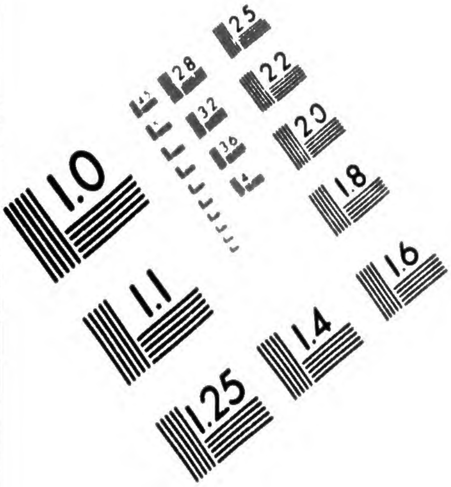

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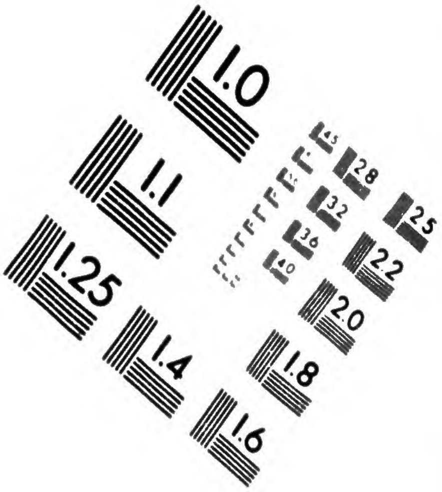

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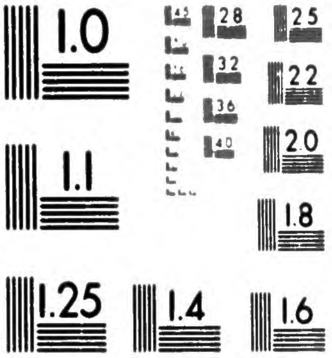

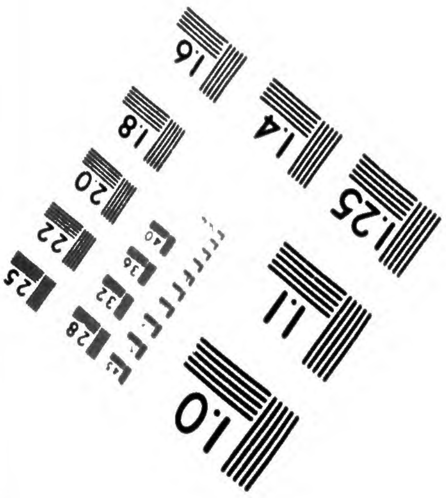

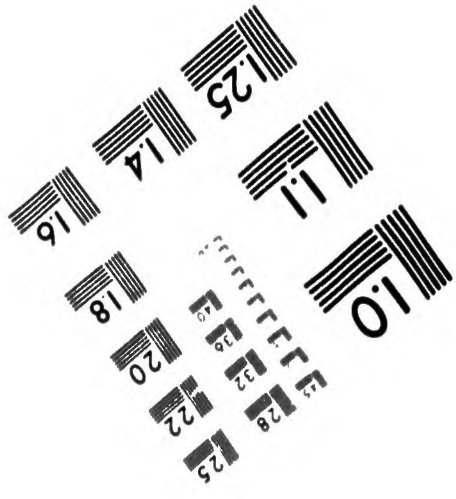

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ABSTRACT

This monograph describes a University Affiliated Program's (UAP) initiative that targets the development needs of children from birth to 5 years of age who are homeless and the services and supports provided to their families. The Georgetown University Child Development Center, the UAP for the District of Columbia, has implemented a homelessness initiative that revolves around two projects. The first, Kidstart, is a national project funded by the Better Homes Fund and the Fannie Mae Foundation. Its primary focus is advocacy and developmental services for school-age children and their families who are homeless. The Georgetown Kidstart program is located in a child care center for homeless children. Project staff provide developmental screening and service coordination. The second project, Knock on Every Door, receives primary funding from the Hasbro Children's Foundation to provide developmental screening, assessment, service coordination, advocacy, and support to homeless families with children birth to 5 years of age. Since its inception, over 300 children have received services. Information is provided about: (1) the approaches of both programs, which feature community collaboration and interdisciplinary service delivery; (2) developmental screening and assessment of young children; (3) barriers to accessing services and supports; (4) profiles of two families using services; and (5) recommendations for advocacy and policy development. (Contains 32 references.) (SLD)

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A University Affiliated Program's Response

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A University Affiliated Program's Response

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Prepared by:
Tawara D. Taylor
&
Marisa C. Brown

The Georgetown University Child Development Center
Center for Child Health and Mental Health Policy
A University Affiliated Program
3307 M Street, NW, Suite 401
Washington, DC 20007-3935
(202) 687-8807

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Georgetown University Child Development Center:

The Georgetown University Child Development Center (GUCDC), Center for Child Health and Mental Health Policy, is a division of the Department of Pediatrics of Georgetown University. The GUCDC was established over three decades ago to improve the quality of life for children with, or at-risk for, special needs as well as adults with developmental disabilities and their families. Supported by a broad array of federal, state, local, and private funding, the GUCDC provides an interdisciplinary approach to service, training, technical assistance, research, community outreach, and policy analysis. The GUCDC is a member of the network of University Affiliated Programs funded by the Administration on Developmental Disabilities, Administration for Children and Families, U.S. Department of Health and Human Services.

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Table of Contents

7

Acknowledgments

In 1989, Phyllis R. Magrab, PhD, Director of the Georgetown University Child Development Center, brought the issue of homelessness to the Georgetown University community by conducting a university-wide forum. Dr. Magrab's foresight led to the establishment of an initiative that would begin to address the developmental needs of young children who are homeless and their families in the District of Columbia. Under her leadership, homelessness has been a targeted area for service, community outreach, training, technical assistance, and policy development within the Georgetown University Child Development Center.

The Administration on Developmental Disabilities is to be commended for the recognition it has given to the impact of homelessness on the development of young children. The Administration on Developmental Disabilities, Administration for Children and Families, U.S. Department of Health and Human Services, provided resources to the Georgetown University Child Development Center, a University Affiliated Program, to bring this issue to a national audience, particularly within the developmental disabilities network, through the publication of this monograph.

The contributions of the Hasbro Children's Foundation, the Better Homes Fund, and the Fannie Mae Foundation are gratefully acknowledged. These foundations have provided the resources to create and implement two service delivery models for children who are homeless and their families—the Knock On Every Door and Kidstart projects.

The Georgetown University Child Development Center was able to implement the homeless initiative in the spirit of community collaboration because of the tireless efforts of Virginia Williams, MA, Senior Advisor. She participated on several task forces on emergency shelter and homelessness within the District of Columbia and helped to influence policy that was driven by the needs of young children at risk for developmental delays or disabilities and their families.

The Kidstart and Knock On Every Door projects shared interdisciplinary team members. Every aspect of project development, implementation, and evaluation was made possible by the genuine caring and expertise of Georgetown University Child Development Center faculty, staff, and trainees. The contributions of the following individuals are sincerely appreciated: Jennie Austin, MSN, RN, CPNT; Rosalind Coleman, Parent Coordinator for Family Advocacy; Diane Jacobstein, PhD; Chahira Kozma, MD; Delyse Slayton, Administrative Assistant; Janet Thomas, MEd, OTR; and Sharon Willig, MA, CCC-SLP.

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Tawara D. Taylor, MA
Associate Director for Community Planning

Marisa C. Brown, MSN, RN
Knock on Every Door Project Coordinator

Introduction

The Changing Face of Homelessness in America

The past decade has witnessed a marked increase in the number of individuals who are homeless. Although estimates vary widely, approximately 2.5 million Americans are homeless (Bassuk & Rosenberg, 1992). There is, however, no one definition of homelessness (Dornbusch, 1994). The term *residential instability* has been used to describe homelessness as a continuum extending from those individuals who may be subjected to multiple unplanned moves in a single year to others who live on the street or in abandoned buildings or cars (Buckner, 1991). Homelessness has traditionally been associated with adult males living in "skid row" environments. In recent years, however, there have been significant changes in the demographic makeup of those who actually comprise the homeless population in America.

During the 1970s, the homeless population increased as a result of a movement to deinstitutionalize adults with chronic mental illness. Today, families comprise the fastest growing segment of the homeless population. The number of families who are homeless has increased from 27% of the homeless population in 1985 to 36.5% of the population in 1995 (U.S. Conference of Mayors, 1995). It is anticipated that, as the safety nets of public support are diminished, this disturbing trend of homelessness among children and families will continue and, in fact, may increase.

While all families who are homeless are by definition poor, poverty in and of itself does not result in homelessness. Families who are homeless experience crisis poverty. *Crisis poverty* refers to the combination of poverty and one or more of the following factors: disability, substance abuse, or chronic stress from the effects of substance abuse in the environment, including violence, and the incarceration or death of family members. Furthermore, these destabilizing factors occur in conjunction with inadequate community supports. (Martin, 1994).

Risk Factors for Developmental Delays and Disabilities Among Children Who Are Homeless

Children who are homeless experience environmental, socioeconomic, and biological risk factors which place them at higher risk than other children for developmental delays and disabilities. Recent studies have documented the effects of homelessness on child development, including increased incidence of learning disabilities, cognitive impairment, language and fine motor delays, and psychological problems such as anxiety, depression, and behavioral disorders. These effects on child development are not surprising given that families who are homeless experience crisis poverty. All of the factors associated with crisis poverty are integrally linked to risk factors for developmental delays and disabilities among young children.

Substance abuse is one of the most prevalent problems among adults who are homeless (Nuñez, 1994). Children whose parents are substance abusers are in double jeopardy due both to biological and environmental risk factors. While some children who are exposed prenatally to substances experience no adverse effects on their development, others are significantly affected (Carta et al., 1994; Coles & Platzman, 1993) Children born to substance abusing women may present with a range of problems that negatively affect their development. These problems include low birth weight, prematurity, HIV infection, and sudden infant death. These biological risk factors can result in higher incidence of developmental delays and disabilities. Babies with low birth weight are significantly more likely to have neurodevelopmental disabilities than normal birth weight babies (Willis & Holden, 1990). Among these are cerebral palsy, mental retardation, autism, and hearing impairments. Low birth weight is also associated in later life with learning disabilities, developmental delays, and attention deficit disorder/hyperactivity (Hack et al., 1994).

Families affected by substance abuse typically live in extremely chaotic environments which negatively impact child development. Research notes the difficulty in isolating the effects of prenatal substance exposure on the development of infants and children from the effects of the environment in which they reside (Rodning, Beckwith, & Howard, 1989). These children often live in dangerous, unstable, and transient living environments where their basic needs may not be met or are inadequately met due to their parents' drug dependency (Taylor, 1991). Under these circumstances, parents are often unable to provide consistent nurturing and guidance to promote optimum child development. Children residing in such environments may be undernourished, receive sporadic health care, and are at increased risk for child abuse and neglect.

Unstable and overcrowded living conditions, which are precursors to homelessness, also increase women's and children's exposure to domestic and community violence. Researchers have cited the correlation between domestic violence and the maltreatment of infants and children. Mothers who were abused by their male partners had higher rates of child abuse than non-battered women (Strauss, 1993). Studies note that domestic violence increases in families living in shelters (Waxman & Reyes, 1987). Numerous studies show that homeless women are twice as likely to be abused and beaten as non-homeless poor women (Nuñez, 1994). Since exposure to violence affects children differently at different ages, repeated exposure to violence may lead to more significant or severe effects as children grow older

(Osofsky & Fenichel, 1994). Exposure to violence affects children's development in multiple ways including disrupted eating and sleeping patterns, fearfulness, anxiety, difficulties attending and relating (Drell, Siegel, & Gaensbauer, 1993), and aggression and withdrawn behaviors (Cummings, Ballard, El-Sheikh, & Lake, 1991).

The adverse effects of poverty on child development have long been recognized. The Children's Defense Fund special report entitled *The Costs of Child Poverty* (1994) notes that poor children are over two times more likely to suffer from health problems including stunted growth, severe physical or mental disabilities, fatal accidental injuries, fair or poor health, iron deficiency, and severe asthma. When compared to non-poor peers, low income children are more likely to be born at low birth weight, have learning disabilities, and exhibit extreme behavior problems.

The literature reflects longitudinal data that support the outcomes described above. However, the increasing numbers of young children who are homeless is a recent phenomenon, and, while the cumulative effects of these risk factors can be surmised to have a negative impact, the actual long term consequences of homelessness on young children are yet to be determined.

Overview of Monograph

This monograph describes a University Affiliated Program's initiative which targets the developmental needs of children birth to five years of age who are homeless and the services and supports provided to their families. It provides a description of the children and families served by one of the initiative's projects and an approach for the identification and referral of children who present with developmental delays and disabilities. Interventions that have been successful with families as well as barriers to accessing services are delineated. Finally, recommendations for advocacy and policy development within the developmental disabilities network are given. The goal of this monograph is to bring the issue of homelessness and its impact on the development of young children to the attention of a national audience and to influence state and national policy through the developmental disabilities network.

A University Affiliated Program's Response to Homelessness

In 1990, the Georgetown University Child Development Center (GUCDC), the University Affiliated Program (UAP) for the District of Columbia, conducted a campus-wide forum to explore the role the university could play to address issues of homelessness in the city. A variety of university volunteer efforts ensued. Through its collaboration with a local pilot project which provided mental health services to families who were homeless, the GUCDC identified the need to assess the developmental status of young children residing in emergency shelter. The GUCDC then implemented a faculty volunteer program that provided developmental screening for children birth to five years of age living in shelters with their families.

This initial effort was the basis for a homelessness initiative that is currently funded by grants from the Hasbro Children's Foundation, the Better Homes Fund, the Fannie Mae Foundation, and the Administration on Developmental Disabilities, U.S. Department of Health and Human Services. These combined resources have resulted in the development and implementation of a family-centered, culturally competent, community-based model of service delivery which responds to the needs of families with young children who are homeless in the District of Columbia. The GUCDC has used this model to successfully influence local policy development and planning for the delivery of services and supports to the District's homeless population. While this model has been implemented solely at the local level, it has demonstrated efficacy which merits replication across the nation in other communities and jurisdictions with a high incidence of homelessness.

The GUCDC's homelessness initiative has revolved around two projects. The first, Kidstart, is a national project funded by the Better Homes Fund and the Fannie Mae Foundation. This project was developed in recognition of the fact that preschool-age children who are homeless experience an increased incidence of developmental delays and emotional difficulties. Moreover, nationally, services and supports are overwhelmingly geared toward the school-age child. The primary purpose of Kidstart is to provide advocacy and developmental services for preschool-age children and their families who are homeless. Each of the 17 Kidstart projects nationwide is administered in response to local needs.

The GUCDC Kidstart project is located within a child care center that exclusively serves families who are homeless and their children ages 2½ to 5 years. This child care center is also a Head Start homeless demonstration site. The GUCDC Kidstart project staff consist of a clinical psychologist and a family services coordinator. Project staff provide developmental screening and service coordination to children and their families. Consultation is offered to the teaching and administrative personnel at the demonstration site to facilitate the inclusion of children with developmental delays and disabilities into all aspects of the child care program. Kidstart project staff also provide supportive services to assist children and families with transition from the child care program to local public and private kindergarten programs.

The second project, Knock On Every Door, receives primary funding from the Hasbro Children's Foundation. The project is funded to provide developmental screening, assessment, service coordination, advocacy, and other supports to families who are homeless and have children birth to five years of age. Knock On Every Door is built upon a university-community partnership of outreach to families of young children living in emergency shelter. The Administration on Developmental Disabilities provided funding to Knock On Every

Door in order to expand service coordination and to disseminate information on the relationship between homelessness and developmental delays and disabilities among young children. The Knock On Every Door project is staffed by an interdisciplinary team. The two projects share team members and, through this collective experience, interdisciplinary team members have gained unique insight and expertise in the provision of services, supports, and advocacy to a local population of young children and their families who are homeless.

The District of Columbia: A Demographic Portrait

The Georgetown University Child Development Center is located in the District of Columbia which is home to approximately 606,900 residents. A brief composite of demographic data related to age, family income, and cultural diversity of the residents of the District of Columbia is as follows. The District's total population consists of: 65.8% African American, 29.6% White, 5.4% Latino/Hispanic, and 1.8% Asian (1990 Census). Nationally, the homeless population is estimated to be 56% African-American, 29% White, 12% Hispanic/Latino, 2% Native American, and 1% Asian (U.S. Conference of Mayors, 1995). There are 117,092 children in the District under 18 years of age. Among these, 44,174 are younger than 6 years of age. Eighty percent of the District's child population is African American, 15% is White, 6.2 % is Latino/Hispanic, and 1% is Asian.

The majority (51%) of all households with children in the District are headed by females. Nearly 60% of African American households with children have female heads and 15% of White households with children are headed by females. The majority of all Latino/Hispanic households with children (59%) are married-couple households. Thirteen percent of all Latino/Hispanic households, however, are single parent households with male heads, and 29% are ones with female heads (Children's Defense Fund, 1991).

The District's poverty rate is 16.9%, while the poverty rate for the other jurisdictions within the Washington metropolitan area is 6.4% (D.C. Government Indices, 1992). One in every three District children lives in poverty— a rate 40% higher than the national average.

There are an estimated 7,500 individuals in the District of Columbia who are homeless. Among these, at any given time there are approximately 135 families residing in emergency/temporary housing and an additional 300 families are on a waiting list for this housing. These statistics only reflect those families who are known to the system and who have applied for services. It should be noted that, despite the District's culturally diverse population, the overwhelming majority of families presenting for public emergency shelter services have been African American. While there is no recent, formal data on the incidence of homelessness among other cultural and ethnic groups in the District, anecdotal data reveal that: 1) Hispanic/Latino families typically seek shelter resources from non-profit agencies which specifically target the Hispanic/Latino community, and 2) Asian families seem to provide natural supports or access community supports which prevent homelessness from occurring.

Characteristics of Families Served by This Project

Since the inception of the Knock On Every Door project in 1993, over 300 children from more than 200 families have received services. The families described in this monograph are African Americans who reside in a large urban setting. The majority of households are headed by a single female. Family size ranges from two to ten members—the majority being three-member households.

Families receiving services from the Knock On Every Door project experience residential instability for many months prior to seeking emergency shelter services and they report frequent moves from the residence of one friend or relative to another. Families tend to describe these settings as overcrowded and chaotic with illicit drug activity and domestic violence. Children are often exposed to multiple caretakers. It is not unusual for families to be separated in an effort to house all of their members; for example, older children may live with grandparents or other extended family members. Fathers seem to be involved to some extent with their families although they do not typically reside in the household.

Approach

The GUCDC is committed to the development and implementation of programs which utilize a collaborative community approach and which are interdisciplinary, accessible, family centered, and culturally competent. In keeping with this commitment, the Knock On Every Door Project was designed to include the following components:

- Developmental screening for children birth to five years of age
- Diagnostic assessment for children failing developmental screening criteria
- Collaboration and coordination with existing community service providers for young children and their families.
- Family-centered service coordination that includes advocacy

Community Collaboration

The Knock On Every Door Project involves collaboration with key stakeholders and public and private sector agencies within the District of Columbia which are responsible for services to families who are homeless. Primary collaboration is with the Community Partnership for the Prevention of Homelessness. The Community Partnership was created in 1993 by an agreement between the Mayor of the District of Columbia and the Secretary of the U.S. Department of Housing and Urban Development (HUD) to address the multiplicity of needs for persons who are homeless in the city. As of May 1995, all homeless programs and services formerly administered by the D.C. Office of Emergency Shelter and Support Services became the responsibility of the Community Partnership.

Other collaborators include:

- Private sector emergency housing and supportive services providers
- D.C. Public Schools System
- D.C. Commission on Social Services
- Part H Program and early intervention service providers
- Child care and Head Start centers
- Public and private mental health agencies
- Primary health care providers
- Legal advocates

This community-based approach ensures that multiple resources are used in addressing the special needs of young children and their families and that linkages among community services are established.

Interdisciplinary Service Delivery

An interdisciplinary approach is integral to the delivery of comprehensive services for this vulnerable population. The interdisciplinary team for the Knock On Every Door Project provides developmental screening, diagnostic assessment, service coordination, and advocacy to families of young children living in emergency shelter. The team consists of a nurse specialist in developmental disabilities who serves as the project coordinator, a clinical psychologist, a speech-language pathologist, an occupational therapist, a developmental pediatrician/geneticist, a parent coordinator for family advocacy, and a pediatric nurse practitioner (the latter two function as service coordinators).

Accessible Services

All services provided by the Knock On Every Door project are delivered in community-based settings. Developmental screening and diagnostic assessments are offered at the Family Resource Center, the intake site where District families come to request emergency housing services. Developmental screening is also provided on site at emergency housing units either in the family's apartment or in multi-purpose rooms. Funds are provided to assist families with transportation expenses for appointments at the Family Resource Center and at other community agencies related to receiving assessment services.

General information brochures about the Knock On Every Door Project are written in simple formats. Developmental screening reports and diagnostic assessment reports avoid the use of jargon and are orally reviewed with each family to ensure accessibility of information for parents who are illiterate or low-literate. Any other accommodations needed for family members with sensory disabilities are made on an as-needed basis.

Family-Centered and Culturally Competent Practices

Family-centered services refers to a philosophy built upon the beliefs that: 1) families are composed of competent caregivers, 2) the family is an important social institution that needs to be preserved, 3) families can and should make important decisions about their interactions with agencies and service providers, and 4) families have rights and beliefs that need to be recognized and respected (Roberts, 1988). Service delivery systems that are family centered recognize inherent strengths within all families and value the priorities that each family establishes.

Services and supports must also embrace the diversity among people who comprise American society today (Williams & Taylor, 1994). The Developmental Disabilities Assistance and Bill of Rights Act (1994) defines the term "culturally competent as services, supports, or other assistance that are conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving services, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program (Section 6001 [7])."

The Knock On Every Door project is committed to incorporating the principles and practices of family-centered services and cultural competence, as espoused in the definitions cited above, into all aspects of service delivery. Families who are homeless come from backgrounds that include a high incidence of foster care, substance abuse, domestic violence, inadequate health care, and poor education (Nuñez, 1994.) These factors heavily influence what constitutes family-centered and culturally competent practices for homeless families. The Knock On Every Door interdisciplinary team considered the following to be critical elements in the design and implementation of the project:

- The receptivity of families to developmental screening and other intervention services given the various crises that led them to seek emergency shelter;
- How much information should be collected on each child, balancing information needed to guide clinical decisions with respect for a family's privacy;
- The approach to service coordination as families receive services from multiple agencies and continue to be highly mobile; and
- The infusion of culturally competent practices into all aspects of service delivery.

Receptivity

Families experience significant stress when faced with the possibility that their child may have a developmental delay or disability. Families who are homeless are already facing a crisis about their housing situation. The pressure of this additional stress prompts the legitimate question of whether developmental screening and diagnostic assessment is an appropriate activity to be coupled with the provision of emergency shelter. Over 90% of families who are offered services agree to participate. The families who have participated in the Knock On Every Door Project demonstrate a genuine interest in the development of their children regardless of the crises they are experiencing. A significant proportion of them are referred through word of mouth by other families who have used the service.

Approximately 10% of families refused developmental screening or declined further diagnostic assessment indicated by such screening. It is important to note that any family, not just those who are homeless, may not be ready to pursue diagnostic assessment of their children for a variety of reasons. These wishes must be respected and families should be given information on how to access services at a later time.

Information Collection

The Knock On Every Door Project employs a philosophy that it should solicit only information needed to complete developmental screening. Families typically have to repeat their story of homelessness to many agency representatives before they receive housing. The interdisciplinary team's experience indicates that family participation is enhanced by collecting information strictly on a "need to know" basis. Families are asked if they have any concerns about their child's development, including nutritional or health concerns. Families have responded positively to this approach which respects their privacy. Information sought that is pertinent to developmental screening includes: the child's name, date of birth, history of prematurity, and the parents names. Due to the high mobility of homeless families and the lack of phone availability, follow-up activities are often compromised. For this reason, it is helpful if the parent is willing to provide the name and phone number of a family member or friend for future contact.

Service Coordination

Families who are homeless receive services from a variety of agencies including Aid to Families With Dependent Children (AFDC), the Women Infants and Children (WIC) nutritional program, Medicaid, Title IV-A AFDC/JOBS Child Care programs, Child Protective Services, and social services provided by emergency shelter agencies. Fragmentation of services often results from the multiplicity of agencies involved in meeting the complex needs of families with young children who are homeless. The traditional focus of agencies providing emergency shelter has been locating stable housing, and, in some instances, providing job placement or training. Services and supports focusing on the developmental needs of young children have been absent. The Knock On Every Door Project has recognized the importance of providing service coordination which bridges the gap between the providers of emergency housing services and the providers of early intervention and special education services.

The service coordination component of Knock On Every Door is designed to provide an array of follow-up services that include: conducting home visits to families residing in emergency shelters and permanent housing; attending meetings with families to develop Individual Family Service Plans and Individual Education Plans for their children; providing consultation to mental health, early intervention, child care, and special education service providers; and fostering self-advocacy. Family members are encouraged to contact the

Knock On Every Door project when additional developmental concerns for their child arise or when other services are indicated even if the families have exited emergency shelter.

For most families, becoming aware that their child may have a developmental delay or disability that could permanently affect his or her life is a crisis situation. This factor, added to other crisis factors that have precipitated homelessness, requires service providers to develop a genuine sensitivity to complex family needs. The Knock On Every Door interdisciplinary team has extended the concept of service coordination beyond the provision of direct services to families and offers technical assistance to agencies serving this population to build their capacity to better serve families of young children with developmental delays or disabilities who are homeless.

Infusion of Culturally Competent Practices

The Knock on Every Door team places a high value on acquiring the knowledge, skills, and attributes to work effectively in cross cultural situations. Several areas that receive particular attention from the team include: 1) the administration and interpretation of standardized tests; 2) the selection of children's literature and play materials; 3) understanding and valuing cultural differences in child-rearing practices; and 4) the influence of culture on the perception of the disability.

All standardized assessment instruments raise concerns about cultural bias. Team members carefully monitor children's responses to particular test items that may be negatively influenced by the experience of homelessness. For example, parents frequently lack a safe place where their infants can crawl and explore their environment. This means that valuable learning experiences related to exploration and experimentation are missed. Shelters are often crowded, which necessitates interactions with many different people. As a result, parents have a tendency to keep their toddlers quiet, which increases the child's complacency and may have a detrimental impact on language and cognitive development. Play materials that enhance fine motor and cognitive development for preschool-age children are at a minimum, which may impact school readiness. Test results must be interpreted cautiously in light of these factors.

The Knock On Every Door team members have little control over most of the environments in which they deliver services. However, the team ensures that play materials, children's books, and other resources reflect the cultural heritage of the children and families they are serving.

Families from different cultures have different expectations of their children for acquiring toilet training, dressing, feeding, and other self-help skills. Traditional approaches to disciplining children also are influenced by culture. The team has engaged in meaningful dialogue to recognize its members' cultural and professional biases around these issues. An area that has presented a challenge for the team has been responding to frequent requests for information from parents on effective discipline. It has been necessary for the team to demonstrate sensitivity in presenting information on alternative child discipline approaches while still honoring and respecting those traditional practices bound by family and cultural beliefs.

The perception of disability and its causes varies significantly according to cultural as well as religious beliefs. This includes how disability is viewed, understood, and accepted among diverse cultures. These perceptions impact service delivery systems—both for those seeking services and those providing services. Nationally there exists a history of discrimination in the identification and placement of students from ethnic groups of color within special education programs (Artiles, 1994). Some students have been and continue to be over-represented in special education settings, particularly in the categories of mental retardation and serious emotional and behavioral disorders. This may lead to parents' well founded skepticism in seeking evaluation, which they feel may automatically lead to unfair labels and life-long placement in restrictive educational settings.

Developmental Screening, Diagnostic Assessment, and Referral Services

The Knock On Every Door interdisciplinary team uses the DENVER II (1992) and the First STEP (1993) developmental screening tools. The team has found the First STEP screening instrument to be more comprehensive and sensitive in detecting mild to moderate delays which may not be identified by the DENVER II. These tools measure the following areas of a child's development: 1) social-emotional, 2) speech and language, 3) cognitive, 4) fine motor, 5) gross motor, and 6) self-help skills. Team members decide which tool to use based on their professional judgment.

Parents are present during developmental screening and play an active role in the screening process. They provide information related to their child's self-help, social, and emotional skills. Once the developmental screening is completed, a team member discusses results with parents and provides them with a written report. This is an opportunity to review a child's progress, reinforce good parenting skills, and offer suggestions for parents to engage their children in enrichment activities. Each child who receives developmental screening is given a book or play kit, items which the child may not have had prior exposure to—or may have lost due to—the homeless experience.

The Knock On Every Door project relies heavily on the clinical judgment of the interdisciplinary developmental screening team members to refer for diagnostic assessment children who may have passed screening but who exhibit qualitative concerns or discrepancies in performance. For example, for those children who passed the DENVER II yet were referred for speech and language assessment based on clinical judgement, all were found to have a 25% delay. This finding validates the use of clinical judgment for referral in this population of children. Whenever developmental screening results indicate a need for further evaluation, a diagnostic assessment is scheduled with the appropriate combination of interdisciplinary team member(s).

Parents are actively involved in the discussion of all diagnostic assessment results, including delineating service needs and discussing options for accessing such services. The Knock On Every Door project is committed to serving the needs of the whole family. Families have been assisted in accessing child care and preschool programs, special education services, specialty medical consultations, mental health services, and drug rehabilitation services. While the primary emphasis is on services to children birth to five years of age who are at risk for or have developmental delays, school-aged siblings have also been given advocacy services to access special education programs on a limited basis. Every effort is made to inform and advise families of their child's right to early intervention and special education services and to show them how to advocate on their child's behalf and how to become collaborators in their child's developmental program. Families are referred to community agencies which provide advocacy and support services so that families can continue being helped to advocate on behalf of their children.

Developmental Screening and Assessment Results of Young Young Who Are Homeless

The Knock on Every Door project was designed as a model service delivery effort, not as a research study. However, data collected since 1993 from the over 300 children who have been served by this project do suggest some trends. A convenience sample of the most recent 150 children who received developmental screening, their subsequent referral for evaluation, and the results of the evaluation were compiled.

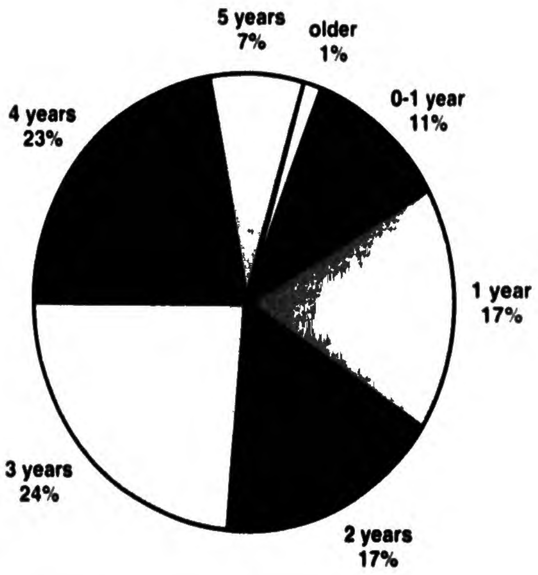
Each interdisciplinary team member has provided an analysis of the evaluation data from the convenience sample. Salient findings are listed by discipline for the purpose of sharing insights and information useful to colleagues delivering services to young children who are homeless and their families.

CHILDREN WHO RECEIVED DEVELOPMENTAL SCREENING
1995-1996

Children who received developmental screening:	150
Children whose developmental screening was age appropriate:	60
Children referred for speech and language assessment:	68
Children with completed speech and language assessments:	36
Children referred for cognitive evaluation:	17
Children with completed cognitive evaluations:	12
Children referred for motor evaluation:	25
Children with completed motor evaluations:	18
Children referred for developmental pediatric evaluation:	16
Children with completed developmental pediatric evaluation:	13
	n=150

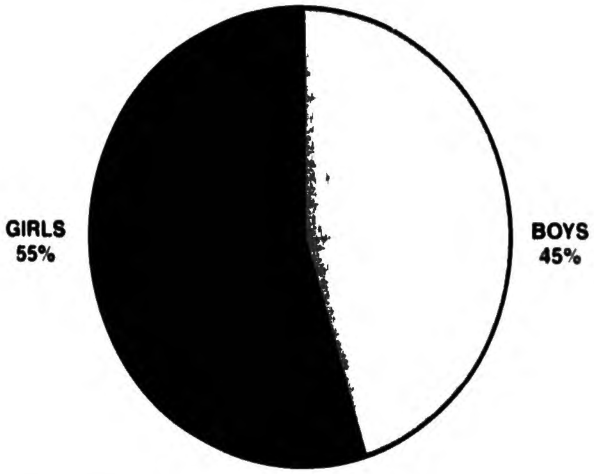
Ages of Children Who Received Developmental Screening

1995–1996

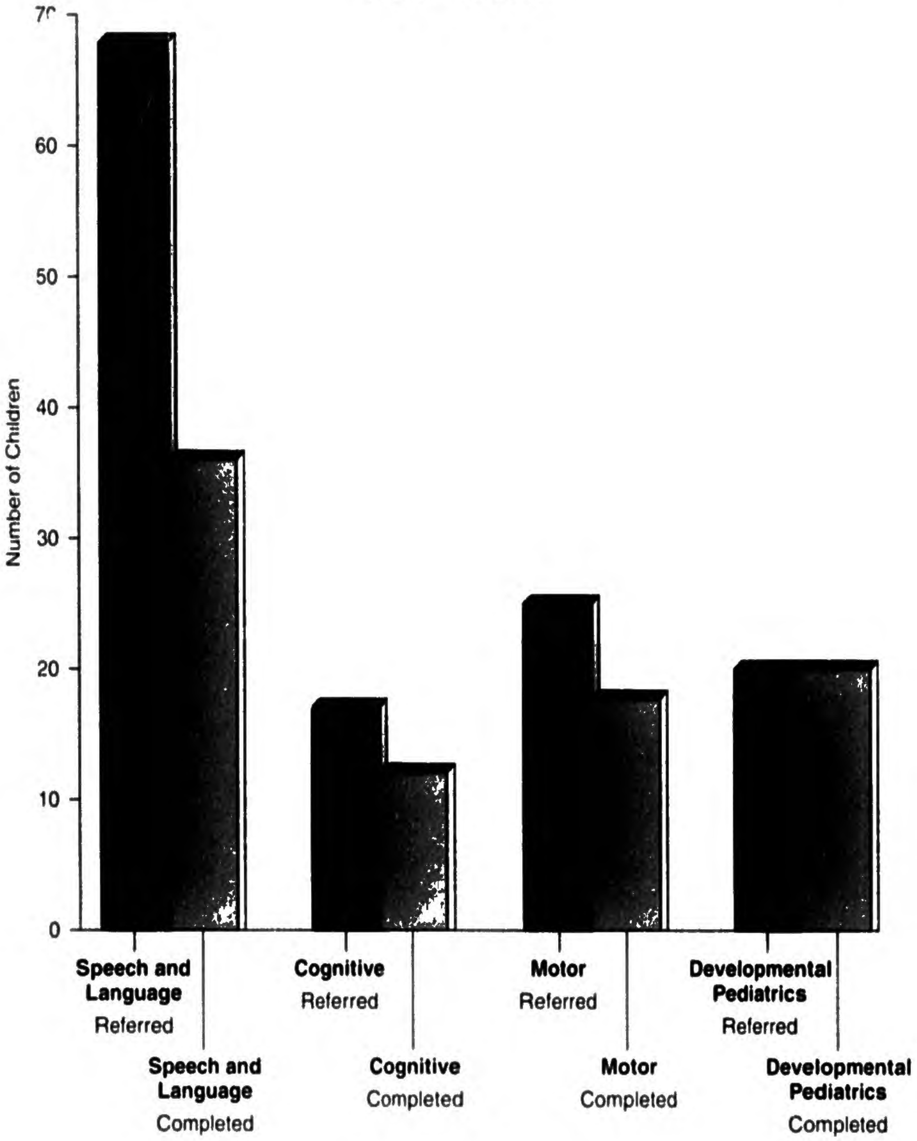


Sex of Children Who Received Developmental Screening

1995–1996



n=150

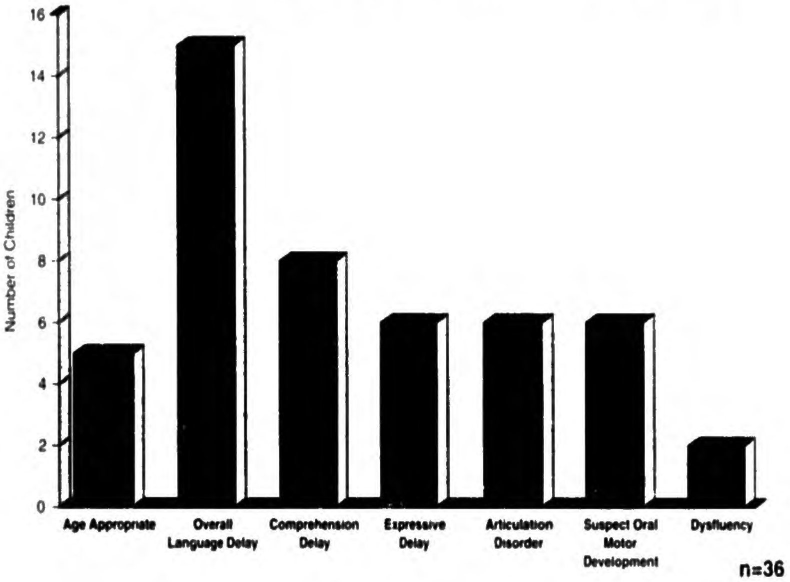


Children Who Received Developmental Screening
1995–1996

Children Screened:	**150**
Children with age-appropriate screening results:	**60**

Although 68 children were referred for a speech and language evaluation based on the results of their developmental screening, only 36 children had completed evaluation when the convenience sample was gathered. There are several reasons for this discrepancy in the ratio of completed evaluations compared to the other disciplines. First, more children are referred for speech and language evaluations, and there is only one speech-language pathologist on the team. Second, this number reflects children lost to follow up because speech-language is usually the first evaluation to be completed.

Speech and Language Evaluation Findings



All children receiving a speech and language evaluation are referred for a complete audiologic assessment through their primary care provider.

Instruments used:

The Peabody Picture Vocabulary Test - Revised (PPVT-R), forms L & M. This is only used to structure the children to a testing situation. It is not used in formulating a diagnosis because of the cultural bias of the test.

The Receptive-Expressive-Emergent Language Scale (REEL-2) is used for children functioning in the birth to 36-month age range.

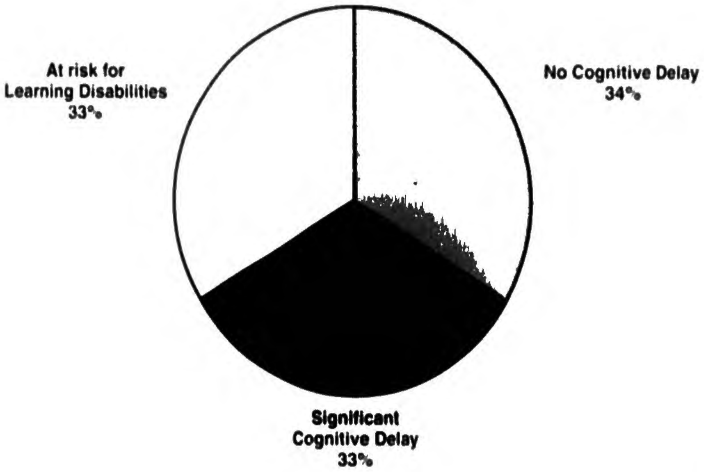
The Reynell Developmental Language Scales (RDLS) are used for children functioning over the 36-month developmental level and up to age 5.0 years. However, the test norms indicate it is standardized for children from birth to 6 years, 11 months.

The speech and language evaluation also includes:
- The completion of an informal social communication checklist.
- Observations and tests of the child's articulation proficiency.
- An assessment of voice quality, fluency, speech rate, loudness level, and overall intelligibility.
- Family interviews regarding the child's feeding behaviors to determine if oral sensory motor development is age appropriate.
- Formal and informal evaluation of the child's ability to control tongue, soft palate, and lips.

Some observations of the speech/language pathologist regarding this population of children who are homeless:
- All test instruments are culturally biased.
- The children demonstrate reduced receptive and expressive vocabulary development.
- There is an absence of literary materials in the children's environment which contributes to a negative impact on language development.
- The children seem to have a lack of experience in performing certain test-related tasks, i.e. discussing experiences they have had, labeling pictures in books, and naming colors.

Cognitive Evaluation Findings

Children Referred for Suspected Generalized Delay or Significant Language Delay



n=12

Cognitive measures used:

Bayley II Mental Scale is an infant developmental scale normed through 42 months. It can also be used with older children who have delays. The Bayley Behavior Rating Scale was used to quantify behavior observed during testing with the Mental Scale.

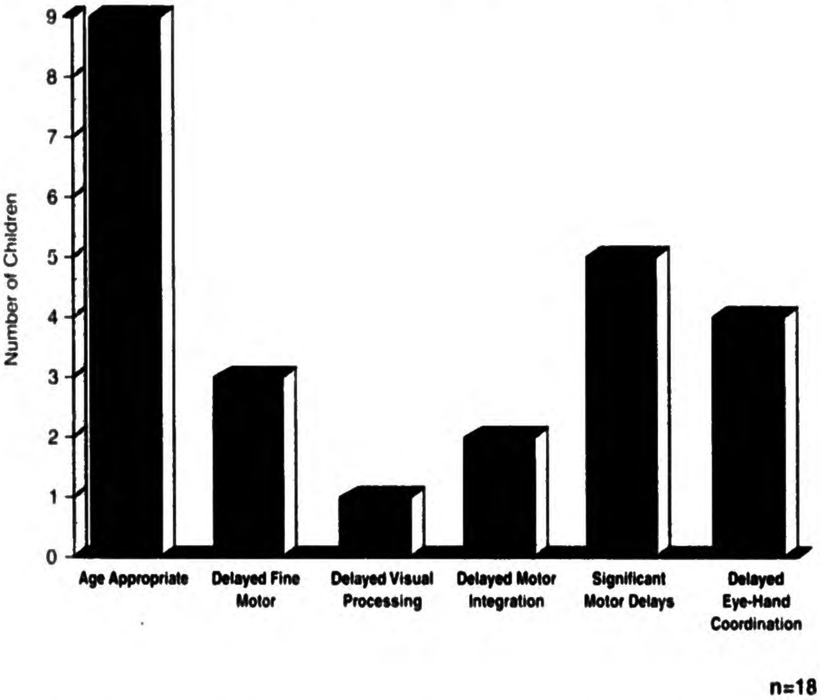
Stanford-Binet - Fourth Edition is an intellectual test used mainly with 4-year-old children (norms are given for ages 2 years through adult).

Wechsler Preschool and Primary Scale of Intelligence - Revised is an intellectual test mainly reserved in this sample for selected 5-year-old children because of subtest length and high language demands (norms are available for ages 3 years to 7 years, 0 months).

Some observations of the clinical psychologist concerning cognitive and adaptive evaluations in this population of children who are homeless:

- All of the screening and assessment instruments available raise concerns about cultural bias.
- Most of the children had little exposure to classroom materials and enriching language experiences.
- Care must be taken with many adaptive and behavior checklists. Some must be administered orally because of parent's reading level and may be unduly tedious or intrusive for parents.
- Accurate assessment of very young children with serious language delays is especially problematic because of the receptive language demands of the standardized tests.
- Classroom observation or feedback from teachers is crucial as many children who pass developmental screening do not exhibit task-persistence and self-management skills in the classroom
- Many children and their parents exhibit enormous resilience and impressive strengths.

Gross and Fine Motor Evaluation Findings



All motor assessments were completed by an occupational therapist. Areas assessed include movement skills, hand development, and visual processing.

Instruments used:

<u>Bayley Motor Scale II</u>: This is an individually administered norm-referenced test which assesses gross and fine motor development in children from birth to 3 1/2 years of age.

<u>Peabody Fine Motor Scale</u>: This scale is used to determine children's hand skills development. This scale is divided into several areas including grasping, hand use, eye-hand coordination, and manual dexterity. It is standardized on children from birth to 7 years of age.

<u>Beery Developmental Test of Visual-Motor Integration</u>: This assesses a child's ability to copy increasingly complex geometric designs. It is standardized on children from 2 1/2 years to 15 years of age.

<u>Motor Free Test of Visual Perception</u>: This measures a child's visual processing abilities. It is used with children from 4 to 7 years of age.

Some observations of the occupational therapist regarding this population of children who are homeless:

- The children often demonstrated adequate hand and finger dexterity and were able to adequately manipulate a variety of objects.
- The children often demonstrated delayed eye-hand coordination and were not as skilled at performing tasks associated with preschool environments such as drawing, copying, coloring, and writing.
- The children seem to have had few experiences with materials such as puzzles, block design, scissors, paper, and crayons. This may in part be attributable to their living environment.

Developmental Pediatric Evaluation Findings

Prenatal Care History

Inadequate care	3
Maternal illnesses	7
Substance exposure	7
Prescribed medications	4
Others	3

Neonatal History

Prematurity	3
Abnormal birth weight	5
Neonatal complications	5
Others	2

Postnatal History

Feeding difficulties	5
Respiratory problems	7
Ear infections	7
Seizures	4
Inadequate medical care	3
Others	4

Family History

Asthma	13
Diabetes	4
Sibling death	3
Developmental Disabilities/Mental Retardation	4

Physical Findings

Microcephaly	2
Growth retardation	4
Minor anomalies	3
Dysmorphic facies	3
Abnormal neurologic findings	4
Acute medical problems	11

Diagnoses

Teratogenic exposure	4
Specific conditions	2
Non specific conditions	12
Major malformations	2

Recommendations Made

Rx of acute illnesses	12
Genetic diagnostic tests	4
Nutrition counseling	3
Genetic counseling	7
Substance abuse counseling	9
Other	17

n=20

Children were referred to the developmental pediatrician by members of the interdisciplinary team based on the following criteria: global developmental delays, a history of prenatal exposure to alcohol or other drugs, notation of dysmorphic features, or a family history of developmental disabilities. Therefore, this sample is skewed in that it only represents those children who met the above referring criteria.

Some observations of the developmental pediatrician regarding this population of children who are homeless:

- All children evaluated had access to a primary care physician through Medicaid.
- Primary health services were frequently disrupted due to the high mobility of families who are homeless.
- Although the children examined in this sample were referred for a specialty evaluation, there was among them a high incidence of acute illnesses that were not being treated.
- Among these children there are higher than expected rates of asthma, sibling death, and substance exposure in utero.
- Lack of telephone access and knowledge of transportation resources directly impacted these children's visits to primary health providers.
- Many families in this convenience sample are enrolled in Medicaid managed care plans. Although the developmental pediatrician often contacted the primary care provider directly, it is not clear if the primary care physicians actually followed through with the recommendations for other specialty consultations or testing.

The presentation of the data in this chapter and the observations made by the individual clinicians has been provided to aid in the replication of this service model by other University Affiliated Programs and community agencies serving families of young children who are homeless.

Barriers to Accessing Services and Supports

Understanding the barriers faced by families as they attempt to access appropriate services for their children was a learning experience for the Knock On Every Door interdisciplinary team. Individual families face unique challenges in overcoming homelessness and all its ramifications. Major barriers commonly faced by families served by the Knock On Every Door project are as follows:

Mobility

- Families typically experience frequent moves before becoming homeless. Even after families receive emergency shelter, they may be relocated several times before they can access permanent housing (i.e., public housing or Section 8 housing).

- Families are often placed in the position of having to relocate to sections of the city with which they are unfamiliar and in which family and neighborhood support systems are missing. This further isolates families and increases their vulnerability and stress.

- Frequent moves make it difficult for families to access services which may benefit their children such as a child find, Head Start, and other child care programs, as well as a consistent primary health care provider who can track their children's developmental progress.

- Young children who experience such residential instability are at increased risk for social-emotional problems. Parents report that their children often: 1) lose their sense of where home is, 2) demonstrate increased fearfulness exhibited by difficulty in sleeping, and 3) have a tendency to either be insecure or overly friendly with unfamiliar adults. Young children may be separated from their parents and siblings when any of them must live with extended family in an attempt to find adequate housing and avoid overcrowding. This further erodes a child's sense of trust and stability.

Scarcity of Supportive Services

Another barrier is the scarcity of supportive social services in the District of Columbia. During the past two fiscal years, the Mayor of the District of Columbia and the City Council have been forced to make tough choices to significantly reduce or discontinue program funding among many constituencies with equally compelling needs. During these times of fiscal austerity, families who are homeless, and the network of public and private agencies which support them, are engaged in fierce competition for scarce District appropriated funds. Families exert the most important influences in children's lives, but they cannot do it alone. Low income parents, in particular, need extra support, not just financially, but through links with caring communities. Conversely, while the public and private sectors cannot solve all problems, they must be strong and active partners in supporting families who are homeless (Children's Defense Fund, 1994). Support services in the District can be characterized as follows:

- A well-defined support system to prevent the occurrence of homelessness among families does not exist in the District of Columbia.

- There are inadequate services and supports available while a family resides in emergency shelter, particularly in the areas of drug rehabilitation and mental health services.

- Models of service delivery that provide long-term support (an average of 2 years) to families in the form of health care, drug rehabilitation, employment training, child care, and parent education programs are insufficient to meet the demand.

- Agencies providing supportive services to the homeless population have policies and procedures which exclude families at critical points in the continuum of care. For example, a history of substance abuse renders families ineligible for long-term supportive services even though they are the families most in need. Also, agencies discontinue supportive services once they locate permanent housing for families, although such services may still be needed.

Lack of Efficient Communication Systems

One of the most frustrating barriers to both families and service providers is the lack of efficient communication systems. A significant number of families do not have access to any telephone service and communication by mail is hindered by incorrect addresses due to frequent moving.

- Most families who are homeless have to rely on public phone systems. Families have a critical need to access telephone service in order to place and receive calls related to employment opportunities, housing alternatives, or their children's health and education. Many public phones are inoperable or do not take incoming calls. Parents with many young children cannot leave them unsupervised to travel several blocks to use a public phone. The use of public phones is costly for families as money is often lost in missed connections, in having to reach multiple agencies, or by having to leave messages on voice mail.

- Mail contact is equally unreliable. Families move frequently and do not necessarily report changes of address to the U.S. Postal Service. Written communication may also present barriers for those parents who are illiterate or have low literacy skills.

- When a child is identified as needing developmental services, multiple contacts with various agencies may be required to enroll the child and family. Families frustrated by these communication challenges may give up or agencies may interpret families' lack of response in a timely manner as disinterest.

Scarcity of Head Start and Child Care Services

The District of Columbia has committed significant fiscal resources to providing early childhood services for young children and their families. However, the demand for child care and early childhood services far exceeds the current supply, particularly for children of low income families. During fiscal year 1994, a total of 28 million dollars was expended for subsidized child care in the District of Columbia. Of this amount, $22,239,000 were District-appropriated funds with the remainder coming from federal sources. The District has 7,100 subsidized child care slots which include children in foster care, protective services, working families, and families who have children with disabilities . The availability of Head Start slots is limited. According to a 1993 survey conducted by the Office of Early Childhood, Commission on Social Services, D.C. Department of Human Services, Head Start grantees have the capacity to serve 2,605 children and their families. The D.C. Public Schools System is the only jurisdiction in the Washington metropolitan area to offer optional pre-kindergarten for 4-year-old children. Yet many families desiring child care, Head Start, and pre-kindergarten placement for their children are turned away. In spite of this strong commitment to early childhood and child care services by the District of Columbia, long waiting lists exist. Barriers encountered by families include:

- It is difficult for families who are homeless to gain entrance for their children to Head Start or pre-kindergarten programs due to frequent moves. Children must be registered in the spring for the fall program, but families may be forced to move to other neighborhoods before the fall term begins. Enrollment spaces are not transferable from one Head Start program to another.

- Subsidized child care slots are at a premium, even for parents who are enrolled in educational or job training programs.

- Even when child care is obtained, child care providers and programs often do not have the knowledge and resources they need to address the complex needs of children who are homeless and their families, particularly those children with developmental delays and disabilities.

Family Characteristics

The daily trauma, uncertainty, and painful deprivation among individuals who are homeless frequently produce profound feelings of sadness and hopelessness which can lead to severe clinical depression. Substance abuse problems also affect a growing number of homeless families; it now ranks as the most prevalent health problem in this population. Nuñez (1994) documents the plight of families in New York City who are homeless and indicates that these problems often increase the risk for child abuse and neglect. The experiences of the Knock On Every Door project and of other agencies providing services to District families who are homeless is similar:

- For families who are dependent upon Medicaid, mental health services are inadequate, inaccessible, and generally do not subscribe to culturally competent practices.

- Substance abuse services often needed by these families are limited and frequently do not have programs which are designed to accommodate women with children.

- Supportive services which specifically target the prevention of child abuse and neglect are insufficient.

Lack of Interagency Coordination

Families who are homeless often require a variety of service options that fall outside the scope of any single agency. Services for people with developmental and other disabilities are not well integrated within the human service network in the District of Columbia. There is no strategic plan of action across District government agencies to coordinate new and existing programs/initiatives in child care, disability services, family support, family preservation, health, transportation, or housing, particularly those services impacting families with young children who are homeless.

- Families who are homeless qualify for a number of federal and local entitlements. Many of these programs emanate from different funding streams and have different mandates and eligibility criteria which have resulted in boundaries that make such programs difficult to access in combination with each other (Taylor, 1994).

- Families may have multiple case managers who are unaware of each other and, thus, are unable to coordinate family service plans.

Portrait of Two Families

The following scenarios provide insight into two families served by the Knock On Every Door project. These scenarios describe family characteristics, barriers families faced in accessing services for their children, and interventions provided by the Knock On Every Door interdisciplinary team. These portraits are not unusual examples and underscore the difficulty of delivering services and supports to this vulnerable population.

The Madison Family

The Family

Tina Madison is 19 years old and the single parent of two children, Tanika, age 4 years, and Donte, age 12 months. Tanika is in the custody of the District's Commission on Social Services as a result of confirmed child abuse. Donte lives with his mother. Ms. Madison had formerly resided with extended family until she became pregnant with her second child. She then lived for a brief period of time in a shelter for single adult women, but was required to move after her child was born. She was referred to the Knock On Every Door team when she was placed in the Highland Place shelter by the Family Resource Center.

The Knock On Every Door team provides services on a weekly basis at the Highland Place shelter. The week following her placement there, a team member met with Ms. Madison and asked if she was willing to have Donte receive developmental screening. Ms. Madison agreed and stated that she had a number of concerns about Donte's develop-ment. During screening, Ms. Madison shared with a team member that fact that her older child was in foster care because of child abuse. She expressed the fear that she may follow the same pattern of behavior towards Donte. Ms. Madison describes Donte as a very irritable baby who cries frequently and is not easily comforted. Developmental screening results revealed that Donte displayed excessive drooling, was not yet sitting unsupported, and his irritability interfered with his ability to interact socially with others, including his mother. Recommendations were given to Ms. Madison for additional diagnostic assessment to determine the nature and extent of Donte's developmental delays. She agreed to return for appointments scheduled at the Family Resource Center and was given an appointment slip.

Two days before the scheduled appointment, a team member left a reminder message for Ms. Madison with the resident manager of Highland Place shelter. Ms. Madison failed to keep her appointment and did not call to cancel. During the next weekly shelter visit, a team member made a home visit to determine her level of interest in pursing diagnostic assessment. Ms. Madison reported that she had lost the appointment slip and had never received the phone reminder message. Ms. Madison indicated that she was still interested in having Donte evaluated, but she was feeling a great deal of pressure to find permanent housing within the next 30 days. Additionally, the social worker from the Department of Social Services was asking her to establish weekly visits with Tanika and to attend twice weekly parenting classes in order for family reunification to occur. Ms. Madison said she felt completely overwhelmed. She was encouraged to share these concerns with the social worker who was assigned to the Highland Place shelter. Ms. Madison expressed reluctance and commented that the social worker was only interested in whether she kept her apartment clean and if she complied with curfew. It was agreed that appointments for diagnostic assessment would be postponed and a team member would contact her within two to three weeks.

A team member phoned the resident manager of Highland Place shelter to schedule a visit with Ms. Madison and was informed that she no longer was residing at the shelter. Ms. Madison had left a forwarding address, but authorization for the release of this information had not been obtained by the resident manager.

Barriers

- Ms. Madison did not have a telephone in her apartment. The resident manager does not reliably relay telephone messages.
- Ms. Madison was assigned social workers from several different agencies who placed competing demands on her.
- Ms. Madison did not view her social worker at Highland Place shelter as someone who would assist her with personal problems because the worker seemed primarily interested in enforcing the rules of the shelter.
- Ms. Madison's frequent moves make it difficult to establish rapport with service providers and obtain needed services for her family.
- Efficient tracking and continuity of services is hindered by confidentiality policies and procedures which prevent the release of information among agencies.

Interventions

Ms. Madison has complex needs and seemed unable to establish a trusting relationship with any of the service providers during her brief time in emergency shelter. The Knock On Every Door team did not have the opportunity to conduct the recommended diagnostic assessment to determine the nature and extent of Donte's developmental delays.

This portrait characterizes many of the barriers cited within this monograph to the delivery of services and support to families who are homeless.

The Thompson Family

The Family

Gina Thompson is 36 years old and the single parent of three children ages 14, 4, and 2. Ms. Thompson applied for emergency shelter after losing her apartment due to drug addiction. She has not been employed since the birth of her 4-year-old son. Ms. Thompson's 14-year-old son, Darren, is attending high school in his old neighborhood where he is receiving special education services related to a specific learning disability. The two younger children, Adam, who is 4 years old, and Malik, who is 2 years old, have never attended child care or preschool programs. Ms. Thompson has no contact with her children's biological father and she has no family members who reside in the Washington DC metropolitan area.

The Knock On Every Door interdisciplinary team provides developmental screening and diagnostic assessment on site at the shelter where Ms. Thompson was staying. When approached by an interdisciplinary team member, Ms. Thompson cautiously agreed to have Adam and Malik receive developmental screening. She expressed some concerns about Malik's speech development, but did not convey any concerns about Adam. Adam's developmental screening results turned out to be age appropriate. However, developmental screening results for Malik indicated delays in receptive and expressive language. Interdisciplinary team members assisted Ms. Thompson in accessing early childhood programs that would meet the developmental needs of her sons. Additionally, interdisciplinary team members referred Ms. Thompson to an outreach mental health program to seek treatment for her drug addiction. Ms. Thompson remained in emergency shelter for two months and was subsequently moved to permanent housing.

The Knock On Every Door interdisciplinary team members had no further contact with the Thompson family for six months. While conducting a home visit to another family who had moved to permanent housing, two of the team members encountered Ms. Thompson in the apartment complex. On subsequent weekly visits to the apartment complex, Ms. Thompson shared with those team members the fact that she had resumed her drug habit. Her life had become so chaotic that she was no longer able to get her two younger children to their early childhood programs, and her older son was frequently absent from school as he assumed the responsibility of caring for both his siblings and his mother.

Barriers

- Ms. Thompson was moved to a neighborhood with which she was unfamiliar and in which illicit drugs were easily available.
- The supportive counseling that Ms. Thompson received in emergency shelter was significantly reduced once the family moved to permanent housing.
- Ms. Thompson was unable to develop a trusting relationship with the case manager assigned to her in transitional housing.
- The early childhood program in which her younger sons were enrolled was a great distance from her new home and few child care options were available in the new neighborhood.

Interventions

Although Ms. Thompson was initially hesitant and avoided interaction with the interdisciplinary team members who were conducting home visits within the apartment complex, the Knock on Every Door team members continued to make informal contacts with Ms. Thompson and made her aware that they were available to offer support whenever she desired. For two months, informal home visits were continued but, on occasion, Ms. Thompson did not answer her door. She gradually began to share that she was unhappy with her current situation and that she was ready for change. Ms. Thompson later confided that her initial hesitancy was due to embarrassment that she had resumed her drug abusing behaviors. Ms. Thompson had participated in four drug treatment programs unsuccessfully in the past and she feared failing yet another time.

Ms. Thompson was referred to a drug counselor who provided information about treatment programs and options. Before she reached a decision about treatment, the emergency housing office relocated her to another transitional housing program which offered a more structured environment. This program had a strong policy against drug abuse and mandated urine testing for adult residents. It offered a range of services including group counseling, employment counseling and job referral, parenting classes, and tutoring and child enrichment activities. The program's emphasis on personal responsibility and planning was crucial in Ms. Thompson's recovery. This transitional housing program is among the emergency housing agencies to which Knock On Every Door provides services.

Ms. Thompson's first four days in this transitional housing program were extremely difficult as she began withdrawal. An interdisciplinary team member made daily home visits to Ms. Thompson and, with her permission, established communication with the transitional housing program staff to advocate on her behalf.

A Knock On Every Door team member assisted Ms. Thompson in enrolling Adam in a local kindergarten and Malik in a Head Start program. Weekly home visits continued for a four-month period during which Ms. Thompson moved to permanent housing and assumed full-time employment. Counseling sessions provided by team members focused on her continued recovery, parenting skills to enhance her children's development, and decision making strategies for daily living. Concurrently, a staff member from the transitional housing program made daily telephone contacts with Ms. Thompson.

Ms. Thompson has now developed a new network of friends within her apartment complex. She is continuing to attend recovery meetings and has remained drug free. Ms Thompson has begun to assume a leadership role within her neighborhood organization, and she continues to have intermittent contact with Knock On Every Door interdisciplinary team members. She has expressed pride in the progress that she has been able to make and is confident about her future.

Recommendations for Advocacy and Policy Development Within the Developmental Disabilities Network

A national dialogue on the correlation between homelessness and risk factors for developmental disabilities in young children is long overdue. The Administration on Developmental Disabilities has demonstrated leadership in this area by commissioning this monograph for dissemination to the national network of University Affiliated Programs, Developmental Disabilities Councils, and Protection and Advocacy agencies. Since programs funded by the Administration on Developmental Disabilities have a mandate to address the needs of unserved and underserved populations, the issue of homelessness should be given a high priority by the American Association of University Affiliated Programs, the National Association of Developmental Disabilities Councils, and the National Association of Protection and Advocacy Agencies. These national agencies should collaborate to assess the needs of families who are homeless and to identify strategies that respond to the needs of family members at risk for and with developmental disabilities within their states. Specific recommendations for University Affiliated Programs, Developmental Disabilities Planning Councils, and Protection and Advocacy agencies follow.

Role of the University Affiliated Program

Needs Assessment

- ➤ Conduct an assessment to determine the incidence of homelessness within the state and the needs of families who have members at risk for and with developmental disabilities. This should be done in partnership with the state Developmental Disabilities Planning Council and the Protection and Advocacy agency.

- ➤ Assess the extent to which the larger university community is involved in issues related to homelessness and promote such involvement.

Technical Assistance

- Facilitate interagency dialogue among state and local agencies which provide services to the homeless population and agencies serving the disability community in order to develop a common agenda.

- Provide consultation to public and private sector agencies responsible for the delivery of emergency shelter and other supportive services for the homeless population in order to increase their capacity to respond to the needs of individuals at risk for and with developmental disabilities.

- Join local and state-level coalitions on homelessness to advocate for the housing and supportive service needs of individuals at risk for and with developmental disabilities and their families.

Training

- Develop culturally competent curricula and inservice training models on developmental disabilities for emergency shelter personnel within the public and private sector.

- Modify existing UAP curricula to incorporate issues related to families who are homeless into pre-service and inservice training activities using a culturally competent approach.

- Provide UAP trainees with practicum experiences in a variety of community settings which serve families who are homeless.

- Ensure that UAP curricula and training activities emphasize the mental health service needs of families who are homeless and the critical importance of culturally competent practices in this area.

Research

- Modify existing data collection systems to include data fields related to the homeless population.
- Conduct studies that document the unique needs and effective interventions for families who are homeless and have children at risk for or with developmental disabilities.
- Conduct longitudinal studies of children who have been homeless to assess their long-term developmental outcomes.

Suggested Role of the Developmental Disabilities Planning Councils and Protection and Advocacy Agencies

- Developmental Disabilities Planning Councils should include individuals at risk for and with developmental disabilities who are homeless as an under served population in their Three-Year State Plan.
- Developmental Disabilities Planning Councils should consider the allocation of fiscal resources to local or state entities to plan and implement innovative approaches to serve individuals at risk for and with developmental disabilities who are homeless.
- Developmental Disabilities Planning Councils should encourage the participation of consumers and agency representatives serving the homeless population in Council activities.
- Protection and Advocacy agencies should specifically target outreach activities to ensure that the rights of individuals with developmental disabilities who are homeless are protected.

Conclusion

Substantial documentation exists that supports the significant developmental risks that young children from vulnerable environments face. Due to the increasing number of families with children who are homeless, and the massive changes anticipated in funding at the federal, state, and local levels, a coordinated effort is needed to stem the effects of homelessness on young children.

The developmental disabilities network, which includes the University Affiliated Programs, the Developmental Disabilities Planning Councils, and the Protection and Advocacy Agencies, has the capacity to provide leadership in this arena. However, the network will need to collaborate with new constituencies that have traditionally been outside the boundaries of developmental disabilities systems. These new constituencies cover a broad range, which may include, but are not limited to, substance abuse and recovery programs; federal, state, and local housing authorities; domestic violence programs; and child advocacy programs.

The experience of the Georgetown University Child Development Center underscores the critical need to develop partnerships with the myriad of agencies providing services to families who are homeless. These relationships enable the needs and interests of young children at risk for or with developmental delays or disabilities and their families to be incorporated into planning and policy decisions made at the state level which affect housing and supportive services for families who are homeless. It has been the intent of this monograph to bring the issue of homelessness and its impact on the development of young children to the attention of a national audience. It is hoped that this monograph will raise our consciousness and provide the impetus to create a national agenda on behalf of these vulnerable children and their families.

References

Artiles, A.J. (1994). Overrepresentation of minority students in special education: A continuing debate. *Journal of Special Education.* 27 (4), 410.

Bassuk, E.L. (1991). Homeless families. *Scientific American,* 265, 66-74.

Bassuk, E.L., & Rosenberg, L. (1990). Psychosocial characteristics of homeless children and children with homes. *Pediatrics,* 85, 257-261.

Buckner, J.C. (1991). Pathways into homelessness. *New Directions for Program Evaluation,* 52, 17-30.

Carta, J., Sideris, G., Rinkel, P., Guimaraes, S., Greenwood, C., Baggett, K., Peterson, P., Atwater, J., McEvoy, M., & McConnell, S. (1994). Behavioral outcomes of young children prenatally exposed to illicit drugs: Review and analysis of experimental literature. *Topics in Early Childhood Special Education,* 14, 184-216.

Coles, C.D., & Platzman, K.A. (1993). Behavioral development in children prenatally exposed to drugs and alcohol. *The International Journal of the Addictions,* 28, 1393-1433.

Children's Defense Fund. (1994). *The costs of child poverty.* Washington, DC.

Children's Defense Fund. (1991). *Bright futures or broken dreams: The status of the children of the District of Columbia and an investment agenda for the 1990s.* Washington, DC.

Cummings, E.M., Ballard, M., El-Sheikh, M., & Lake, M. (1991). Resolution and children's responses to interadult anger. *Developmental Psychology,* 27 462-470.

Developmental Disabilities Assistance and Bill of Rights Act (1994). 42 U.S. Code, Chapter 75, Section 6001 (7).

District of Columbia Government. (1992). *Indices: A statistical index to District of Columbia services.*

Dornbusch, S.M. (1994). Additional perspectives on homeless families. *American Behavioral Scientist*, 37, 404-411.

Drell, M., Siegel, C., & Gaensbauer, T. (1993). Post-traumatic stress disorder. In C.H. Zeanah (Ed.) *Handbook of infant mental health* (pp. 291-304). NY: Guilford Press.

First STEP, (1993). The Psychological Corporation, San Antonio, TX.

Frankenburg, W.K., & Dodds, J.B. (1992) DENVER II, Denver Developmental Materials, Incorporated, Denver, CO.

Hack, M., Taylor, H.G., Klein, N., Eiben, R., Schatschneider, C., & Mercuri-Minich, N. (1994). School-age outcomes in children with birth weights under 750 g. *The New England Journal of Medicine*. 331, 753-759.

Hennessy, K.D., Rabideau, G.J., Cicchetti, D., & Cummings, E.M. (1994). Responses of physically abused children to different forms of interadult anger. *Child Development*, 65, 815-828.

Holden, E.W., Horton, L.A., & Dansceo, E.R. (1995). The mental health of homeless children. *Clinical Psychology: Science and Practice*, 2, 165-178.

Martin, M. (1994, October). The federal response to homelessness. In P. Magrab (Chair), *Developmental disabilities and homelessness*. Symposium conducted at the Georgetown University Child Development Center, Washington, DC.

Nuñez, R. da C. (1994). *Hopes, dreams & promises: The future of homeless children in America.* New York: Institute for Children and Poverty, Homes for the Homeless, Inc.

Osofsky, J., & Fenichel, E. (Eds.). (1994). Caring for infants and toddlers in violent environments: Hurt, healing, and hope. *The ZERO TO THREE Study Group on Violence.* Arlington, VA: ZERO TO THREE/National Center for Clinical Infant Programs.

Roberts, R.N. (1988). Family support in the home: *Home visiting and public law 99-457.* Washington, DC. Association for the Care of Children's Health.

Rodning, C., Beckwith, L., & Howard, J., (1989) *Prenatal exposure to drugs, behavioral distortions reflecting CNS impairment & neurotoxicology,* 10, 629-634.

Strauss, M.A. (1993). Ordinary violence, child abuse and wife-beating—What do they have in common? In D. Finkelhor, R.J. Gelles, G.T. Hotelling, & H. Strauss (Eds.) *The dark side of families.* NY: Sage Publications.

Taylor, T. (1991, November). *Review of current literature on the effects of prenatal substance exposure on infants and young children: Implications for early education programs.* Paper presented at the DHHS/ACF Region III Head Start conference, Philadelphia, PA.

Taylor, T. (1994). *Inclusion of children with disabilities and their families in child care: Focus group summary and recommendations.* Washington, DC: Administration on Developmental Disabilities, Administration for Children and Families, U.S. Department of Health and Human Services.

U.S. Census (1990) as cited in *Every kid counts in the District of Columbia: A starting point.* The D.C. Kids Count Collaborative, 1994.

United States Conference of Mayors, (December, 1995). A Status report on hunger and homelessness in America's cities: 1995, (p2). Washington, DC.

Waxman, L.D., & Reyes, L.M. (1987). *A status report on homeless families in America's cities.* Washington: United States Conference of Mayors.

Williams, V., & Taylor T. (1994). Community services and supports for persons with disabilities. In H. Garner & F. Orelove (Eds.), *Teamwork in human services: Models and applications across the life span.* Boston, MA: Butterworth-Heinemann.

Willis, D.J., & Holden, E.W. (1990). *Developmental assessment in clinical child psychology: A handbook.* NY: Pergamon Press.

Wood, D.L., Valdez, R.B., Hayashi, T., & Shen, A. (1990). Health of homeless children and housed poor. *Pediatrics*, 86, 858-866.