



THE Children's
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**Quality Health Care for Homeless Youth: Examining
Barriers to Care**
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The health profile of homeless youth is unique and complicated. Adolescents are at a critical stage of physical, mental and social development. The precarious nature of adolescent development is further complicated for those who become homeless. A number of factors, personal, family, societal and institutional, contribute to their homelessness. Family trauma, experiences with the foster care system and juvenile justice centers are all common life experiences for homeless youth. Once becoming homeless, life on the street introduces these youth to a street economy and culture that includes drug/alcohol use, drug selling, gang involvement and survival sex. At the same time, mental illness, substance abuse and development challenges further complicate the lives of homeless youth. These youth present a wide range of physical and psycho-social complications to providers that treat them.

By identifying the most pressing health needs of homeless youth, The Children's Health Fund (CHF) will examine current delivery of care for homeless youth, recommend best practices in treating this unique population, and recommend public policy initiatives to better serve homeless youth.

The Children's Health Fund Experience

CHF's New York Children's Health Project serves homeless youth in coordination with The Streetworks Project, an outreach program and a multi-service center, run by Safe Horizon, for homeless and street-involved youth in New York City. Streetworks clients receive legal services, counseling, case management, GED preparation, hot meals and bag lunches, and emergency or transitional housing. The New York Children's Health Project provides medical care to Streetworks clients at the Midtown Drop-In Center in Times Square, and their 24 bed residence in Harlem. The goal of the CHF model is to provide a comprehensive medical home, that is, comprehensive, coordinated and culturally appropriate care, to high-risk adolescents and young adults and their children. Referrals are available to Montefiore Medical Center, among other sites, for specialty care if needed. Transportation to and from specialists, as well as referral case management, is also provided.

To describe the health, mental health and psychosocial needs of the population, The Children's Health Fund conducted a retrospective review of the electronic health

records of a representative random sample of 100 Streetworks users (youth 15-23 years old who were clients of Streetworks and medical patients of the New York Children's Health Project). Only patients for whom a comprehensive social history was taken (or attempted) were included.

Homeless Youth: An Unquantifiable Population

Estimates of the number of homeless adolescents in New York City, and in a broader arena the United States, range widely. In a survey of 27 large cities across the nation, the United States Conference of Mayors estimates that homeless adolescents account for 5% of all homeless persons.¹ Although this number is not quantified, when applied to the estimated at 2.3 to 3.5 million persons experiencing homelessness during a given year, this yield as estimate of from 115,000 to 175,000 homeless youth.² The Department of Health and Human Services also estimates that 0.5 to 1.5 million youth are homeless over the course of any one year in the USA.³ New York City, which has a large homeless and shelter population, also has a sizable population of homeless youth. Accurate counts of homeless adolescents are difficult to ascertain because most, if not all, estimates are based on numbers from shelters and other city agencies. Many homeless youth are reluctant to enter shelters or access city agencies.⁴

While the New York City Department of Homeless Services is charged with addressing the problem of homelessness, it defines only two main categories of homeless people: single adults and families.⁵ The corresponding systems to track these populations are geared towards single adults and families, with no way to directly account for runaway and homeless youth. "Homeless adolescents" does not include adolescents living in shelters with their families.

Who is Homeless?

To be counted as "homeless," a person must both lack a fixed, regular, and adequate night-time residence and be temporarily domiciled in a shelter. This definition excludes the hundreds of thousands of people in New York City who are doubled and tripled up in someone else's apartment, having no home of their own and living in, at best, seriously overcrowded conditions. "Homeless youth" include runaway adolescents

who leave home to escape physical and sexual abuse, throwaways, adolescents who were pushed out of their homes by parents or guardians, youth running away from foster care settings or institutional settings, youth who are discharged from juvenile justice centers and also newly arrived, struggling immigrants.⁶ For runaway youth, the choice to leave an oppressive or dangerous environment often is not an act of rebellion, but rather, their only chance for survival. This self determination is usually the only control that they have over their own lives,⁷ and may represent one of the few actions available to young people to protect themselves from physical and/or emotional abuse suffered in a family or institutional setting.⁸

The Road to Homelessness: What creates a homeless youth?

The etiology of homelessness among youth is multifaceted and includes factors intrinsic to the youth and his/her family (e.g. relationship problems, mental illness) and societal/institutional factors (foster care and prison discharge policy). Family situations and foster care experiences may force a teen to take to the streets. Youth with high risk behaviors, specifically drug, alcohol, and substance abuse are more likely to become homeless and continue to pursue high risk behavior on the street. Youth suffering from mental health problems are also more likely to become homeless.

Family Connections

Family problems, such as physical and sexual abuse, parental substance abuse and irreconcilable differences between parent and the child, are often cited as the impetus for running away.⁹ According to one study, twenty-nine percent of homeless respondents report abuse or neglect in childhood from someone in their household (12 percent neglect, 22 percent physical abuse, and 13 percent sexual abuse).¹⁰ Neglect and abuse have been documented at higher levels and are most often cited by homeless youth as reasons for leaving their families and living on the street.

“Throw-aways” are youth who are kicked out of their homes by their families for various reasons. These reasons often are rooted in the youth’s sexuality, especially when the youth declares they are gay, lesbian, bisexual or pregnant.

Foster Care

In general, homeless persons are more likely to have negotiated the perilous waters of the foster care system. According to a study of homeless persons living in shelters conducted in 2000, 27% of homeless clients had been placed in foster care, a group home, or other institutional setting before their 18th birthday.¹¹ Children reach foster care through many avenues, but more often than not, that avenue involves a life altering tragic event or series of events such as death of parents, removal from the family because of neglect, abuse, sexual abuse, or other circumstances that demand a child be removed from their family situation. Foster homes may not be well equipped to deal with the child's emotional or mental problems. Aging out of foster care at a certain age, which requires assuming a degree of independence for which the teenager may not be prepared, is also a potential pathway to homelessness.

In the Children's Health Fund chart review, 43 percent of homeless youth had been in foster care, frequently immediately prior to the current episode of homelessness. Some had as many as ten different foster care placements, and running away from foster care was common among these foster children. Fifty seven percent reported maltreatment, principally physical and/or sexual abuse, and 46 percent had been homeless previously, generally with multiple episodes of homelessness beginning in childhood. The chart review was conducted of patients who were 52% male, 45% female, 3% transgender; average age was 20 years; 95% were race-ethnic minority.

Health Profile

Homeless youth are at an increased risk for health problems, including mental illness, substance abuse and chronic disease. The day-to-day reality of homelessness poses significant challenges not faced by adolescents who have a permanent home and adult caregiver. These challenges include unstable living situations such as shelters that are often characterized by unsanitary conditions, and poor personal hygiene due to lack of access to running water and bathroom facilities. Moreover, exposure to the street

economy, sex and substance abuse contributes to the overall health status deterioration of homeless youth.

Many homeless youth have multiple health problems including medical, substance abuse, and emotional and mental illness problems. These problems may exist prior to becoming homeless and are therefore exacerbated by the homeless situation or these problems develop in reaction to homeless life.¹² Homeless adolescents have increased prevalence rates of respiratory infections, diarrheal diseases, skin infections such as lice and scabies, eye infections, dental disease and genitourinary infections. Nutritional deficiencies and lack of proper immunizations are also common. Chronic diseases, including asthma, epilepsy, and diabetes tend to be more prevalent, and because they go untreated, more severe when diagnosed in homeless adolescents.¹³

The Children's Health Fund study shows that 28 percent of homeless youth are diagnosed with a chronic condition that requires ongoing medical maintenance. This includes a 23 percent prevalence of patients with asthma. Other chronic conditions include diabetes and seizure disorder. Additional health risk is notable in that 89 percent are regular tobacco users.

Health compromising behaviors such as substance abuse and survival sex put homeless youth at a significantly greater risk for medical and mental health issues. Such conditions include HIV/AIDS, hepatitis, pregnancy, trauma and depression.¹⁴

Mental Health

Homeless youth are at an elevated risk for emotional distress and depression.¹⁵ Estimates of the prevalence of mental health disorders in homeless youth range widely from 19 to 50 percent. Typically, these data are derived from screening for symptoms (e.g., DISC or using DSM criteria). Rates of depression range from 19 percent to 26 percent.¹⁶

The Children's Health Fund data are derived from clinical interview in the context of primary medical care delivery. Only diagnosed chronic and persistent mental illness was counted. These data do not include adjustment reactions, personality disorders, acute and reactive depression, etc. In the Streetworks population served by the CHF, 35 percent of youth were diagnosed with major mental illness. Of those diagnosed with major mental illness, 63 percent had depression. This represents a 22 percent prevalence

of chronic depression in the homeless youth population. Twenty-three percent of those with major mental illness were diagnosed with bi-polar disorder, representing 8 percent of the homeless youth population; and 14 percent were psychotic, representing 5 percent of the homeless youth population. More than half, 53 percent, of street youth diagnosed with mental illness attempted suicide at least once. This represents a prevalence of suicide attempt in the homeless youth population of 18 percent. However, of these seriously mentally ill adolescents, only 18 percent had been psychiatrically hospitalized at least once.

To place these prevalence rates among homeless youth in context, we can refer to recently published data from the National Comorbidity Survey Replication. Three-fourths of mood disorders had an initial onset by age 24, which generates a prevalence rate among adolescents and young adults of 15.6%. CHF data show a 30% prevalence of mood disorders (depression and bipolar) among homeless youth 15-23 years of age, which is about twice this typical rate.¹⁷

Substance Abuse, STDs, HIV/AIDS

Alcoholism and substance abuse are common among homeless youth, with studies showing more than a quarter of homeless youth exhibiting three or more symptoms of drug dependency.¹⁸ Substance abuse may have origins in recreational use but for many it is a form of self medication for mental illness. Alcohol and drug abuse kills the effects of hunger, numbs acute trauma and dulls the reality of life on the street.

Drug use or substance abuse may be associated with risky sexual behavior (e.g., having unprotected sex, sex with a stranger). Having sex with higher risk partners, having a greater number of partners, having sex with partners without knowledge of the partner's history or lifestyle and giving sex in exchange for money, drugs, and/or food or shelter are all behaviors associated with marijuana use among homeless youth.¹⁹

In the Children's Health Fund chart review, about half, 49 percent, used alcohol, marijuana, and/or other drugs on a regular, generally daily basis.

Barriers to Care

Homeless youth are traditionally reluctant to access services through the shelter system and social services. Not only does this make documentation of their unique health

concerns difficult, but it also complicates their own health problems, resulting in an emergency situation. Beyond the hesitancy to access care, homeless youth also do not have access to health insurance. Furthermore, fulfilling eligibility requirements for free or low cost health insurance (i.e. Medicaid) may be complicated by their runaway status, as most programs require applicants document their residence or mailing address. Even when eligible for public health insurance, homeless youth do not access care for a variety of reasons. Transportation problems, along with a perceived lack of respect from providers and fear of being judged by health care workers, create physical and psychological barriers to accessing care. Surveys of homeless youth have found that health advice is most often sought from other homeless persons, followed by self-treatment, and finally accessing clinics when self-treatment no longer works.²⁰

In New York State, emancipated minors are eligible for Medicaid if they meet all other income and identification qualifications.²¹ Because Medicaid enrollment requires identification and some homeless adolescents may not have the preferred verification of a birth certificate, New York State allows verification from collateral sources and also allows districts to accept information from agencies or other persons who can identify the applicant or any form of identification that the person possesses.²² Although eligible for Medicaid, homeless adolescents face limited availability of care, lack awareness of available services, lack trust of medical providers in institutional settings, face inadequacy of care and do not have a way to pay for care.²³ When considering these barriers, it is apparent that traditional models of care are not suited for treating and providing care to homeless youth.

Conclusion

Lack of accessible health care services, inadequate housing and high-risk behaviors all converge to threaten the physical and mental well being of homeless youth, who are, beyond doubt, among the most needy and marginalized groups in society. Services tailored to meet their unique needs are necessary to treat homeless youth and help them out of homelessness.

Recommendations

To meet the unique needs of homeless adolescents, the Children's Health Fund recommends:

- To respond to the high prevalence of mental illness among homeless youth, CHF recommends that supportive housing options be more generally available and easier to access. We recommend a step down approach consistent with the functional abilities of the individuals in need, ranging from community housing with mental health professionals regularly available to increased numbers of residential treatment facilities.
- To respond to high risk youth in the foster care system, CHF recommends better support for foster parents who accept special needs youth into their homes. All children in state supervised foster care require preparation for independent living when exiting the foster system when they turn 18.
- To address the health needs of homeless adolescents, CHF recommends increased outreach to enroll adolescents in health insurance programs if eligible. Alternative service delivery, such as walk-in clinics in areas such as Times Square where homeless youth congregate, mobile medical units and school based health centers increase the opportunity to access health care for adolescents.

- ¹ U.S. Conference of Mayors, Hunger and Homelessness Survey 2004, 62. This survey did not include data from New York City.
- ² The Urban Institute, Helping America's Homeless, 2001. States that 3.5 million people are likely to experience homelessness in a given year.
- ³ Robertson, M.J., and Toro P.A. Homeless Youth: Research, Intervention and Policy. Presented at The 1998 National Symposium on Homelessness Research, at the United States Department of Health and Human Services.
- ⁴ Taylor, D., Lydon, J., Bougie, E., Johannsen, K. "Street Kids": Towards an Understanding of Their Motivational Context. *Canadian Journal of Behavioural Science* 2004, 36:1, 1-16.
- ⁵ New York City Department of Homeless Services, Policy and Planning. Emerging Trends in Client Demographics 1998-2002.
- ⁶ Jarvis and Kurtz (1991)
- ⁷ Hyde, J. From Home to Street: Understanding Young People's Transitions to Homelessness. *Journal of Adolescence* 28 (2005) 171-183.
- ⁸ Ibid. Milburn, N., Rotheram-Borus, M.J., Batterham, P., Brumback, B., Rosental, D., Mallett, Predictors of Close Family Relationships over One Year Among Homeless Young People. *Journal of Adolescence* 28 (2005) 263-275. (Milburn, N. et. al.)
- ⁹ Tyler, K.A., Cauce, A.M., and Whitbeck, L. Family Risk Factors and Prevalence of Dissociative Symptoms Among Homeless and Runaway Youth. *Child Abuse and Neglect*, 28(3), 355-366.
- ¹⁰ Ibid, 25.
- ¹¹ Burt, M., Aron, L., Douglas, T., Valente, J., Lee, E., and Iwen, B. Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients. December, 1999, 25.
- ¹² Milburn, N., et al.
- ¹³ Patel, D., MD, Greydanus, D., MD. Homeless Adolescents in the United States: An Overview for Pediatricians. *International Pediatrics* 17:2:71-75, 2002.
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- ¹⁵ Robertson, M.J., and Toro P.A.
- ¹⁶ Ibid.
- ¹⁷ Kessler RC, Berglund, P., Demler, O., Jin, R., Merikangas, KR, Walters, EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. 2005. *Archives of General Psychiatry*, 62:593-602.
- ¹⁸ Baily, S, Camlin, C, and Ennet, S. Substance Use and Risky Sexual Behavior Among Homeless and Runaway Youth, *Journal of Adolescent Health* 1998;23:6:381.
- ¹⁹ Ibid, 382.
- ²⁰ Ensign, J. and Panke, A. Barriers and Bridges to Care: Voices of Homeless Adolescent Youth in Seattle, Washington. *Journal of Advanced Nursing* 37:2, p166. January 2002.
- ²¹ According to the New York State Department of Health, Medicaid Reference Guide, an "emancipated minor" is a person who is 16 years of age or older, has completed his/her compulsory education, is living separate and apart from their family, and is not in receipt of or in need of foster care.
- ²² Ibid, 423. Other acceptable documents include baptismal certificates, immigration papers, passports, driver's licenses, vaccination records or employer records.
- ²³ Patel, D., Greydanus, D. p 74.