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CLINICAL CASE
A Mother and Infant with No Home
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Mrs. Patterson delivered her child by cesarean section in a community hospital. She and her child were in good health and ready to be discharged 2 days later. In speaking with Mrs. Patterson, Dr. Blake discovered that she was homeless, a fact that no one else in the hospital knew. When admitted, Mrs. Patterson had given the registrar an old driver's license and did not report that she was currently living in her car and staying with friends occasionally.

When Dr. Blake asked her what she intended to do once she left the hospital, Mrs. Patterson explained that she would not go to a shelter—she was afraid of random violence, substance abuse by fellow tenants, and unsanitary conditions. Friends offered her periodical financial assistance but not a permanent place to stay. Contacting her family or husband, who had been physically abusive, were not options, and she was adamant that social workers not be involved. She planned to live in her car until she could get back on her feet, which she said would only take a few months.

Dr. Blake was conflicted about what to do. On the one hand, she understood why her patient did not want to return home or stay in a shelter. She did not want to put her child in foster care. Even though Mrs. Patterson was mentally sound and competent, a patient could not be discharged without someplace to go. Communities were cracking down on the practice of "patient dumping."

Commentary
This is an interesting case that raises many issues pertaining to both the mother and the infant as well as policies that shape the problem of homelessness in America. The probable gulf in life experience between the evaluating physician and her patient creates a clear potential for judgments to be made based on the biases of the physician and a lack of understanding or appreciation of the circumstances of the homeless mother. The gap can be exacerbated further if there are differences in ethnicity. Thus, it is essential that Dr. Blake be aware of her own biases and susceptibility to stereotyping and respect her patient's autonomy in making ethical and management decisions.

The definition of homelessness is critical to clinical evaluation; the development of prevention and intervention programs and federal- and state-funding decisions all depend on it. The McKinney-Vento Act of 1987, which was renewed in 2002 and is followed by the U.S. Department of Health and Human Services, defines a homeless

person as “an individual who lacks a fixed, regular, and adequate nighttime residence” [1]. This includes not only individuals who are living on the street but also those who live in shelters or are temporarily staying with friends. Mrs. Patterson fits this description.

Dr. Blake’s concern in discharging the infant to a homeless parent is understandable given the accompanying risks—most the result of lack of health services and exposure to environmental and social dangers found in shelters and substandard housing. Homeless children are more likely than poor, housed children to be hospitalized or visit an emergency department; they are twice as likely to get sick, four times as likely to have asthma, and over six times more likely than poor, housed children to have multiple health problems. They are five times more likely to have infections associated with crowded living quarters such as upper respiratory infections, scabies, and diarrhea. Homeless children go hungry twice as often as nonhomeless children and are twice as likely to repeat a grade in school. Playing in unconventional areas puts them at higher risk for injury and toxic exposure, and they have higher rates of lead poisoning and lower rates of lead testing than comparable housed, low-income children because of time spent in dusty, dilapidated shelters [2, 3]. Homeless children also have delays in immunizations and access to treatment for acute and chronic medical conditions.

Every year 600,000 families with 1.35 million children, or about 1 in 50 American children, experience homelessness [4, 5]. Homeless families are the fastest-growing segment of homeless people, now making up about 40 percent of the homeless population on any given night [6]. They are typically headed by a single parent—about 85 percent are single mothers with children [7]. Homeless children are homeless on average for 10 months at a time, and about 25 percent have been homeless more than once [8]. With the current economic crisis, the inevitable increase in unemployment, and expiration of unemployment benefits, homelessness of adults and children will undoubtedly rise significantly in the coming years.

In Mrs. Patterson’s world, the demand for subsidized housing outstrips its supply, the federal government has failed to promote low-income housing since 1980, and broad economic forces beyond the control of any individual appear to be framing her homeless status. Her experiences with trauma and loss may shape her emotional responses, mental health, or substance use. Intimate partner violence has profound effects on mental health and behavior, not only of the immediate victim, but for children that witness these relationships. Those children are sometimes referred to as “invisible victims” since, when the problems are brought to the attention of physicians, social workers, police, or others, the focus is generally on the evident problems of the adult, and the child’s needs are commonly neglected [12].

Right to Autonomy and a Child’s Best Interests

The mother’s right to autonomy must be balanced against the need to assure the safety and well-being of the infant. In general, parents are presumed to act in the best interest of their children and hold the legal and ethical right to consent for them in

health care and housing matters. But parental right is not absolute, and the capacity of a parent to act in the best interest of the child must be assessed. Defining the best interests of the infant can be complex, given both his or her physical safety and security and the threat to disruption of early attachment to the mother. Nurturance and stability of attachment during the first years of life, when essential characteristics such as the capacity to love and trust are developed, are critical to emotional health.

Emotional development and growth are largely mediated through the stability and consistency of attachment to the primary caregiver, usually the mother. Even though the mother may be able to supply only an unstable physical environment for the infant, she may be the person most capable of providing a stable emotional bond. Given the complete dependence of the newborn on the adult caregiver, it is important to make a critical assessment of Mrs. Patterson's competency. Many of the problems that Mrs. Patterson confronts are related to a lack of resources, family and social supports, and stable living environment. Stabilization in housing can create circumstances far more conducive to the child's development and safety—though it seems evident that Mrs. Patterson and her infant could also benefit from mental health services, parenting classes, and other supportive services.

Mrs. Patterson declined an offer to go to a shelter for several reasons such as lack of safety, violence, and substance abuse that staff of homeless shelters are generally well aware of, especially as they affect small children. Many times, women with children are put at the head of the line to be afforded more desirable housing including vouchers for hotels or apartments as they become available. Although the hospital may have capacity and finance concerns, it would be unconscionable to discharge a new mother and her infant to an obviously unsafe environment. Among all the possibly conflicting interests at stake—the infant's, the mother's, and the hospital's—Dr. Blake must decide which has priority. Given Dr. Blake's work situation in the hospital, she may experience overt and covert pressures to put the hospital's interest above the patient's, depriving the patient of her most important advocate. Because of such pressures, many states have laws to protect indigent patients from discharge to the street.

Determining Available Options

Quite likely Dr. Blake does not know what services and placement options exist for homeless mothers in the local community. In that case, she must identify sources that are knowledgeable about local shelters that can house mothers with infants or alternative placements such as maternity homes or extended family members. Many communities in the United States, particularly in urban centers, have dealt with homelessness for decades and have such resources.

Mrs. Patterson is adamant that social workers not be involved, but we aren't told why. Dr. Blake can ethically and legally notify a social worker despite her patient's insistence not to involve one if she sees a probable cause to do so. Homelessness carries with it great stigma; homeless people are subjected to both the disapproval and judgment of others and to being stereotyped as mentally ill, criminal, or

substance abusers, all of which are commonly inaccurate; they may experience fear, loss of pride, and dependency on others. But perhaps what Mrs. Patterson most fears from involvement of a social worker is the loss of her child. It is reasonable for her to be suspicious of the motives that physicians, social workers, and others have when they question her.

Conclusion

In the end, it is the infant who is most vulnerable in this situation, and whose interest Dr. Blake must place above others. Physicians are "mandated reporters" of suspected child abuse and neglect. These reports are made to Child Protective Services (CPS) in the county in most areas. There are regional differences in the availability and quality of services to families through CPS, but homelessness is not a criterion for removal of a child. In the more advanced systems, however, which exist in many urban areas, CPS can work with the parent toward supervised stabilization including kinship care where children are placed with extended family members in preference to strangers in foster care, and provided additional supportive services.

It is possible to argue that the infant should be removed from the custody of the mother because of her homeless status and placed in child-protective custody, despite the lack of evidence of child neglect or maltreatment. This approach would certainly carry the risk of bringing about significant unintended, if predictable, consequences. Poverty and homelessness do not equate with maltreatment or neglect and are not in themselves a basis for removing a child from his or her parent. Though placement in CPS may seem like a facile response to a complex situation, and could ultimately even be the path that is chosen if a significant risk of child endangerment can be identified, placement in the system puts development of early attachment of the infant and mother in jeopardy. If placed in CPS, it is likely that the child will have multiple changes in housing and caregivers and repeatedly disrupted early childhood attachment. Finally, if placing the children of homeless women in foster care becomes the practice of the hospital in addressing this problem, it is unlikely that other homeless women would choose to deliver their babies in such a facility.

Homelessness affects every major U.S. urban area and many smaller ones. It is a complex issue that carries a threat not only to the physical health of those affected, but to their long-term social and personal development. Though mental health problems and substance abuse do play a role in initiating and prolonging homelessness for some, these are not the predominant problems for the vast majority of homeless people, and reflect to a large degree the inadequacy of current mental health services. Many people confront a period of homelessness in life, and for most it is a temporary, not chronic problem. Physicians are frequently the individuals who make the first link toward stabilization.

Notes and References

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