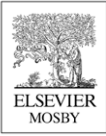

Advances in Pediatrics 54 (2007) 173–187

ADVANCES IN PEDIATRICS

The Health of Homeless Children Revisited

Roy Grant, MA[a,*], Alan Shapiro, MD[b,c], Sharon Joseph, MD[b,e], Sandra Goldsmith, MS, RD[c], Lourdes Rigual-Lynch, PhD[b,c], Irwin Redlener, MD[a,d]

[a]The Children's Health Fund, 215 West 125th Street, New York, NY 10027, USA
[b]Albert Einstein College of Medicine, New York, NY, USA
[c]Community Pediatrics, Children's Hospital at Montefiore, 315 East 64th Street, New York, NY 10021, USA
[d]Mailman School of Public Health, Columbia University, 722 West 168th Street, New York, NY 10032, USA
[e]New York Children's Health Project, 315 East 64th Street, New York, NY 10021, USA

FAMILY HOMELESSNESS IN PERSPECTIVE

Homelessness in America steadily declined through the 1950s and 1960s and ceased to be viewed as a problem during the 1970s [1]. It then began to re-emerge and, based on a finding that homelessness could no longer be ignored, the McKinney-Vento Homeless Assistance Act was passed by Congress and signed into law in July 1987 [2]. This legislation protects access to health care and a free, appropriate public education for the homeless.

McKinney-Vento defines the term homeless as applying to individuals who lack a fixed, regular, and adequate nighttime residence *and* have a primary nighttime residence in a supervised shelter or other transitional housing situation or a public place not designed as sleeping accommodations [3]. This definition excludes as homeless individuals or families who have children who do not have a fixed residence, ie, a home, but who are able to find accommodations in someone else's home. As such, this definition severely undercounts the extent of family homelessness and contributes to confusion about the actual number of homeless people in the United States [4].

In New York City, for example, there were 1134 sheltered homeless families in 1982, increasing to more than 4600 homeless families in 1987 [5]. An estimated 17,000 families, however, were doubled-up in New York City in 1983, growing to more than 100,000 families with more than 300,000 people by the end of 1986 [6]. Nationally nearly 3 million households were living in overcrowded conditions in 1983, according to the US Census Bureau [7]. In 1988 the US General Accounting Office estimated that 73% of the nation's

*Corresponding author. *E-mail address*: rgrant@chfund.org (R. Grant).

0065-3101/07/$ – see front matter
doi:10.1016/j.yapd.2007.03.010 © 2007 Elsevier Inc. All rights reserved.

homeless children and youth were living in doubled-up situations, with only 10% in shelters and welfare hotels [8].

In 1998 it was estimated that 2 million single parent households in the United States were living in doubled-up housing. In New York City the number of doubled-up households in public housing alone was 20 times the number of homeless families in shelters. Doubled-up housing is associated with homelessness, because families whose overcrowded conditions become untenable often seek emergency shelter. In a national household telephone survey, 59% of those who had been doubled-up also reported periods of homelessness [9]. Families who find themselves in doubled-up situations after exiting the homeless shelter system are more likely to become homeless again, whereas families who are able to obtain rent subsidies when they exit shelters are more likely to remain housed [10].

Policy analysts generally attribute the growth of child and family homelessness to economic conditions, specifically consistent reductions in federal support for new or subsidized housing and stagnation of public assistance benefits and the minimum wage. US Department of Housing and Urban Development (HUD) funding declined from $32 billion in 1980 to $7 billion in 1987 [6]. The US Conference of Mayors reported that the demand for emergency shelter increased in 92% of the large cities surveyed during 1986. There was an 88% increase in demand for low-income housing, with only 30% of eligible households (10% in New York City) having their housing needs met. The population whose shelter needs grew most during this period was families with children [2,11]. These economic factors especially impacted families with psychosocial vulnerabilities, including domestic violence, substance abuse, and mental illness [12].

Throughout the 1990s the disparity between income and market-based rental costs, together with limited housing assistance, continued to place low-income families at risk for homelessness or overcrowded, doubled-up housing conditions [13]. The percentage of rental households with a heavy rent burden (more than 35% of monthly income spent on rent) peaked in 1995 at 35.6% and remained at greater than 30% at least through 2001. Recent US Census Bureau, American Housing Survey data show that more than 14 million American households pay 50% or more of their income for rent [14].

The typical homeless family in the 1980s was headed by a single mother who had been receiving public assistance benefits for 2 or more years and did not have a job or work history. Social isolation was common [15]. Socially isolated families are by definition less likely to have a support network that would make doubled-up housing an alternative to the homeless shelter system. Other factors associated with family homelessness include family violence (intimate partner violence or a history of having been abused as a child) that may have contributed to social isolation. Serious mental illness only affected a small minority of homeless mothers [16].

This general profile has remained consistent. A 1999 national survey found the following demographic characteristics for homeless families: female head of household (95%); race-ethnic minority: African American (58%), Latino (13%), white (22%); unemployed (79%); median earned income, current or previous,

$11,400; children younger than 5 years of age (47%), 5 to 17 years (53%) [17]. More generally the demographics of homeless families mirror those of poverty in each community [18].

A 2004 study by the Vera Institute describing New York City's homeless families found that for most their last address was in 1 of 10 low-income communities, all predominantly African American and Latino. The two most common reasons for entering the shelter system were overcrowded housing and eviction, followed by domestic violence, unsafe housing conditions, and economic strain [19].

As family homelessness increased, so did hunger and food insecurity. These trends are tracked annually by the US Conference of Mayors. Food emergencies and need for food assistance increased in 76% of the large cities surveyed during 2004, with an average 7% increase among families who had children. Nearly one out of five (18%) of requests for food assistance could not be met [11].

In New York City from 2003 to 2005, one in six residents (1.25 million) could not afford enough food, and 15.4% lived in a food-insecure household, an increase of 112,000 people over 2000 to 2003. Nearly half (46%) of the city's emergency food pantries did not have sufficient food to meet demand, turning people away, rationing, or limiting hours of operation [20].

HOMELESSNESS AND CHILD HEALTH

As family homelessness grew, many studies were published describing the health status of homeless children. A 1988 study of children younger than 5 years of age in the New York City shelter system found that, based on retrospective review of medical charts, homeless children had more serious medical problems than low-income housed children, including immunization delay, high lead levels, and hospital admissions [21]. Also in 1988, survey data from Seattle found a high obesity rate (35%) based on weight-for-height. Homeless children were much more likely to be rated as being in fair or poor health than typical, and emergency department use was two to three times greater than for the general pediatric population. Combined with a high rate of under-immunization, the data strongly suggested that homeless children did not have access to preventive healthcare [22].

A 1991 survey of homeless children in Philadelphia found high rates of accidents and injuries, elevated lead levels, and speech-language delay [23]. A 1990 Los Angeles study found homeless children frequently had poorly balanced diets. Compared with housed low-income children, homeless children had a higher rate of obesity and higher rates of developmental delay, school failure, and behavior problems [12]. These health problems have persisted for homeless children. In a 1998 Boston study, homeless children had higher rates of acute illnesses, including ear infections and chronic conditions including asthma, and of emergency department use, than did low-income housed children [24].

Nutritional problems were emphasized in a 1991 study that found a high rate of growth delay, specifically stunting without wasting, suggestive of chronic

nutritional stress, among New York City homeless children [25]. Homeless shelters are especially challenging environments in which to maintain adequate nutritional intake. Most do not have cooking facilities, and some do not allow food, even infant formula, to be stored in shelter rooms. These problems are often compounded by extreme poverty and geographic isolation from adequate food shopping options [26,27].

School attendance for homeless children is frequently disrupted because of moves among unstable housing situations and shelters and logistic problems of transportation, obtaining school books and clothes, space to do homework, and so on. Too often the legal rights to an appropriate education are not honored for homeless children despite the protections of the McKinney-Vento Act [28].

By 1987 studies done in Massachusetts established high rates of developmental delay, depression, anxiety, and academic problems among homeless children. Approximately half required psychiatric referral [29]. A 1990 Boston study found a higher rate of developmental delay among preschool homeless children compared with poor housed children [16]. More recent data show that more than half (57%) of school-age homeless children had depressive symptoms based on the Children's Depression Inventory (CDI), and one fourth (26%) required psychiatric evaluation based on CDI and Child Behavior Checklist (CBCL) scores [30].

Studies of homeless children in Los Angeles found that approximately three fourths (78%) showed signs of depression, anxiety, or academic delay based on results of standardized measures, with only 15% having received mental health or special education services. Fewer than half of the 45% of homeless children who met criteria for special education evaluation received any intervention [31,32].

In a 1991 descriptive study at the once-notorious Hotel Martinique in New York City, three fourths of 3- and 4-year-old children presented with speech-language delay and/or behavioral problems characterized by impulsivity on entry to an on-site comprehensive day care center. Delivery of preschool education in a normalizing setting was sufficient to restore age-appropriate functioning for most of these young children [33]. These findings were consistent with earlier studies [34,35]. Environmental factors negatively impacting the development of young homeless children in the late 1980s included extremely harsh shelter conditions marked by small, overcrowded hotel rooms fraught with potential sources of accidental injury [36].

Recent studies of the health impact of homelessness have focused on asthma. Shelter-based surveillance in New York City found a lifetime asthma rate (using a screening instrument consistent with National Heart, Lung and Blood Institute guidelines) of 40% among homeless children in 1999, the highest documented pediatric asthma prevalence rate in the United States [37]. Continued screening with this protocol in subsequent years (1999–2002) showed the asthma prevalence rate leveling off at 32% [38]. These findings are consistent with data from a school-based health center in East Harlem, a New York

City community with a high pediatric asthma prevalence rate [39]. Homeless patients were 2.5 times as likely to have a health problem and 3 times as likely to have a severe health problem as were housed children using the school health center. The asthma rate among the homeless patients was 33% [40].

SETTING FOR THE STUDY

The New York Children's Health Project (NYCHP), a program of The Children's Health Fund (CHF), has provided comprehensive health care to homeless children and families in a medical home model continuously since 1987. Health care is delivered through mobile medical units parked in front of shelters or in clinics established on-site at shelters. Typically children have their first pediatric visit within weeks of their entry to the shelter system. As the number of homeless children in New York City grew (reaching 9090 families with 16,594 children in December 2003) [41] and attention to the health of homeless children diminished, investigators at NYCHP and CHF conducted a comparison study of health status of homeless children in 1988 and 1998.

Results showed statistically significant improvement in immunization status and prevalence of iron-deficiency anemia and significantly higher rates of asthma and otitis media based on retrospective electronic health record review of representative samples of pediatric patients for those years. There was a trend toward increased obesity, defined within the limitations of anthropometrics taken at the time, as weight at or greater than the ninety-fifth percentile [42]. The present study was designed to expand on that study, comprehensively describing the health status of homeless children in 2004.

METHODOLOGY

A representative random sample of homeless pediatric patients age 3 months to 19 years (n = 520) was derived from a list of all pediatric patients of the NYCHP seen during 2004 (n = 3380). The age distribution mirrored that of the general patient population: 3 to 23 months, n = 180 (35%); 24 months to 5 years, n = 140 (27%); 6 to 19 years, n = 200 (38%). Data were extracted from electronic health records, and key health conditions were recorded as yes/no for each patient. An additional random sample of 100 patients aged 19 to 35 months was assessed for immunization status.

Immunization status was assessed relative to American Academy of Pediatrics and Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines in effect during the service year. For the 2004 sample, obesity was determined by body mass index (BMI) and percentile. Obesity was defined as BMI at or greater than the ninety-fifth percentile on CDC 2000 growth charts. Iron-deficiency anemia was determined by hemoglobin values relative to CDC criteria [43]. Asthma data were based on lifetime diagnosis and included diagnosis of reactive airways disease. Otitis media data were based on primary care providers' recorded ICD-9 code for visit and included diagnoses of acute otitis media, chronic otitis media, serous otitis media, and, least frequently, otitis media with effusion (OME).

By 2004 NYCHP behavioral health services had expanded, and data were recorded for developmental and mental health conditions. Diagnoses were made using ICD-9 and DSM-IV criteria by a clinical psychologist following referral by the primary care provider or parent. Formal testing was not done. Children who had developmental or behavioral problems were referred to the age-appropriate service system (Early Intervention Program, Preschool or School-Age Special Education), and the authors were concerned that a practice effect from repetition of formal testing might influence eligibility determination for these Individuals With Disabilities Education Act (IDEA) programs.

All diagnosed children were referred for services, and all who followed through with an IDEA program evaluation met eligibility criteria. In New York State, IDEA eligibility criteria are developmental delay of at least 33% relative to chronologic age in one developmental domain or at least 25% in two developmental domains, or test scores of at least 1.5 standard deviations below the mean on a norm-referenced test.

Where possible, comparisons were made between prevalence in this homeless population and available data for typical and at-risk pediatric populations.

STUDY RESULTS

Demographic characteristics

The mean age of the sample was 5.4 years; the mean age of all pediatric users for 2004 was 5.6 years. Race-ethnicity of the patients was 56% African American, 42% Latino, and 2% other or unknown. Forty-nine percent were male. All were eligible for Medicaid. Virtually all lived in single parent, female-headed households.

Immunization status

In 2004 78% of homeless children were up-to-date for mandatory immunizations. These data exclude patients who did not have an immunization record available for inspection. This up-to-date rate is comparable to immunization data from a 2004 national study of children 19 to 35 months of age participating in the Women, Infants, and Children (WIC) supplemental nutrition program. Investigators found 77% up-to-date for WIC participants and 71% up-to-date for WIC-eligible children who had never participated [44].

The immunization rate in this homeless population is consistent with 2005 data from the New York City Department of Health and Mental Hygiene for many of the city's low-income communities [45]. This rate for homeless children meets the CDC Healthy People 2010 target of 80% up-to-date for DTP, polio, HiB, MMR, and HepB immunizations [46]. This 2004 up-to-date rate is a statistically significant improvement ($P < .01$) over the 54% rate found for 1998.

By 2004 the WIC program required that participating infants and toddlers have mandated immunizations to receive nutrition benefits. The authors attribute the improved immunization rate to the fact most young homeless patients participate in WIC and have their immunization status monitored there. Also

most New York City medical providers participated in New York's Citywide Immunization Registry. This computerized repository of immunization records allows providers to verify immunization status, minimizing or eliminating unnecessary duplication of vaccinations. The impact of the Registry on lost immunization records is notable. In 2004 only 7% of patients did not have a record ready for review, compared with 13% in 1998 (and 17% in 1988).

Otitis media

For children 3 to 23 months of age, 37% were diagnosed with otitis media. Among patients 24 to 71 months of age, the prevalence rate was 24%. Because of the transient nature of a homeless population, not all patients were seen over time. For patients who did not remain in the care of the NYCHP, prior history of otitis media was obtained by parent report. Patients who had otitis media who remained in NYCHP care were seen for multiple otitis media visits over time.

Otitis media is an extremely common childhood illness, the incidence of which has been increasing. The rate and frequency of recurrence of otitis media in this homeless population exceed those documented for other pediatric populations. Epidemiologic studies have shown that 71% of children have had at least one acute episode by 36 months of age, with one third having had three or more acute episodes. Highest incidence is generally between 6 and 11 months of age. Three or more episodes of otitis media affects up to 20% of infants by 12 months of age [47,48]. In this homeless population, highest incidence was for toddlers older than 12 months of age, and frequency of recurrence was such that some had eight or more episodes during the course of a year.

Risk factors associated with recurrent otitis media include African American or Latino race-ethnicity, day care or other congregate care, early termination of breast feeding, and poor access to health care [49,50], all of which affect homeless children. An additional risk factor for otitis media is exposure to environmental tobacco smoke [51]. Most NYCHP pediatric patients spend time each day cared for by adults who smoke in their presence.

Although there are controversies about whether or not to treat otitis media with antibiotics [52], in this population pediatricians found that failure to complete the prescribed course of antibiotics was associated with recurrence. Issues in failing to comply with medication instructions included hoarding antibiotics for possible later use when access to health care may be more difficult and misunderstanding directions, with antibiotic administration stopped as soon as the child was no longer symptomatic.

Asthma

The asthma prevalence rate for this homeless pediatric population was 31.5%. Because of controversies about early diagnosis of asthma [53], the authors also determined the rate for children less than 36 months of age. This rate (32.2%) does not differ significantly from the overall rate for this homeless population. These data are consistent with the 32% asthma prevalence rate from CHF's homeless shelter surveillance data (reflecting health status while still housed)

and the 33% rate among homeless school-based health center patients in East Harlem referenced previously.

The CDC (National Health Interview Survey, National Center for Health Statistics) report a lifetime child asthma prevalence of 12% for 2004, with a current asthma prevalence rate for children in poverty (household income below the federal poverty level) of 10% [54]. The asthma rate among homeless children far exceeds these figures.

Comparable community data are found in a study by the Harlem Children's Zone (HCZ) using methodology similar to that used in the CHF homeless shelter surveillance study. The community surveyed, Central Harlem, is one that has been identified as a main community of origin for families entering the city shelter system. HCZ investigators found a diagnosed asthma prevalence rate of 28.5%. Including children who had pulmonary findings consistent with asthma and who had not yet been diagnosed, the Central Harlem child asthma prevalence rate increased to 30.3% [55].

The issue of under-diagnosis of children in high-risk communities may contribute to variations in asthma prevalence data. In the CHF homeless shelter screening data cumulative for 1998 to 2002 (n = 2376), 16% of children who had moderate to severe asthma symptoms had not been previously diagnosed [38].

Iron-deficiency anemia

For homeless children younger than 3 years of age, the iron-deficiency anemia prevalence rate was 19%. For comparison, the CDC rate (2000) was 7% [56], and the National Health and Nutrition Examination Survey (NHANES) III rate was 9% [57]. There are significant racial-ethnic disparities in iron-deficiency anemia prevalence, with the rate for white children younger than age 36 months being 6%, for African American children, 8%, and for Mexican American children, 17% [58]. The rate for homeless children exceeds the highest of these rates.

Prevalence of iron-deficiency anemia in 2004 was significantly higher than in 1998 ($P < .05$). The 9% rate in 1998 and significant improvement over 1988 was consistent with a trend toward reduced prevalence of iron-deficiency anemia among low-income young children through the 1990s [59]. The increase in 2004 is consistent with the more recent increase in hunger and food insecurity as tracked and reported by the US Conference of Mayors over the past years [11].

Among the factors associated with iron depletion and anemia are bottle feeding during the second and third year of life [60], which often affects homeless children. Iron-deficiency anemia is also associated with food insecurity, including food insufficiency, poor nutrition, and hunger [61]. Many homeless families regularly experience food insecurity, and young children in food-insecure families are more likely to be in fair or poor health, to be hospitalized, and to experience psychologic stress and anxiety [62].

Iron-deficiency anemia may also be associated over time with compromised cognitive outcomes. Longitudinal studies, however, have been limited by confounding variables associated with poverty also impacting children

who have a history of early iron-deficiency anemia [63,64]. Iron-deficiency anemia was not associated with developmental delay in this homeless population.

Overweight and obesity

Overweight and obesity prevalence for children 6 to 19 years old were 12% overweight (BMI between eighty-fifth and ninety-fourth percentile) and 31% obese. An additional 3% were underweight (BMI, $\leq$ fifth percentile). Only 54% had a BMI percentile within normal range.

For children 6 to 11 years of age (n = 129), 32% were obese; for children 12 to 19 years of age (n = 71), 28% were obese. These far exceed typical rates. CDC reports a steady increase in child and adolescent obesity, with rates in 2004 of 19% for children 6 to 11 years of age and 17% for adolescents 12 to 19 years of age [65].

Pediatric obesity is a condition with marked racial-ethnic disparities in prevalence and sequelae that may include type 2 diabetes and cardiovascular disease. African American and Latino children are most impacted. Nationally among African Americans, the overweight and obesity rates are 40% (6–11 years of age) and 36% (12–19 years of age). Data for Mexican American children and youth are 43% overweight (6–11 years of age) and 34% obese (12–19 years of age) [66]. The combined prevalence of overweight and obesity in the homeless population was consistent with these race-ethnic disparity data. A higher percentage of homeless children were obese, however, and therefore at higher risk for associated health problems.

This comparison is similar for data from a 2004 New York City Department of Health and Mental Hygiene study of overweight and obesity in public elementary school children (corresponding to the 6–11-year age group). The city public school data showed a 43% rate of overweight and obesity, comparable to the homeless population. Obesity prevalence was 24% [67], however, compared with 32% in the homeless population.

Obese children may show other signs of poor nutrition, including iron-deficiency anemia [68]. For low-income children, obesity may be associated with household food insecurity [69]. Taken together, the rates of iron-deficiency anemia in young homeless children and obesity in school-age homeless children indicate a high degree of health risk associated with poor nutrition.

Mental health and child development

For the homeless population 12 months to 19 years of age, 30% had a developmental or psychiatric diagnosis. For infants younger than 12 months of age (n = 82), 15% had a developmental problem. One third of these infants were diagnosed with psychosocial failure to thrive, the others with developmental delay. Overall for the birth to 35-month-old population age-eligible for the Early Intervention Program, 19% met eligibility criteria based on developmental delay. For comparison, data from the New York City Early Intervention Program show that 8% of live births from an annual birth cohort were referred to the program, with virtually all who were evaluated meeting eligibility criteria

(unpublished data from the New York City Local Early Intervention Coordinating Council, 2003).

Among 3- and 4-year-old children (n = 81) age-eligible for preschool special education, 41% had developmental delays or behavior problems. Of these children, 52% were diagnosed with developmental delays, 27% with adjustment reactions, 15% with attention deficit hyperactivity disorder (ADHD), and 6% with post-traumatic stress disorder (PTSD). In this homeless population, recurrent otitis media is associated with diagnosed early developmental conditions and is likely to be a contributing factor to developmental delays [70].

Among elementary school-age children (5–11 years of age; n = 157), 34% were diagnosed with a developmental or psychiatric problem. Of these children, 17% were diagnosed with a developmental or learning problem, 47% with an adjustment reaction, 25% with ADHD, and 11% with PTSD.

Among adolescents 12 to 19 years of age (n = 71), 24% were diagnosed with a psychiatric disorder, of whom 29% were diagnosed with an adjustment reaction, 29% with depression, 24% with PTSD, and 18% with ADHD.

Exposure to domestic violence (DV) is associated with having a behavioral health diagnosis. The overall prevalence of DV exposure for this homeless population was 34%; for children who had a developmental or psychiatric diagnosis, prevalence was 44% ($P < .01$).

Prevalence data for developmental and psychiatric disorders of childhood are inconsistent. For example, a comprehensive review of the literature on behavior problems among low-income preschool children found ranges of 16% to 30% for externalizing problems and 7% to 31% for internalizing problems [71]. One study concluded that approximately 50% of Americans meet criteria for a psychiatric diagnosis at some point in their lifetime, and approximately half of them (25%) meet criteria during childhood or adolescence [72].

The US Surgeon General's 1999 Report on Childhood Mental Health found 20.9% of children have a current mental disorder causing at least minimal impairment [73]. This is a lower threshold than was applied to the homeless population. The Urban Institute, citing its 2002 National Survey of American Families, found a 13% rate of emotional or behavioral problems among Medicaid-eligible children aged 6 to11 years, and 14% for children aged 12 to 17 years [74]. The rates in this homeless population were 33% and 24%, respectively.

A limitation of the authors' chart review methodology is that the authors could not include teacher reports of academic failure, grade retention, special education, and school problem behavior independent of a clinical diagnosis [75,76]. Even with this limitation, the prevalence of behavioral health problems in this homeless population exceeds rates generally considered typical for children and adolescents, including the higher rates for children and adolescents in poverty.

The authors' data suggest that the most serious impact of homelessness and its antecedent conditions is on younger children, which is to be expected given patterns of typical development. This finding is consistent with a 1998 study

comparing developmental status of homeless and housed low-income infants and young children, which concluded that the impact of homelessness and poverty is cumulative and emerges over time [77].

SUMMARY

To the extent that representative data are available for specific health conditions (eg, under-immunization, asthma prevalence), the authors' data suggest that the gap between the health status of homeless children and housed children in minority, low-income families is narrowing. Studies of the health status of homeless children allow a window into the health status of medically underserved children whose needs may not be readily documented because of their lack of access to the health care system.

Although prevalence rates of most of the health conditions discussed in this article exceeded national norms, they were generally consistent with rates characteristic of health disparities based on race-ethnicity and income. It must be emphasized that in most instances, children were seen for their first pediatric visit within weeks of entering the homeless shelter system. The health conditions identified were often present before the child and family became homeless. The high prevalence of asthma among homeless children should therefore be a matter of concern to health providers and payors, because the authors' data strongly suggest that this is not confined to children in homeless shelters as a special population. Similarly, childhood obesity predates homelessness (or at least the episode of homelessness during which health care was provided) and as such the authors' data may indicate the extent of this problem more generally among medically underserved children in the communities of origin.

These conditions seem to be exacerbated by the specific conditions associated with homeless shelter life. Asthma care, assuming it was previously available, is disrupted when housing is lost, and shelter conditions may have multiple asthma triggers. Nutrition often suffers as a result of inadequate access to nutritious food and cooking facilities in shelters, as indicated by the high rate of iron-deficiency anemia among very young children.

It is clear that homeless children in shelters require enhanced access to primary and specialist care. Shelter placement necessarily disrupts prior health care relationships (if any), while simultaneously placing additional stress on the child's physical and emotional well being. A medical home model is strongly recommended to allow for continuous, culturally competent care.

Developmental and mental health problems are also more prevalent among homeless children. These conditions may jeopardize life successes. The overcrowding associated with homeless shelters and the housing conditions that frequently precede episodes of homelessness are associated with the higher prevalence of otitis media found among young children. This in turn is associated with developmental delay. Also contributing to the developmental risk associated with homelessness is exposure to DV, which is also frequently an antecedent of homelessness.

Developmental surveillance for young homeless children, monitoring of school attendance and academic performance, and assessment of mental status for homeless adolescents are recommended to facilitate early identification of problems and delivery of necessary interventions. For young children, providers of health care to the homeless should be well networked into the Early Intervention and Preschool Special Education programs in their locality.

Given the multiplicity of needs for homeless families, which of course includes help finding affordable housing, health care providers serving this population should also develop linkages with community agencies, including those that can help parents develop the skills necessary for economic self-sufficiency and long-term ability to sustain independent housing.

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