Sheltered Homeless Children: Their Eligibility and Unmet Need for Special Education Evaluations

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ABSTRACT

Objectives. This study described the proportion of sheltered homeless children in Los Angeles, Calif, who were eligible for special education evaluations because of a probable behavioral disorder, learning disability, or mental retardation, and to explore their level of unmet need for special education services.

Methods. This was a cross-sectional study of 118 parents and 169 children aged 6 through 12 years living in 18 emergency homeless family shelters in Los Angeles County, California. Parents and children were interviewed with standardized mental health and academic skill measures in English and Spanish.

Results. Almost half (45%) of the children met criteria for a special education evaluation, yet less than one quarter (22%) had ever received special education testing or placement. The main point of contact for children with behavioral disorders and learning problems was the general health care sector.

Conclusions. School-aged sheltered homeless children have a high level of unmet need for special education evaluations, the first step toward accessing special education programs. Interventions for homeless children should include integration of services across special education, general health care, and housing service sectors. (*Am J Public Health.* 1997;87:236–240)

Introduction

Homeless school-aged children are at risk for not receiving the education needed to break their cycle of poverty[1,2] owing to disproportionately high levels of poor academic skills, erratic school attendance,[3,4] and school failure.[5–9] Their academic achievement may be further hampered by developmental delays and behavioral disorders,[10,11] problems that are common among homeless children and often remain untreated.[6–9,12–14] Such findings appear intuitive, as homeless children experience extreme residential instability and frequent school changes[6–8,12,14,15] in addition to risk factors common to other impoverished children, such as poor nutrition, untreated acute and chronic physical illness, single-parent families, and poor parental education.[6,8,16–25]

Schooling, however, may ameliorate some of the negative consequences of homelessness, and special education programs with more individualized teaching may be particularly beneficial.[26,27] The structured environment of a school program fosters the child's concept of personal place[28] and may be a main source of stability for a homeless child.[26,27] Emotional and behavioral disorders were found to be at similar high levels among school-age homeless children and domiciled poor children,[5,14,29] but developmental delays were greater among homeless preschoolers who were not in early education programs.[7]

Under federal law, homeless children are guaranteed a free and appropriate public education, even if they have significant disabilities.[30] Children are eligible for special education if they meet criteria for a disability category, such as serious emotional disturbance, learning disability, mental retardation, or physical handicap.[30] Among elementary school students in special education programs, more than half (58%) qualify for special classes because of a mental health or learning problem.[31] Further, equal access to elementary and secondary education for homeless children is mandated under a federal law protecting the rights of homeless persons.[32]

Yet homeless children face numerous barriers to educational services, such as residency requirements for school registration and poor transfer of records.[3,4,15,33–37] Determination of eligibility for special education, the first step to accessing programs, may be especially problematic for homeless children because of their transiency and lengthy Individualized Education Program timelines for evaluation and placement.[26] In an earlier study in Los Angeles County, 19% of homeless sheltered children had been in special classes, compared with almost one third of poor children with housing.[8]

Few, if any, studies have assessed eligibility for a special education evaluation among homeless children and explored whether those with signs of a behavioral disorder or learning problem had ever received special education test-

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This paper was accepted September 26, 1996.

Note. The views expressed here are those of the authors and do not necessarily represent those of The Robert Wood Johnson Foundation.

ing or placement. The purpose of this study is to describe the proportion of sheltered homeless children with a probable behavior disorder, learning disability, or mental retardation, and to examine the level of unmet need for a special education evaluation.

Methods

The design and methods of this study are described elsewhere.[9,38] Twenty-two emergency homeless family shelters were identified in Los Angeles County, and eligibility was confirmed by a brief telephone survey. An emergency shelter was defined as any program that allowed homeless families to sleep overnight, but for short-term stays only. Homeless shelters were selected in random order and were surveyed twice between February and May 1991. Families were eligible if they had at least one child aged 6 to 12 years and had stayed at least one night at the facility. The parent who felt she or he knew the child best was interviewed. If there were more than two eligible children in a family, two were randomly selected. The survey was translated and back-translated into Spanish.

Parent interviews and child testing were conducted simultaneously at the shelter. Informed consent was obtained from the parent and child following UCLA Human Subjects Protection Committee approved procedures. Testing conditions varied, but most interviews were done in a relatively quiet area, such as an empty meeting room or chapel. Parent interviews were performed by trained lay interviewers with a graduate-level education. Child testing in English was conducted by a board-certified child psychiatrist (B.Z.), and child interviews in Spanish were performed by two trained bilingual graduate research assistants with additional training in child measures and on-site supervision. All lay interviewers received 3 weeks of training in general survey administration and standardized child measures. Bilingual children were tested in both languages, and their best receptive vocabulary and reading scores were taken.

Measures

Child homeless history was assessed from parent report by means of questions adapted from the RAND Course of Homelessness Study.[39] Homeless history items included the amount of time homeless and number of different places lived during the past 12 months. Homelessness was defined as having no regular place to live, such as a house, apartment, room, or home of a family member or friend, but having to stay in a shelter, an abandoned building, a car, outdoors, or another place not meant to be a permanent living space.

Behavioral disorders were evaluated by means of the Child Behavior Checklist.[40] The checklist, a 118-item parent report scale, is a widely accepted measure for behavioral disorders in special education evaluations.[41] The measure is norm-referenced for large populations within and outside the United States; socioeconomic status and race have little effect on standardized scores.[40]

Receptive vocabulary was measured with the Peabody Picture Vocabulary Test–Revised,[42] in which the child is asked to point to one of four pictures that best describes the spoken word. The Woodcock-Johnson Language Proficiency Battery assessed three reading skills—letter-word identification, word attack (enunciating nonsense words phonetically), and passage comprehension—with the reading subtest.[43] Both instruments had standardized Spanish translations with norms for Spanish-speaking populations, and total standard scores were normed for age.

Special Education Evaluation Criteria

Criteria for meriting a special education evaluation were developed by means of age-adjusted scores with English and Spanish norms for three main disability categories and adapated standards for ethnic minority samples.[44] A probable behavioral disorder was defined as a total behavior problem T score at or above 60 (≥82nd percentile), corresponding to the borderline clinical range.[40] This cutpoint is conservative, as children may be eligible for a special education program if they score below this range but manifest clinical symptoms that limit their ability to learn in a regular classroom setting.[45]

A probable learning disability was defined as a Peabody standard score above 75 and a Woodcock-Johnson total reading standard score greater than one standard deviation (≥15 points) below the Peabody standard score. Probable mental retardation was defined as standard scores on both the Peabody and Woodcock-Johnson (total reading) of 75 or below. While the Peabody test is not a proxy for intelligence testing, the use of the discrepancy between the spoken and written word is an acceptable diagnostic marker for learning disability,[46,47] and a generalized deficit in cognitive functioning has considerable support as being diagnostic for mild mental retardation.[48] This testing approach for learning disability and mental retardation disability categories is consistent with practice nationally[30] and in California county school districts in particular, because intelligence testing is prohibited in special education evaluations for minority children.[49] These criteria are also considered conservative,[50] potentially underestimating the number of children with learning disabilities or mental retardation.

Service Use

School history and service use were assessed from parent report. Use of special education services was defined as having received an evaluation for special education or being enrolled in a special class. School records were not available to verify special education placement or disability category because of the transiency of the families and school district policies protecting confidentiality.

Use of mental and general health services was evaluated by means of questions from the National Health Interview Survey, 1988 Child Health Supplement.[51] A child was identified as using mental health services if he or she had received treatment or counseling in the past 12 months for a developmental delay, a learning disability, or an emotional or behavioral problem. If a child had received medication for any of the above conditions in the past 12 months, he or she was deemed to have taken medication for a mental health problem. Use of general health services was defined as going to a clinic, health center, hospital, or doctor's office in the past 6 months and was assessed for routine care and treatment for sickness or injury.

Data Analysis

Data were weighted by number of eligible children per family. The ethnic group "Other" was dropped from the analysis because it was a small (n = 12), heterogeneous group. Bivariate analyses were conducted with a chi-square test of proportions. To guard against overestimation of significance, ethnic differences were reported only if the *P* value remained at an alpha level of .05 or less when ethnic groups were collapsed into two categories. There were no overall differences in significance statistics between analyses using weighted and un-

TABLE 1—Characteristics of Sheltered Homeless Children (%), by Race/Ethnicity: Los Angeles County, 1991

	African Americans (n = 83)	Latinos (n = 69)	Whites (n = 25)	Total Sample (n = 177)	χ^{2a}
Gender					4.66
Female	55	54	30	50	
Male	45	46	70	50	
Age, y					1.72
6–9	33	44	38	39	
10–12	67	56	62	61	
Amount of lifetime homelessness					8.14**
≤2 mo	63	44	65	55	
>2 mo	37	56	35	45	
No. places lived past 12 mo					11.92**
<3	55	59	23	53	
≥3	45	41	77	47	
Enrolled in school					4.72
Yes	89	92	78	89	
No	11	8	22	11	
Attendance past 3 mo					2.17
Missed ≤1 wk	60	67	48	61	
Missed >1 wk	40	33	52	39	
Changed schools past 12 mo					7.18*
0–1 schools	51	72	61	60	
2–5 schools	49	28	39	40	

Note. Data are weighted for number of eligible children per family.
[a]Overall χ^2 for all three ethnic groups ($df = 2$).
*$P < .05$; **$P < .005$.

TABLE 2—Use of Services (%) among Sheltered Homeless Children Aged 6 through 12 Years Who Warranted a Special Education Evaluation, by Disability: Los Angeles County, 1991

	Behavioral Disorder (n = 48)	Learning Disability (n = 36)	Mental Retardation (n = 14)	Any Disability (n = 80)
Lifetime special education evaluation or placement				
Yes (n = 27)	31**	17	36*	23**
No (n = 150)	69	83	64	77
Mental health counseling/ treatment past 12 mo				
Yes (n = 30)	33**	14	29	22
No (n = 147)	67	86	71	78
Routine health care past 6 mo				
Yes (n = 117)	70	68	79	68
No (n = 59)	30	32	21	32
Sick/injury care past 6 mo				
Yes (n = 81)	58	52	50	54
No (n = 92)	42	48	50	46

Note. Data are weighted for number of eligible children per family. Cases are missing as follows: 6 for behavioral disorder; 1 for learning disability; 1 for mental retardation; 4 for any disability; 4 for sick/injury care.
*$P < .05$; **$P < .005$.

weighted data; hence, inferential statistics are reported using weighted data because the unit of analysis was the child.

Results

Eighteen of the 22 (82%) of the homeless shelters participated, ranging from missions to publicly funded facilities. Interviews were completed on 118 of 121 families (98%) and 169 children (100%). Parent and family sociodemographic characteristics are described elsewhere.[9,38]

Forty-five percent of the children (n = 79) had been homeless for more than 2 months, and 47% (n = 83) had lived in three or more different places in the past year (Table 1). Latino children were more likely to be homeless longer than children from other ethnic groups ($\chi^2_{(1df)} = 8.14$; $P = .004$), and White children were more likely to experience greater residential instability than children from minority backgrounds ($\chi^2_{(1df)} = 11.48$; $P = .001$). The majority of children (89%; n = 157) were enrolled in school, but 39% (n = 69) had missed more than 1 week of school in the past 3 months and 40% (n = 70) had changed schools between two and five times in the past 12 months. Latino children were more likely than non-Latino children to have stayed in the same school or to have changed schools only once in the past year ($\chi^2_{(1df)} = 6.48$; $P = .011$).

Overall, more than one quarter of the children (28%) merited a special education evaluation for a behavioral disorder (n = 48), 20% (n = 36) for a learning disability, and 8% (n = 14) for mental retardation, yet few received special education services (Table 2). Less than one third of the children with a probable behavioral disorder (31%; n = 15), 17% (n = 6) of those with signs of a learning disability, 36% (n = 5) of those in the borderline or lower range for mental retardation, and 23% (n = 18) of those with signs of a behavior or learning problem had ever received a special education evaluation or placement. Children who screened positive for a behavioral disorder, mental retardation, or any disability were more likely to receive special education services than children who tested negative (behavioral disorder: $\chi^2_{(1df)} = 10.95$; $P = .001$; mental retardation: $\chi^2_{(1df)} = 6.99$; $P = .008$; any disability: $\chi^2_{(1df)} = 6.99$; $P = .008$).

Likewise, one third of children (n = 16) with a probable behavioral disorder, 14% (n = 5) of those with a probable learning disability, 29% (n = 4)

of those with probable mental retardation, and 22% (n = 18) of those with signs of any disability had received any counseling or mental health treatment in the past 12 months. Children with a probable behavioral disorder were more likely to have received mental health services than children without a problem ($\chi^2_{(1df)}$ = 10.37; P = .001). Only 2% (n = 3) of the children had taken medication for an emotional or behavioral problem, developmental delay, or learning disability in the past 12 months. In contrast, among children testing positive for any disability, almost two thirds (66%; n = 117) had received routine health care and 47% (n = 81/173) had received care for sickness or injury in the past 6 months. With the exception that non-White children were more likely to receive routine general health care ($\chi^2_{(1df)}$ = 4.11; P = .043), use of special education, mental health, and general health services did not vary by age, sex, ethnicity, homeless history, or school attendance or changes.

Discussion

Almost one half (45%) of school-aged sheltered homeless children in our study merited a special education evaluation, yet less than one quarter (23%) of those with any disability had ever received special education testing or had been in special classes. The proportion of children with either a probable behavioral disorder or a learning disability was similar to those found in earlier homeless child studies.[7,12,14,52] Compared with children in the general population, sheltered homeless children in our study were four times more likely to test positive for a behavioral disorder,[53] three times more likely to have signs of a learning disability,[54] and eight times more likely to screen positive for mental retardation.[55] Comparable data on prevalence rates of special education disabilities among housed low-income children are not available.[56]

More than three fourths of homeless children eligible for a special education evaluation in this sample had not received special education services, suggesting a high level of unmet need. Use of mental health services was at similarly poor levels. In contrast, the main point of contact for homeless children with signs of a behavioral disorder, learning disability, or mental retardation was the general health care sector. Our findings underscore the need for primary care providers to look closely for behavioral disorders and developmental delays when evaluating a homeless child and to become familiar with eligibility criteria and mechanisms to access special education programs.

The main limitations of our study are the use of screening measures and the lack of a comparison group. The level of need and unmet need for a special education evaluation may be overestimated by including children who scored in the borderline range and by relying on parent report, which may be inaccurate, for a history of special education testing and programs. Our estimates of unmet need for special education evaluations, however, may also be conservative because our cutpoints were lower than those used clinically to determine eligibility for special education.[45,49,50] The sample also had a selection bias toward homeless children in school (a requirement for shelter stay) and thus may not be representative of the needs of the larger homeless child population who live doubled up with relatives or in cars, theaters, or campgrounds.[57,58] Further, the absence of a comparison group of poor housed children, a common methodologic problem in studies on use of school or mental health services among children,[59] prohibits any conclusions about the impact of homelessness.

Our findings nonetheless suggest that homeless children have a high level of unmet need for special education evaluations, services they are entitled to under federal law. Procedures for determining eligibility and placement into special education programs should be adapted to accommodate the extreme transiency of homeless children, and interventions for school-aged homeless children should be coordinated with special education professionals, general health care providers, and housing services. □

Acknowledgments

This research was conducted through the Robert Wood Johnson Clinical Scholars Program at the University of California at Los Angeles and data analysis was supported by The Robert Wood Johnson Foundation (Grant 18945).

The authors would like to express their gratitude to the residents and shelter staff for their strong support that made this study possible; to Dr Ken Wells for his outstanding mentorship; to Beth Ojeena, Jean Gutierrez, and Nathana Schooler for their consultation as educators of homeless children; to Barbara Genovese, Enrique Godinez, Adam Oberweiser, and Monica Paez for data collection in the shelters; and to The Robert Wood Johnson Foundation for its commitment to health services research training.

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