Improving screening for problem behaviors among homeless children in Georgia

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Improving Screening for Problem Behaviors among Homeless Children in Georgia

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UHI forges vital university and community partnerships in health care, education, and community planning, with all partners working to change the trajectory for the children, youth, and families of Metro Atlanta and the state of Georgia.

Four focus areas:
• Community programs
• Community engaged learning
• Training of health professionals
• Research

www.urbanhealthinitiative.emory.edu
Homeless
Homeless
Lazy
Criminal
Addict
Poor choices
Insane
Carefree
Bum
Taking Advantage
Forte (2002)
Another view...

https://www.youtube.com/watch?v=QYIQo4NSgwo
A Series of Questions

- What does family homelessness look like in Georgia?
- What impacts does homelessness have on kids and families?
- What can be done to help?
- What did we do?
- What did we learn?
- How do we apply it?
What does family homelessness look like in Georgia?
Promising trends, but progress for families has been slow

National Alliance to End Homelessness (2016); U.S. Department of Housing and Urban Development (2015)
On a given night in 2015, 1 in 3 homeless individuals were in a family with children

Georgia Department of Community Affairs (2015)
GA experienced one of the largest declines in overall homeless, but less change for families.

From 2014 to 2015:

- Overall homelessness declined 17% (2,731 people)
- Family homelessness declined <1% (30 people)
In GA, homeless children are more commonly in rural areas and small towns

What impacts does homelessness have on kids and families?
Physical Health

- More environmental exposures
- Nutritional deficits related to food insecurity and shelter conditions
- More chronic conditions including childhood overweight/obesity and dental decay

Mental Health

- Higher rates of child mental health problems
- Higher rates and intensity of depression
- Common exposure to violence and trauma
- Parental depression and mental health problems often related to higher child psychiatric issues

Grant, et al. (2013); Bassuk, Richard, & Tsurtvadze (2015); Rigual-Lynch, et al., 2006; Chiu, DiMarco, & Prokop (2013)
• Vocabulary deficits, reading delays, and learning disabilities
• Lower rates of referrals to special education than other low-income children
• Similar absenteeism and standardized test performance to other low-income kids, but more enrollment instability

• Higher rates of delayed speech and language development
• Higher rates of emotional-behavioral problems and hyperactivity / inattentiveness

Grant, et al. (2013); Zima, et al. (1997); Fantuzzo, et al. (2012)
What can be done to help homeless families?
Lifting Up What Works

- Enhanced coordination across players in a family’s system of care (e.g., schools)
- Addressing barriers pertaining to safety, transportation, and access
- Evidence-based programs to enhance child resilience and manage behaviors
- Screening for developmental delay and behavioral problems in the shelter setting

Bassuk, et al. (2016); Thomas & So (2016); Masten (2012)
So, what did we do?
Phase 1. Focus Group Discussions with Providers

Provider Participants
- Physicians (MD, DO)
- Nurses (RN, NP, etc.)
- Psychologists
- Social Workers
- Therapists (LPC, MFT, etc.)

Ideas Generated
- Training shelter personnel on developmental milestones
- Educating families on child development while in shelter
- Placing screeners in shelter-based clinics

https://www.focusgroupit.com/
AAP Recommendations

“Administer a standardized developmental screening tool for children who appear to be at risk of a developmental disorder at the 9-, 18- or 30-month visit”

“Children should be screened at regular intervals for behavioral and emotional problems with standardized, well-validated measures beginning in infancy and continuing through adolescence.”
Phase 2. Quality Improvement Initiative

**Plan**
- Objectives
- Questions and Predictions
- Plan to carry out the cycle

**Do**
- Carry out the plan
- Document problems, unexpected findings
- Begin data analysis

**Act**
- Complete analysis
- Compare to prediction
- Summarize learnings

**Study**
- Complete analysis
- Compare to prediction
- Summarize learnings

*Speroff & O’Connor (2004)*
Phase 2. Quality Improvement Initiative

- 3 shelters representing distinct geographies
- QI training via Practice Improvement Modules
- Multiple meetings per month

**Shelter A** | **Shelter B** | **Shelter C**
--- | --- | ---
Consumers

Case Management

Medical Providers | Administrative Staff
--- | ---
Executive Director

Duffy, et al. (2008)
## Behavioral and Emotional Screening Measures Used

<table>
<thead>
<tr>
<th>Strengths and Difficulties Questionnaire (SDQ-2)</th>
<th>Pediatric Symptom Checklist (PSC-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3-17 years</td>
<td>• 4-16 years</td>
</tr>
<tr>
<td>• 25 items</td>
<td>• 17 items</td>
</tr>
<tr>
<td>• Parent version</td>
<td>• Parent version</td>
</tr>
<tr>
<td>• Sensitivity: 63-94%</td>
<td>• Sensitivity: 82-96%</td>
</tr>
<tr>
<td>• Specificity: 88-96%</td>
<td>• Specificity: 77-95%</td>
</tr>
</tbody>
</table>

**Subscales**
- Emotional Problems
- Conduct Problems
- Hyperactivity/Inattention
- Peer Relationship Problems
- Prosocial Behavior

**Subscales**
- Internalizing Behaviors
- Attention
- Externalizing Behaviors

What did we learn?
Aim 1. Characteristics of screening rates over time

% of Children receiving shelter-based healthcare screened

Shelter A
Shelter B
Shelter C
Aim 2. Barriers and Facilitators to PDSA Cycle

Plan

Identify the issue and plan for change

Primary Facilitator: Previous QI Experience

“It really helped get everyone on the same page and thinking in a cyclical manner. This isn’t how we normally approach problems at [this shelter], so that was sorely needed”

Secondary Facilitators

- Having meetings routinely scheduled in advance
- Facilitating meetings using a structured, rather than free-form or open-ended approach
Aim 2. Barriers and Facilitators to PDSA Cycle

Plan

*Identify the issue and plan for change*

**Primary Barrier: Lack of Time/Commitment by QI Team Lead**

“I care about this work so much, but to be honest it just isn’t feasible to add another task to [my] workload.”

**Secondary Barriers**

- Lack of logistical pre-considerations
- Sense of hopelessness about the QI team’s ability to create change in shelter
- Challenges inherent in having participants from varied roles collaborate
“It would have been very easy for this project to live and die in isolation, separate from everything else. We have the technology room where moms are trying to find jobs, we have addiction programs… how does the kid fit into the picture right there, aside from playing with them? You see, [the medical provider] doesn’t just help families in clinic. He gets out there, goes door-to-door…The families see him and his commitment.
Aim 2. Barriers and Facilitators to PDSA Cycle

**Primary Barrier: Provider Time/Commitment**

“If families are lining up outside my door, you can bet this is the first thing that gets dropped. I end up having to prioritize.”

“Screening kids is unfortunately not as vital as making sure a family gets the shots they’ll need for school or a TB test to stay in shelter”.

**Secondary Barrier**

- Lack of knowledge regarding appropriate medical codes for screening
Aim 2. Barriers and Facilitators to PDSA Cycle

Primary Facilitator: “Improvement Culture”

“It’s how we run the ship around here.”

“This is what we’ve always done. In our weekly team meetings, we take stock of what works and what doesn’t cutting across each of our programs.”

Secondary Facilitators

- QI experience on the team
- Medical provider on the team
- Applied project management and facilitation tools
Aim 2. Barriers and Facilitators to PDSA Cycle

**Primary Barrier: Shelter Leadership on Team**

“We’re lucky to have the voice of a leader here at the table. But at the same time, it makes me feel like I need to hold my punches when talking about what could be improved around [the shelter].”

**Secondary Barrier**

- Lack of ideas about how to best present and facilitate discussion of electronic health record data
Primary Facilitator: Diverse Perspectives

“The catalyst to overcoming the standard of practice is throwing a case manager, some shelter guests, and a doctor in the same room. You know how often that happens? Never. But in this case, it made all the difference – [the doctor] was able to tell us what he needed to accomplish with each of his patients in clinic, while the guests were quick to advocate for their and their kids’ own needs. I think moving the needle could only really have happened with all of us there.”
Aim 2. Barriers and Facilitators to PDSA Cycle

Primary Barrier: Provider Resistance to Change

“When I was in school, we never really thought about systems, or about continuously improving the way we conducted our clinical practice. It was very much identifying symptoms and providing treatment.”

Secondary Barriers

- Lack of child development knowledge/expertise
- Shelter organizational policies
- Family resistance to screening
How do we apply it?
Interdisciplinary teams that received basic training in QI concepts were able to measurably increase screening rates for children being seen in shelter-affiliated clinics within a ½ year.

We found sustained change in a community setting that often faces challenges to implementing prevention efforts.

Key Influences on QI Initiative Success
- Team Management, Cohesion, Composition
- Sufficient Training is Needed
- Attention must be paid to both Individual and Institutional Factors

Application

Speroff & O’Connor (2004); Kritchevsky & Simmons (1991)
Future Research Needs

• Does screening in shelter actually yield improvements in health and developmental outcomes?
• Could a similar approach be used in other community-based setting serving families at risk for emotional and behavior issues?
• How feasible would it be for non-clinical shelter staff to screen children?
• What does parent engagement look like with families that are homeless?

Considerations

• Small number of pilot sites
• Observer effect bias
• Lack of balancing measures

Application

Speroff & O’Connor (2004); Murphy & Tobin, 2011
Let’s give ‘em the best shot we can.


References


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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Emory School of Medicine, Atlanta Children’s Shelter, Greenbriar Children’s Shelter, Interfaith Hospitality Network, or Emory Rollins School of Public Health.
Additional Slides
Homelessness and Children: A Model of Impact

- Homelessness
  - Deteriorating living conditions
  - Growth of risk factors
  - Harm to well-being

- Unhealthy conditions:
  - Malnutrition
  - Inadequate medical care
  - Social isolation
  - Proximity to victimization
  - Lack of parental support

- Physical damage:
  - Emotional impairment
  - Social deterioration
  - Educational deficit

Murphy & Tobin, 2011
Definition of Homelessness

- Camping with no permanent home to return to
- Doubling-up temporarily with another family
- Having no permanent place to return to after hospitalization
- Living out of a car
- Living in an emergency or transitional shelter

Health Issues among Homeless Children vs. Low-Income Housed Children

Family Housing Fund (1999)
Screening Instruments

Strengths and Difficulties Questionnaire (SDQ)

PSC-17 [Link]