing, 79 percent in Tier II facilities and family centers. There were 8,412 children in these families, and the average length of stay was 296 days.
- ***March 2003:*** 9,242 families were living in temporary housing, of which 42.6% were housed in Tier II facilities. In addition to hotel-type or group shelters, 2,066 families were living in "scatter site" housing, without access to shelter-based services. There were 16,615 children in the shelter system and the average length of stay was 310 days.

Families in NYC Homeless Shelters



Average Length of Stay in NYC Homeless Shelter



Number of Children in NYC Homeless Shelters