The Health and Education Needs of Investing in Families (IIF) Children

I. Introduction

A total of 55 parents enrolled in Investing in Families (IIF) were interviewed at two different intervals. The first interview was conducted within one month of enrolling in IIF. The second interview was completed on average 17.5 weeks later, ranging from 16-20 weeks. The total number of children residing in the 55 households was 129.

Pre and post interviews were designed to document parent perceptions of the health and education needs of 129 children at two different points in time. The information will help inform where, why and how IIF system partners may want to coordinate more intensive child-focused supports, partnerships and referrals.

The tables below present summary data of the age, ethnicity and gender of the 129 children who were members of IIF families at the time of the pre and post interviews. (An additional 7 children who, due to a variety of reasons, were not residing in the household during both the pre and post interviews are not included in this report).

Ages of Children	Number/Percent
0 -5	64 (49%)
6- 11	32 (25%)
12 to 17	33 (26%)
Total Number of Children	129

Ethnicity of Children	Number/Percent
Caucasian	92 (72%)
Hispanic	14 (11%)
African	9 (7%)
African American	5 (3%)
Native American	1 (1%)
Asian	1 (1%)
Multi-Race	7 (5%)
Total Number of Children	129

Gender of Children	Number/Percent
Male	73 (56%)
Female	56 (44%)
Total Number of Children	129

II. Key Findings

Child Health

What kinds of assistance did families need to effectively advocate for and promote the health of their children?

- Age appropriate information about the location and offerings of accessible medical, dental and special need resources
- Information about child development to know what to expect at different ages and stages of a child's development
- Supplies such as age appropriate bikes and helmets to encourage child exercise
- Information about school district developmental disabilities screening and offerings
- Parenting guidance and information (not necessarily classes)
- Information about how to cook affordable, "low budget" nutritional meals
- Resources to send their children to free or affordable afterschool and summer recreational activities, so that children could begin to combat obesity and to limit their unsupervised time

The review of parent comments regarding the health of their child/children revealed that:

- Most families had access to a "medical home" or medical care for their children, through TANF or other subsidies. The access to health services alone, however, did not ensure that they accessed services in a timely or cost-effective manner, or that they had the information necessary to support the development of their child.

- Parents rated their children's health on pre interviews using a five point scale (excellent, above average, average, below average or very poor). (Refer to tables at the end of this section).The majority of ratings were positive with 76% of the birth to 5; 71% of the 6-11 and 66% of the 12-17 describing their child's health as above average or excellent. The health of 10% of the total group of children, however, was described as very poor or below average. Asthma, bronchial and obesity problems were the most frequently mentioned health concerns across all age groups, and were especially prominent among the children who received average, below average and very poor health ratings. In many respects, parents' health ratings were very optimistic given the significant obesity, asthma and attendance problems that their children experienced. One parent noted this by saying, "I downplay all problems now. After being homeless seems like some stuff I should take seriously just does not make the register. If my son (who has severe asthma) is not in the hospital I think his health is good."

- Overall, parent-reported post interview health ratings of children revealed that the health status of birth to 5 children slightly improved between the pre and post interviews. Parents attributed these changes to the fact that they were taking their child more often to prevention-focused (rather than emergency care) types of appointments. Overall, post interview parent ratings of the health of older children (6-11 and 12-17) were slightly lower, however, largely because parents said they had begun focusing more on the behaviors of their older children, and were increasingly aware, as a result of feedback provided by doctors, teachers, and their own observations, that their children were engaging in behaviors that could harm their health.

- The majority of parents of children in all three age groups

- Resources to pay for middle/high school student athletic fees, uniforms and equipment as a way to promote child health and educational persistence
- Nebulizers, air purifiers and dehumidifiers to deal with asthma and allergies.
- Safe non-allergenic cleaning materials and bedding.
- Flu shots and immunizations for parents so they don't unnecessarily expose their children to illnesses
- Respite care for homebound parents who are caring for chronically ill children

IIF Parent Suggestions

who gave higher post ratings of the health of their children said that at the time of the post interview they were better equipped to respond to children's health issues because their lives were more stable. Many also attributed the more positive health assessments to the fact that at the post interview they were no longer living in unsafe, unsanitary and/or congregate "close in" environments where they were doubling up with others and routinely exposing their children to persons who were ill.

- Twelve (12) children faced serious health challenges, including heart, kidney, anemia and a host of other presenting conditions, including cerebral palsy and spinal bifida. These children were all accessing health care. Their parents, however, were most likely to report feeling depressed and isolated, and as having limited support systems. Some were homebound caregivers.

- Families who suspected (but had not yet confirmed) that their children were experiencing autism, developmental delays or learning disabilities, often reported that they did not know how to access needed health services. There was a general lack of awareness among these families of the school, health or community resources available to assist their children. IIF referrals were particularly instrumental in helping families access these types of resources.

- IIF Navigator staff helped connect families to health care resources, via direct referrals and the provision of bus cards and computers: slightly over half (28) of the 55 families accessed health care services for one or more family members as a result of IIF system partner referrals, and four families' accessed mental health counseling. Ten families used IIF bus cards to transport their children to health care services. In addition, 7 families used the IIF laptops they received to locate health care providers who were located in close proximity to their residence.

More specific information about the health needs of children by age group follows:

Children Birth to 5

At the time of the pre interview, despite most being eligible for health care services, only 25% of families with birth to 5 year old

Pre/Post Health Care Circumstances	Pre IIF Interview	Post IIF Interview
Immunizations up to date	25%	70%
Family used emergency room care as sole "health home"	45%	25%

children were up- to-date on their immunizations. The children of young (under 20) parents were most likely to have missed appointments. Most parents who reported that their child's immunization status was not current said they got sidetracked with other significant family issues, and did not routinely take their children to scheduled appointments. Some noted that they had transportation barriers and multiple children in tow that made it difficult to attend well child exams. The percent of children with asthma was high (38%).

Many parents thought children did not need dental care until they were school aged. A few children had teeth that appeared to be very decayed. Closer questioning revealed that some of these children routinely drank apple juice in their baby bottles at night; a practice which their parents thought promoted good health. A fairly large number of families (45%) used emergency care for the 4 to 5 months prior to the post assessment as their primary type of care for their youngest children. A handful of children were observed by the evaluator to have significant speech and other developmental delays, though only 2 of the 5 children with these characteristics had accessed outside resources.

At the time of the post interview more families were connecting their children to needed immunization services, and reducing their dependence on emergency room "after hours" health care. Many families were still unsure about whether their child was developing well (in light of their different health conditions), often noting areas (toileting, literacy, speech development, etc.) where they needed parenting information.

Children Ages 6-11

At the time of the pre-interview children in the 6-11 age group had slightly higher rates of asthma (39%) than the birth to 5 year old children. Many (29%) of the parents said that their children were considered overweight by their pediatricians/doctors. Two children had been diagnosed as having high blood pressure. Parents of children in this age group frequently voiced concerns about child nutrition. On average, children ate fast food 5 nights a week. Children in this age group missed an average of 3 days of school a month, a level which would be disruptive to their education. Most absences were due to asthma or to family moves. Only 45% of the children in this age group had been to a dentist in the last year, even though some were experiencing visible signs of dental decay and associated dental pain.

Health Habits	Pre IIF Interview	Post IIF Interview
Average number of evening meals per week at fast food restaurants	5	3
Average number of days children engage in inside/outside physical exercise	2	7

At the time of the post-interview the 6-11 year old child health ratings had decreased slightly because families had taken children to the doctor and received warnings from their physician about their child's long term health outlook. Two children had been diagnosed with Type 2 diabetes since the pre interview. As a result, one parent who was now exercising more regularly with her 10 year old son said, "I know that my child's health is at

risk. I need and want to do something about it now." In response to suggestions from medical providers a couple of families were making major positive changes in their eating and exercise habits. In the brief period between the interviews 3 children had experienced respiratory problems that resulted in brief hospitalizations. Several parents noted that their children needed mental health counseling services. One child was hoarding food, and another had what appeared to be self-inflicted injuries. Parents of these children were in the process of securing medical help to address these issues.

Adolescent Children – 12 to 17

At the time of the pre interview the adolescents in this age group reported similar rates of asthma (39%) and slightly higher rates of obesity (30%) in the pre interview as the six to eleven year old children. Though they had fewer chronic respiratory problems, they missed more days of school than the 6-11 year old children, averaging four days a month, ranging from perfect attendance to 7 days. Their absences were attributed to a variety of factors, including asthma, refusal to attend school, and suspensions. Diagnosed health issues for two children in this age group included anorexia and obsessive compulsive disorder. Some parents voiced concerns that their child was smoking (25%), and 55% said that they knew their child was experimenting with alcohol or other drugs (55%). One adolescent male was actively engaged in huffing (inhalant abuse) and had been reported by a neighbor. Very few (20%) of the adolescents had received a comprehensive health exam in the last year. A higher number (25%) had visited emergency rooms for treatment of asthma, broken bones, a suspected drug overdose and a variety of other reasons between the pre and post interview. Many (40%) had not visited a dentist in the last two years, and 15% had obvious dental decay and significant unaddressed orthodontia problems.

At least 25% of the parents were concerned that their adolescent children were sexually active and at risk of acquiring sexually transmitted diseases. A fairly large percent of the adolescent children (30%) experienced moderate to severe acne, eczema, or other allergy-related skin problems, but most were not receiving consistent treatment for these conditions.

Pre Interview Rating Child Physical Health						
How would you describe your child's health?	**Excellent**	**Above Average**	**Average**	**Below Average**	**Very Poor**	**Total Children**
0 - 5	29 (45%)	20 (31%)	9 (14%)	2(4%)	4 (6%)	64
6 - 11	12 (37%)	11 (34%)	6 (19%)	2(7%)	1 (3%)	32
12-17	11 (33%)	11 (33%)	6 (19%)	2(7%)	3 (9%)	33
Overall Number/Percent of Total Children by Category	52 (41%)	42 (33%)	21 (16%)	6(4%)	8 (6%)	129

Post Interview Rating Child Physical Health						
How would you describe your child's health?	**Excellent**	**Above Average**	**Average**	**Below Average**	**Very Poor**	**Total Children**
0-5	32 (50%)	23 (35%)	6 (9%)	1(1%)	2 (3%)	64
6-11	10 (31%)	10 (31%)	9 (28%)	1(3%)	2 (7%)	32
12-17	9 (27%)	9 (27%)	10 (30%)	2 (7%)	3(9%)	33
Overall Number/Percent of Total Children By Category	51 (39%)	42 (33%)	25 (19%)	4 (3%)	7 (6%)	129

Summary Observations by Evaluator

About Child Health

IIF services, though not strongly focused on child health, are indirectly yielding some positive health outcomes, such as increases in immunizations and use of preventive, rather than emergency care. It is very likely; however, if more attention was directed to helping parents support the health of their children that positive health outcomes for IIF children would even be more robust.

Parents were very engaged when they discussed the health needs of their children. For some their child's health was an emotional issue. A few were painfully aware that their own pre-natal drug use and nutrition was at least partially responsible for serious and perhaps permanent health conditions that their children encountered and experienced a great deal of guilt.

Most notably, however, many parents wanted to support the emotional and physical health needs of their children, often voicing concerns about their parenting skills, and approach to meeting the nutritional needs of their children. As one parent said, "The convenience store is closer than the grocery store. "All parents might be able to do more, however, if they had the resources to increase their child's engagement in sports and recreation activities that increased their child's safe and positive use of out-of-school time. Many children exhibited an amazing level of resiliency given the many Adverse Childhood Experiences (ACES) they were encountering and accumulating in their young lives, and were thriving physically and emotionally. Some however, were exhibiting behaviors that warrant great concern.

In some families with multiple children it was not uncommon to see that there was one child whose behavior and health presented serious concerns, while the others were thriving. One parent who had three children, two of whom had adjusted rapidly after exiting homelessness and moving into housing, said, "The younger children are fine. My teenage daughter, though, is a casualty of our being homeless. She is unable to shake the unhappiness."

Some parents thought that the lower post ratings of their child's health were due, in large part to the fact that they only recently had time to candidly and thoughtfully reflect on the overall health of their child. The deep interconnections of the health of adults and the child's emotional, mental and physical health were abundantly clear during the interviews, as was the need for and benefits of engaging more children and families in opportunities to reflect on their experiences. One parent who was receiving IIF partner counseling services said, "Due to my involvement in counseling I only recently starting thinking about the reasons driving or contributing to my child's physical or emotional behaviors. I only recently started re-gaining my life." Many parents said that the needs of their older children, in particular, "had gotten lost in the shuffle" right before they enrolled in IIF. Another parent whose children and whole family was receiving counseling services said, "Now I am trying to make sense of why she is acting this way. Why she is barely eating or talking and has trouble trusting her father and me. She can't trust us, she said, because we made her homeless."

IIF may want to be more intentional in connecting families to resources that address the health needs of children. They may also want to engage more children and families in individual or group counseling as these activities yield positive results. IIF partners may want to work with health partners to integrate key health questions and data points (such as timely immunizations and school attendance) into the IIF system in order to ensure that families who most need to be linked with a child health advocate or other child-focused services access these supports.

Some parents said that concerns about their child's health and education (next section) were the underlying reasons why they were not pursuing next step resources. The parents willingness and interest in talking about the health needs of their children suggest that approaching some families first to address these needs might build a stronger bridge between families and all IIF referral partners.

Child Education (For birth to 17 year old children)

Academic Performance

Parents rated their child's progress in school using a five point scale (excellent, above average, average, below average and very poor) in reading, math and interactions with peers. A review of their comments reveals that:

What kinds of assistance did families need to effectively advocate for and promote the health of their children?

- Early literacy/reading materials for parents, and information about child development
- Information about

- Only 15% of the birth to 5 children was engaged in a formal early learning/child care environment. Also, consistency of learning environments for young children with half of this group engaged in an average of two different care settings between the pre and post interviews. Over 80% of the children getting ready to enter kindergarten lacked basic skills that would help them successfully transition to kindergarten. For example, using observational testing the evaluator observed that they were not able to hold a pencil, name or draw a picture of a triangle, circle or square. The children enrolled in childcare were, however, demonstrating significantly higher levels of age appropriate skills. Only 10% of the families routinely read to their children for 20

childcare/preschool programs and scholarships

- School supplies, paper, pens, book bags
- Laptops for older youth; also resources for older youth to take driver's license classes, buy school year books, and other accessories necessary to help them "fit in" with their peers
- Advocacy support to enroll children in afterschool, summer and college preparatory programs
- Assistance to understand the reasons for and content of Individual Education Plans (IEPs)
- Tutoring/homework assistance to help students get caught up with school work
- Referrals to doctors for ADD and ADHD assessments and screenings
- School-based advocacy for youth encountering academic or behavioral challenges
- Indoctrination of school staff/faculty about some of the

minutes a day, an amount regarded as helpful to build foundational early literacy skills, and 70% almost never read to their children.

- Eleven (33%) of the children, ages 6-11 and 12-17 were assessed by parents as doing excellent or above average in language arts (reading/English) in school. (Refer to charts at the end of this section). Many parents reported with pride that their children had worked hard to catch up on their studies and make up for time lost during the time they were homeless, changing schools or moving to different locations. Fewer children (24% of the 6-11 year old children, and 18% of the older 12-17 year olds) were assessed as performing excellent or above average in math. Ten children, ages 6-17, were exemplary students and were enrolled in advanced programs. "I don't know how she did it," one father said of his nine year old daughter. "Even on the night we were forced to leave our apartment she worked on her homework using a flashlight in our car."

- A significant number of 6-11 year old children (34%) and 48% of 12-17 year old children were assessed as making below average or very poor progress in language arts and 37% of 6 -11 year olds and 64% of 12-17 year olds were described as doing below average or very poor in math. Seventeen (26%) of the 6 -17 year old children were identified by parents as having Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

- Very few (15%) of the children, ages 6 to 11, were engaged in academic or enrichment school year programs, and an even smaller number (8%) were engaged in summer programs. Similarly, very few adolescent youth (11%) were engaged in school year academic, sports or enrichment activities. A 14 year old girl said, "The activities are usually expensive or hard to attend without transportation. I am not really a joiner anyway." Cost, lack of transportation, and parent knowledge about these resources contributed to low participation levels. Also, the ethnographer frequently noticed that parents often had misinformation about resources, or were not aware of opportunities to apply for scholarships. Only four of the high school youth were actively engaged in plans to go to college. Eleven youth ages 6-17 told the evaluator that they likely would not have the skills to succeed in college. One added, "Besides there are not any jobs in Snohomish County so why should I go to school."

- Almost half (46%) of the parents assessed the interactions their children ages 6-11, had with peers as being excellent

difficulties that homeless children face

- Help understanding school rules for suspension/expulsion
- Alternate strategies to suspensions for homeless youth because many have already missed a lot of school and some don't see suspensions as a punishment for negative behaviors
- Advocacy to get school-based or community counseling
- Home furniture for desks, lamps, books
- Advocacy during school conferences to help develop plans to address student academic and behavior issues and to ensure that the teachers are aware of issues that are influencing child progress in school
- Transportation assistance to school events/conferences
- Letters of reference/advocacy to help children enroll into special afterschool and summer programs/camps that will introduce them to new ideas, skills, and places that they have never had an

or above average, while 34% were deeply concerned that their children had trouble making friends, and were getting into frequent verbal or physical conflicts. One parent said, "My daughter used to behave well, but with each move her patience and ability to be friendly with other kids seems to have dropped. The parents of 12-17 year old youth assessed 39% as having excellent or above interactions with peers and 36% as having below average or poor interactions.

- Five of the older youth had been suspended from school at least twice between the pre and post interviews. Most families were unaware of available after school resources and a few provided reasons (cost, transportation, safety) that their child could not attend such programs. Similarly, very few of the adolescent youth who were on the brink of dropping out of school were receiving specialized supports to improve their school performance, and a few were considering dropping out of school, or had previously dropped out of school.
- Only 10% of the families of children who were assessed to have reading and/or math academic problems structured homework time into the everyday life of their children. One self-described "exhausted single mom" said, "I know I should be more directive, but we have had to answer to so many rules set by shelter staff and my relatives that I just don't want to do that with my kids right now."
- Many were unsure of how to support their children, often commenting that some teachers and school staff don't really understand homelessness or what their children have experienced. One parent said, "What they don't get is that she is trying and she is there. She needs time to get over life events. She saw me abused. She changed towns. Schools. Homes. Left her friends, and grandparents. The fact that she is sitting in school and trying to make friends deserves praise."
- In most cases parent contact with the schools was minimal. Only 23% of the parents reporting that their children were performing poorly in academic subjects knew the name of even one of their children's teachers, and 7 parents had stopped answering calls from their child's school. One single father said, "I am not sure I can take much distraction at this point. I am in a new job. Can't leave to go to my child's school and don't want to get into a face off with a teacher who has no understanding of what we have and

opportunity to visit

- Attractive storage boxes for child art work, youth possessions so that as one parent said, “They don’t lose the memories of their childhood. Just because we lost housing does not mean that they should not keep a hold of some of the everyday things that mean something to them”.

are going through.”

- Fifteen parents reported that they had longstanding problems with the educational system and did not really know how and when to voice their concerns or ask for help. One 45 year old woman said, “Going way back to my childhood it seemed like school and me are not a good match. Never were. Never will be.”

- Eight parents said that they did not bother to get engaged with the schools because they were in temporary housing and would soon be moving. One single mother of three elementary school aged children said, “I know this sounds terrible - I just don’t feel like my energy can or even should be at my child’s school. I need to find a job. Get ready to move. I hate to say it but this is one of those times that there better be a village out there.”

Summary Observations by Ethnographer

About Child Education

To date, IIF services have not been focused on addressing the education needs of children. It is clear, however, that many families need help negotiating the school system, and in connecting their children to educational and enrichment resources.

Parent comments show that assistance is needed at every age level – from cradle to college and career. The inclusion of school advocacy assistance and of taking a more comprehensive two generation approach would position IIF to support children to succeed in school, addressing one of the key issues that contribute to intergenerational poverty.

Also, by working in partnership with families to help them support their education, IIF would likely make great inroads with getting families into education and employment and other IIF partner resources. For example, the parent of the youth who said “There are no jobs in Snohomish County”, called the ethnographer after the interview to say, “I felt badly that he believed that just because I can’t find a job there are no jobs. I told him I probably need to look harder or get some training- that there are jobs for people who have skills and work hard to get them.” Similarly, when talking with the ethnographer about reading books another parent said, “This question really makes me think about finishing school. I dropped out in 10th grade, and have tried twice to get my GED but always get off track. I want my daughter to think that school is important but soon she will see I did not make it my priority.”

In addition, parent comments suggest that school staff and faculty may need more training to understand the complex issues facing homeless children. Even simple gestures on their part can have a lasting impact. One parent noted that her daughter has a teacher who reached out to her and gave her extra books because she knew that her daughter did not have many books

and had been homeless. “This generosity – act of understanding meant so much to me and my daughter. For the first time I feel like I can join my daughter’s class on activities.”

The interviews and family suggestions suggest strongly that there are many critical points where families need more educational advocacy support. By addressing these issues, families, children and ultimately the economic vitality of the whole community will be strengthened.

Parent Report of Children ages 6-11 Progress in School (N=32)					
	Excellent	**Above Average**	**Average**	**Below Average**	**Very Poor**
Parent report of how child is doing in language arts	5 (15%)	6 (18%)	10 (31%)	1(3%)	10 (31%)
Parents report of how child is doing in math	3 (9%)	5 (15%)	12 (32%)	2 (6%)	10 (31%)
Parent report of how child interacts with peers	8 (25%)	7 (21%)	6 (18%)	9 (28%)	2 (6%)

Parent Report of Adolescent Children ages 12-17 Progress in School (N=33)					
	Excellent	**Above Average**	**Average**	**Below Average**	**Very Poor**
Parent report of how child is doing in language arts	6 (18%)	5 (15%)	6 (18%)	7 (21%)	9 (27%)
Parents report of how child is doing in math	2 (6%)	4 (12%)	6 (18%)	11 (33%)	10 (31%)
Parent report of how child interacts with peers	6 (18%)	7 (21%)	10 (30%)	8 (30%)	2 (6%)