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Behavioral Health among Youth Experiencing Homelessness

Homeless youth represent one of the largest sub-groups of the overall homeless population in the US. In addition to their experiences with unstable housing, most face or have faced a number of adversities, including: family rejection, neglect, and abuse; economic hardship; and difficulties accessing homeless services. As a result, many homeless youth are at increased risk for poor behavioral health outcomes.[1] This issue of *In Focus* provides a synthesis of recent literature on behavioral health issues among homeless youth. It gives an overview of the homeless youth population, prevalence of behavioral health issues, factors that can impact these issues, and implications for practice and policy.

Youth Homelessness: A Snapshot

Inconsistent definitions of homeless youth and the population's transient nature have made it challenging for researchers, community organizations, and government agencies to accurately measure the current number of homeless youth in the United States. Because of this, the estimates of homeless youth vary widely from 1 to 1.7 million in a given year.[2]

When determining the size of this population, one major source of variation is related to the age groups that are considered "youth." The Runaway and Homeless Youth Act defines youth as individuals under age 18 or between ages 16-22 depending on the type of program offered.[2] According to the Department of Housing and Urban Development's (HUD) Annual Homeless Assessment Report (AHAR), individuals between ages 18-24 are considered to be youth, whereas individuals under age 18 are considered to be children.[3] A number of studies of this population, however, have considered youth to be individuals ranging from age 11-25.[2,4]

Two other major sources of variation in determining the size of this population are the pathways to and definitions of youth homelessness. Terms used in the literature include:

- *throwaways* (youth kicked out or asked to leave homes),
- *situational runaways or runaways* (youth who run away from home for a short period of time or never return),
- *systems youth* (youth who age out of or run away from foster care or juvenile justice systems),
- *unaccompanied youth* (youth not a part of a family or without a legal guardian), and
- *street youth* (youth sleeping in non-traditional areas such as under bridges or tent camps).[1,5]

Despite these limitations, data suggests that there is a large number of homeless youth on any given night. On a single night in January 2014 HUD estimated that 194,302 children (under age 18) and youth (18-24) were homeless, 23.3% of whom were unaccompanied. According to this government agency, individuals up to age 24 made up one-third of all homeless people.[3]

> 1/3 *of all individuals experiencing homelessness are youth up to age 24*

It is also important to note that homeless youth are a diverse population varying by race, ethnicity, gender identity, sexual orientation, and pathways into homelessness.[2,4] Youth may be labeled and further marginalized by these factors, increasing their risk of poor mental and physical health outcomes.[4] For the purposes of this review, the use of "homeless youth" may include all sub-populations and varying age groups.

Behavioral Health

Mental Health

Recent studies indicate that, in general, the rates for major psychiatric disorders, including depression, anxiety, posttraumatic stress disorder (PTSD), and substance use disorders are higher among homeless youth compared to housed peers.[6] A 2014 study of 66 homeless youth age 18-24 revealed that the prevalence of having at least one psychiatric disorder may be up to 4 times the national prevalence in youth of the same age group (82% and 19% respectively).[7,8] Similarly high rates were found in a 2012 study of 87 homeless youth where 84% of the sample met the diagnostic criteria for at least one psychiatric disorder.[9]

Rates of having at least one psychiatric disorder among homeless youth can be as high as **FOUR** *times the rate of youth in the general population*

In regards to specific disorders, depression and anxiety are prevalent among homeless youth. Studies varying in sample size have reported rates of depression between 16-54% for homeless youth age 18-24 compared to a rate of 10% for the general youth population of the same age group.[7,10-13] Reported incidence of any anxiety disorder among homeless youth age 18-24, including general anxiety, panic disorder, and PTSD, ranges between 8-34% compared to a rate of 13% in the general youth population of the same age group.[7,11-14]

In 2013, suicide was the third and second leading cause of death for ages 10-14 and 15-24 years, respectively, in the general youth population.[15] The suicide rate among homeless youth is also high.[6] In a 2008 study of 133 homeless youth age 14-22 in a Southwestern urban center of the US, 44% reported that they had attempted suicide in their lifetime.[16] Comparably, a larger study of 444 homeless youth age 16-19 reported that 52% of participants had made multiple lifetime suicide attempts and two thirds had thought of death in the year prior to the study.[17]

Disruptive behavior disorder (DBD) is a group of disorders (i.e. oppositional defiant and conduct disorder) used to describe patterns of ongoing uncooperative, defiant, and hostile behaviors toward peers and authority figures.[18] Studies have found that youth with DBD may also have co-occurring attention deficit disorder and may be predisposed for development of mood disorders and risky behaviors contributing to substance use issues and involvement with the justice system.[19-21] It is estimated that rates of disruptive behaviors among homeless youth are four times higher compared to housed youth (20% and 5% respectively).[22] Of the 444 homeless youth, in the aforementioned study, 76% met diagnostic criteria for conduct disorders.[23]

Substance Use

Substance use rates are similarly elevated in the homeless youth population, ranging from 28-81%.[12,24-26] A 2011 study of 419 traveling and non-traveling homeless youth age 13-24 in Los Angeles, CA, reported that in the past 30 days 38% of participants had used alcohol heavily, 65% had used marijuana, 39% had used harder drugs (i.e. crack, cocaine, heroin, etc.), and 8% had used drugs by injection.[26] Another study of 156 homeless youth age 15-25 revealed that 87% of participants were recent alcohol users, 59% were cocaine users, 54% were methamphetamine users, and 28% were injection drug users.[24]

Polysubstance use (the use of multiple substances in a given time period) is also common among homeless youth. A 2014 study of 457 homeless youth and young adults age 13-28 revealed that 9-13.5% of participants were current users of prescription drugs and heroin, cocaine, or methamphetamine, and 4% were current users of all four substances in the past 30 days.[27] Prescription drug misuse, including opioids, sedatives,

and stimulants, has been noted to be the second most common form of illicit drug use among the general youth population in the US and is also problematic among those experiencing homelessness. In a 2014 study of 451 homeless youth in Los Angeles, CA, 15% of participants reported use of some combination of prescription drugs.[28]

Prescription drug misuse is the 2nd MOST COMMON form of illicit drug use among general youth population in the US

When episodic substance use becomes regular use, then homeless youth may meet the criteria for a substance use disorder.[4] Using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition Text Revised (DSM-IV-TR), Merscham, et al. (2009) found that 6% of homeless youth participants age 16-25 met the diagnostic criteria for polysubstance dependence. Bender et al. (2014) reported that up to 60% of 601 homeless youth participants met DSM-IV-TR diagnostic criteria for a substance use disorder for at least one substance. More specifically 50% met DSM-IV-TR criteria for alcohol addiction, 60% for drug addiction, and 49% for substance dependence.[29]

Homeless youth who have substance use issues are more likely to have co-occurring mental health disorders, including depression, anxiety, and conduct disorders. They are also more likely to engage in high risk behaviors including unprotected sex, sex while under the influence of drugs or alcohol, and multiple sex partners, placing them at greater risks for sexually transmitted infections (STI) and unintended pregnancies.[4,26,30-32]

Factors Influencing Behavioral Health Outcomes: Protective and Risk Factors

As with other populations, risk factors for poor behavioral health outcomes among homeless youth are multifactorial and include familial, individual, social, and environmental factors (Figure 1).[4,33-35] Studies have shown that family dysfunction and history of psychiatric disorders is one of the most important risk factors for poor behavioral health outcomes in youth. Characteristics of family dysfunction include: physical, emotional, or sexual abuse by family members and/or caregivers; parental neglect; and family conflict.[4,36]

Individual factors—including age, history of involvement with the justice system, length of time of homelessness, having risky sexual behaviors, and coping abilities—are associated with psychiatric disorders.[4,7,24,37] For example, in an aforementioned study of 66 homeless youth, increased length of homelessness was significantly associated with an increased number of depression, social phobia, and substance use disorders.[7]

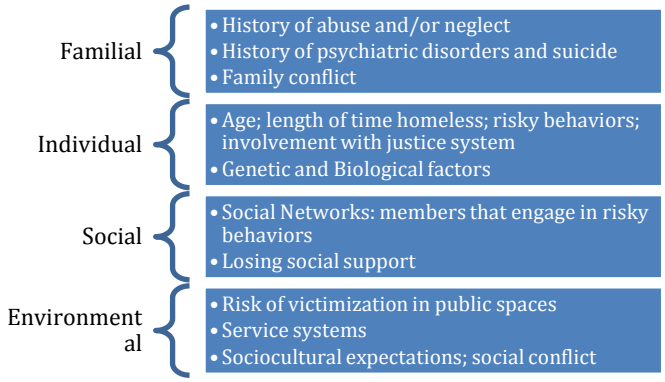

Figure 1: Multifactorial influences on behavioral health outcomes

The role of non-kin social networks is also important when assessing risk of behavioral health disorders. Homeless youth are more likely to engage in substance use and risky sex if their network includes members who also engage in these risky behaviors, especially those of influence.[26,38] In addition, street youth who lose emotional and instrumental support from home-based network members are at an increased risk of depression and anxiety disorders.[39,40]

Conversely, having adult network members (kin or non-kin), who are in a position of power and influence, as well as having peers who are enrolled in school and who refrain from risky behaviors, has a positive impact in deterring homeless youth from substance use and risky sexual behaviors.[41] Additionally, having network members who provide emotional support can reduce risk of psychiatric disorders.[42,43] Social networks are important as they provide many kinds of support

including tangible, advice, belonging, and self-esteem support.[43]

Sub-Population: LGBTQ youth

Studies have demonstrated that rates of mental illness and substance use can vary considerably according to specific subgroups of homeless youth.[4] Homeless youth that identify as lesbian, gay, bisexual, or transgender, for example, are at an even greater risk for these deleterious outcomes compared to their cis-gender and heterosexual peers.[44-46] They experience higher rates of familial rejection, pervasive societal discrimination, violence and trauma, which in turn can contribute to self-hatred, the development of psychiatric disorders, and suicidal ideation.[47-49]

Accessing Behavioral Health Services

Out of the patients served by the 268 health centers funded through the federal Health Care for the Homeless (HCH) program in 2014, only 12% were youth age 11-24.[50] While not reported specifically by HCH users, homeless youth face a number of barriers to accessing health services, including but not limited to:

- lack of knowledge of services available,
- feeling embarrassed to seek help,
- past negative experiences with staff (feelings that they were rude or judgmental),
- poor coordination of services,
- lack of transportation,
- inability to afford care,
- concerns of being reported to a social worker or police and ending up in the juvenile or justice system,
- not being of age to consent for care, and
- perception that there are not enough services available.[51-54]

Another challenging factor in delivering behavioral health care to homeless youth patients is engaging them to seek and accept care.[51,54] Furthermore, retaining them in care is critical for services to be provided consistently and for patients to adhere to treatment longitudinally.[55]

Implications

This literature review demonstrates that homeless youth experience a number of vulnerabilities resulting in an increased risk of mental health outcomes such as depression, anxiety, PTSD, and disruptive behavior disorders. Moreover, homeless youth also report engagement in high risk behaviors including substance use and risky sexual behaviors. Untreated behavioral health issues may lead to more complex health outcomes (e.g. comorbid behavioral health issues) and challenges in achieving good quality of life and well-being in emerging adulthood.[4,56-57] Possible impacts of behavioral health issues on quality of life and well-being include socioeconomic security (material and other resources), social cohesion (shared identity, values and norms), social inclusion (access to and integration in institutions and structures), and empowerment (ability to act and interact) (Figure 2).[57]

Figure 2: Conditional factors for quality of life and well-being among homeless youth (adopted from Altena et al. 2010)

Practice implications

Recent reviews of a wide range of homeless youth interventions (e.g. STI, vocational training, and behavioral health interventions) have revealed that they are generally ineffective due to a narrow focus on

specific health issues or aspects of an individual's life.[4,57] Homeless youth experience multiple forms of trauma, co-occurring behavioral and physical health issues, and competing priorities among basic necessities. Programs or service models need to address multiple aspects of the individual including complex mental and physical health issues, multiple stressors and risk factors, and competing priorities.[4,12]

An additional challenge in service delivery and assessing the effectiveness of a program or service model has been issues in engagement and retention of homeless youth clients. The development of peer-based programs and use of technology (i.e. cell phones, electronic case management, email, social media) are promising practices in addressing these issues.[58-60]

Recommendations

To better understand behavioral health issues among homeless youth and to ensure positive outcomes, the following actions are recommended:

- Increase our understanding of co-occurring behavioral health issues with respect to diagnosis and treatment[12],
- Increase our understanding of the multifaceted experiences before and during bouts of homelessness among youth,
- Implement service delivery models that reduce and eliminate barriers to accessing behavioral health services, such as streamlining and coordinating services; and
- Increase the capacity of safety net programs such as the Runaway and Homeless Youth Act (an authorization of the use of federal funds for programs that help street youth through outreach, shelter, transitional housing, and other intervention initiatives) programs through policy changes.[2]

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