Case Management, Care Planning, and Behavioral Health for Homeless Individuals

inFOCUS

A Quarterly Research Review of the National HCH Council

Volume 4, Issue I | April 2016

Vital Role of Case Management for Individuals Experiencing Homelessness

Implemented during the 1980s to increase access, efficiency, coordination, and accountability of services, case management has become an integral feature of health care delivery as well as support services to meet the complex needs of individuals experiencing homelessness.(1) As health insurance coverage increases in this population and national health reform efforts focus on reducing health care costs while improving health outcomes, researchers, policy experts, health insurers, and service providers have begun to more deeply examine the value of case management services. This issue of *In Focus* will provide: an overview of case management; its positive outcomes; the role these services play in enhancing health and housing interventions; the importance of care coordination as an aspect of case management; as well as discuss the implications for practice, policy, and future research.

What Is Case Management?

Case management has been described in various ways in the literature based on the desired outcomes, intensity of services, and implementing provider; however, the goal is to ensure timely access to and coordination of fragmented medical and psychosocial services for an individual while considering costs, preventing duplication of services, and improving health outcomes.(2-4) The basic components of case management include intake, assessment of needs, service planning, linkage to services, continuous monitoring, and client advocacy. In addition to increasing access to medical and psychosocial services, case management can also include crisis intervention, discharge planning and direct services such as emotional support, client education, and skill building.(2)

Over the past few decades, five major models of case management have emerged: general or standard case management (SCM), intensive case management (ICM), clinical case management (CCM), assertive community treatment (ACT), and critical time intervention (CTI).(2-3) An overview of these models can be found in Figure 1.

Case Management Positive Outcomes

Outcomes of case management tend to focus on specific subpopulations of individuals experiencing homelessness (e.g. those with co-occurring disorders, severe mental illness, chronically homeless, and frequent users), making comparisons across studies challenging. A recent literature review examining case management interventions between 1994 and 2008 revealed multiple positive effects for individuals experiencing homelessness, including: increased housing stability; increased engagement in medical and non-medical services; reduced use of high cost health system services; improved mental health status; reduced use of drug and alcohol; and improved quality of life.(2) The extent of the outcomes varied across different studies and models of case management, depending on individual program design/factors.

Trends of positive outcomes are still being demonstrated in more recent studies. For example,

CCM

- **Clinical/Rehabilitation Case Management**
  - Avg. caseload for CM-10
  - High intensity client-CM contact
  - Combine coordination and acquisition of resources and clinical activities

ACT

- **Assertive Community Treatment**
  - Avg. caseload for CM team-15
  - High intensity client- multidisciplinary team approach that include clinical providers
  - Compared to ICM, more intensive

ICM

- **Intensive Case Management**
  - Avg. caseload for CM-15
  - High intensity client-CM contact
  - May provide additional direct services
  - Compared to SCM, more intensive

CTI

- **Critical Time Intervention**
  - Avg. caseload for CM-25
  - Moderate intensity client-CM contact (Time limited)
  - Implemented at critical transitioning periods to ensure continuity in delivery of care

SCM

- **Standard Case Management**
  - Avg. caseload for CM-35
  - Low intensity limited client-CM contact
  - Step above simply identifying resources

Figure 1: Overview of the different models of case management.(2,3,17,32,35)

Gordon et al. (2012) demonstrated that individuals receiving ICM had reduced substance use and psychiatric symptoms over 12 months. ICM interventions have also shown an impact in reducing the number of days homeless, emergency department (ED) visits and length of hospitalization.(5-7) ACT interventions have been effective in reducing substance use, psychiatric symptoms, and homelessness as well as change in service use patterns.(8-9) A summary of positive outcomes that different models of case management have had on individuals experiencing homelessness can be found in figure 2.

Role of Case Management in Specific Interventions

While case management has been demonstrated to be a vital service in general, it has also increasingly been used to enhance specific interventions such as housing and targeted health education.(10-20) However, there are few studies that compare these interventions to case management only or 'usual care'.

For targeted health education, two studies have investigated the use of nurse case management (NCM) in improving hepatitis A, B, and C outcomes. Nyamathi et al. (2009) found that homeless adults who received NCM paired with targeted hepatitis education were more likely to complete hepatitis A and B virus vaccine series compared to those that received targeted education only. Tyler et al. (2014) reported that homeless adults who received NCM paired with targeted hepatitis education had a significantly greater increase in hepatitis C virus knowledge compared to those that received targeted education only. Both studies exemplify the benefits of adding a case management component to a specific health intervention for positive infectious disease outcomes.

Importance of Care Coordination within Case Management Models

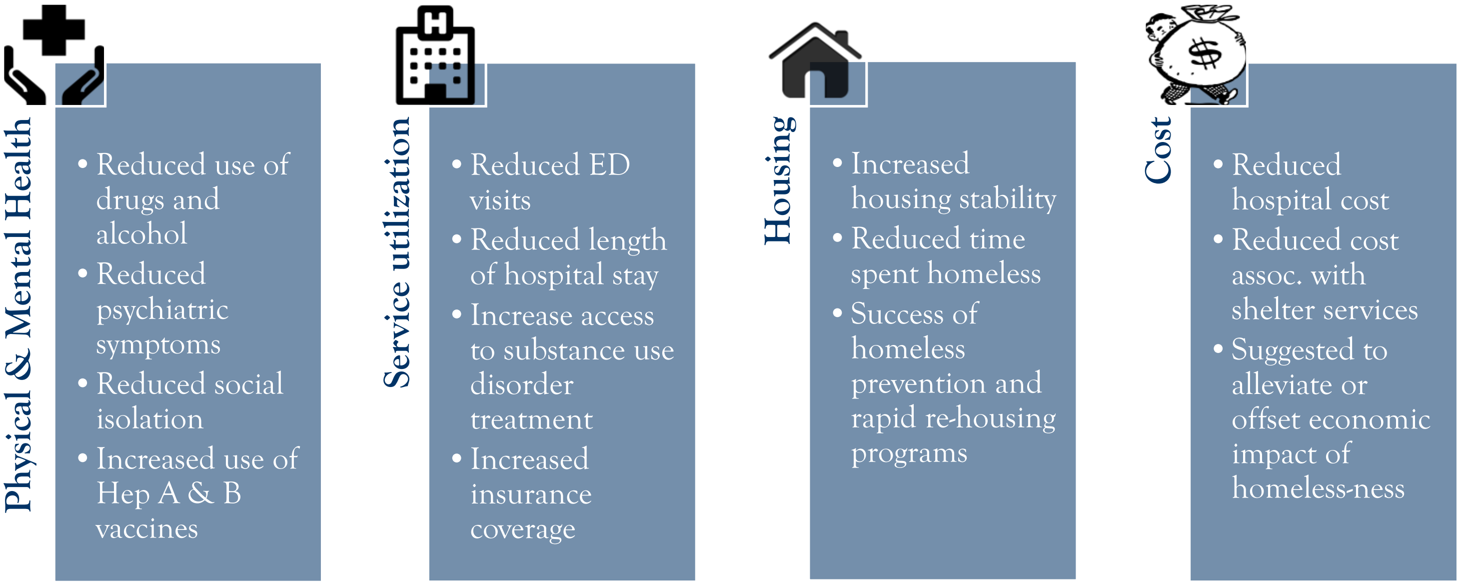
Care coordination and case management are often used interchangeably by professionals because both contain the basic elements of case management listed earlier.(4,21) However, care coordination activities ensure that medical progress is achieved by enhancing the delivery of care and access to resources for appropriate treatment;(22) hence they are central to the case management process, and key to improving medical care delivery.(23)

Care coordination activities that are critical to case management include but are not limited to (24):

- Identify client health needs and prioritize issues
- Develop a plan that is not only cost-effective but feasible to implement
- Identify appropriate clinical provider and coordinate patient-centered care
- Identify barriers to achieving health goals
- Accompany clients to doctor appointments
- Facilitate the exchange of health information
- Promote the client's understanding of health information including the condition/disease and treatment plan
- Facilitate development of self-management health skills
- Arrange and connect clients to social service needs (e.g. housing, transportation, food/meals, or any other social determinants of health); and
- Provide ongoing monitoring and evaluation to ensure medical progress is achieved

In a recent study of 834 case managers, 63% reported dedicating 50% or more of their time to care coordination activities.(23)

All models of case management have some elements of care coordination activities, but the intensity of these services varies. CTI, a moderate intensity client-case manager contact, has been successful in coordinating care for frequent ED users who are also experiencing homelessness, ultimately reducing acute care admissions, ED visits, and length of hospitalization at the Community Memorial Hospital in Ventura, CA.(6) Two other studies, conducted in Connecticut and New Hampshire, compared SCM (low intensity) and ACT (high intensity) interventions and their effect on individuals with severe mental and substance abuse disorders. Both studies showed that ACT was more effective in reducing length of hospitalization, substance use, and days of homelessness compared to SCM groups because it had a



Physical & Mental Health
- Reduced use of drugs and alcohol
- Reduced psychiatric symptoms
- Reduced social isolation
- Increased use of Hep A & B vaccines

Service utilization
- Reduced ED visits
- Reduced length of hospital stay
- Increase access to substance use disorder treatment
- Increased insurance coverage

Housing
- Increased housing stability
- Reduced time spent homeless
- Success of homeless prevention and rapid re-housing programs

Cost
- Reduced hospital cost
- Reduced cost assoc. with shelter services
- Suggested to alleviate or offset economic impact of homeless-ness

Figure 2: Reported positive outcomes of case management

**Positive outcomes vary across studies and case management models with some reporting positive, mixed, or no change in outcome measures.*

built-in multidisciplinary team approach that allowed for better care coordination.(8)

Implications

As this literature review suggests, case management plays an integral role in achieving positive medical and non-medical outcomes for individuals experiencing homelessness through communication, health education, client advocacy, identification of service resources, and service facilitation.(25) It may be especially beneficial for the highest need, most vulnerable, individuals including the chronically ill, frequent service users, and those with severe mental illness and substance use disorders.

Though the benefits of case management are evident, organizations may face multiple challenges in implementation. For example, implementing ACT in programs funded through the U.S. Department of Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment for Homeless program was challenging due to difficulties:

- Recruiting and retaining clinical staff;
- Funding vital clinical staff such as vocational specialist and behavioral health providers;
- Recruiting and retaining individuals experiencing homelessness;
  Incorporating family, friend, and significant other involvement;
- Developing staff knowledge base of integrated treatment services and working in a team-oriented setting; and
- Billing for outreach and delivery of services in the community vs time spent on-site.(26)

These challenges may be seen across other case management models as they all provide the same basic functions and are not mutually exclusive.(2)

Nevertheless, over the past 30 years, Health Care for the Homeless (HCH) projects and other federally funded programs targeting homeless populations have recognized the importance of case management in being a one-stop-shop to connect to multiple resources.(27) In fact, the US Department of Health and Human Service's Health Resources and Services Administration (HRSA) requires all federally funded health centers to provide case management services including counseling, referrals, follow-up services, and assistance in helping patients establish eligibility for and gain access to federal, state, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services.(28) In 2014, HCH projects reported over 500,000 visits for case managers accounting for 13% of all clinical visits.(29)

HRSA requires all federally funded health centers to provide case management services

Policy Implications

National health reform goals include a focus on the "Triple Aim," which seeks to increase quality of care and positive health outcomes while decreasing health care costs. As health care providers are increasingly held accountable to achieve these goals at the patient level, the need for and value of case management services has increased.(23) However, case management can be a costly service, as high needs clients may require services for an extended period of time from multiple sources. Few studies have examined the cost outcomes of case management in relation to its impact on the homeless population and society; however, existing literature reveals that it has been effective in reducing total hospital costs.(30-32)

Case management can help reduce costs because it alleviates the economic impact of homelessness through changes in service utilization patterns.(30) For example, case management interventions have been shown to reduce homelessness (by connecting clients to rent subsidies, permanent supportive housing, rapid re-housing, and housing first programs), increase insurance coverage, and decrease substance use and psychiatric symptoms. These outcomes may offset costs associated with emergency shelters, hospital readmissions, reduced use of over-utilized health services, and increased use of under-utilized health services.(17,30-31)

Recommendations

To better understand the effectiveness of case management interventions on homeless populations and to ensure positive outcomes, the following actions are recommended:

- Increase understanding of the needs of the homeless population and the "inefficient use of resources associated with homelessness" through research;(33)
- Conduct research that is experimental in nature: comparing medical care interventions with and without case management ; conduct research that includes previously understudied homeless populations;
- Conduct cost analysis research in regards to the benefits of case management and the economic impact on society;
- Implement appropriate case management models based on the needs of the individual to reduce and eliminate barriers to medical and non-medical services;
- Consult with the State Medicaid agency regarding whether a statewide strategy—such as adopting coverage for case management services—is feasible; such coverage would likely stabilize continuity for community providers and maximize grant funds.(34)

These recommendations can ensure a more effective use of resources and enable policymakers to recognize the benefits of case management for individuals experiencing homelessness while at the same time lowering health care costs.

inFOCUS
A Quarterly Research Review of the National HCH Council
Volume 4, Issue 2 | June 2016

Advance Care Planning for Individuals Experiencing Homelessness

In the United States and other industrialized countries, rates of disease and mortality are high among those experiencing homelessness.(1-3) In addition, the number of older adults without homes is expected to increase to 95,000 by 2050.(4) This growth is evident in Health Care for the Homeless programs, which have already seen a 51% increase in the number of patients age 50 or older between 2008 and 2014.(5,6) With these changing demographics coupled with poor health, there is a growing need for advance care planning (ACP) for this population, given its potential to prevent unnecessary suffering and to support an individuals' preferences related to care at end-of life.(7) This issue of *In Focus* provides a synthesis of recent literature on advance care planning among individuals experiencing homelessness. It gives an overview of morbidity and mortality of the homeless population, their concerns about death, advance care preferences, and implications for practice and policy.

Morbidity and Mortality

High rates of disease exist in the general U.S. population. However, homelessness can contribute to poorer health outcomes by exacerbating existing conditions and creating new ones.(8) In particular, chronic health conditions such as diabetes, hypertension, and cardiovascular and lung diseases are common and rates of substance use disorders, mental illness, and infectious diseases are higher in this population (see Table 1).(2-3,10) Furthermore, the health of older adults without homes (age 50 and older) is comparable to the general elderly population (age 70 and over) with both groups at an increased risk of developing chronic diseases and geriatric symptoms—"conditions that occur in older adults and cross discrete disease categories" (e.g., cognitive impairment, falls, and depression).(12-14)

> *The number of older adults experiencing homelessness is expected to* ***increase to 95,000 by 2050***

A lack of permanent housing, competing priorities associated with homelessness (e.g., food, shelter, and safety), high-risk behaviors (e.g., smoking and substance use), and barriers to health care services add to the complex challenges in managing these health issues. This may lead to further decline in overall health and ultimately result in a shortened lifespan and high mortality rates.(2,13,15) As shown by recent studies, mortality rates are estimated to be three-to-four times greater than the general U.S. population; and the average life expectancy is estimated to be 12 years less than the general U.S. population (66.5 vs. 78.8 yrs.).(16) Given the increased risk of disease and mortality in the homeless population, ACP should be facilitated earlier than for the general population.(14,17)

> *Average life expectancy for individuals experiencing homelessness is estimated to be* ***12 years less*** *than the general U.S. population (66.5 vs. 78.8 yrs.)*

Table 1: Prevalence of specific health conditions among the homeless population in comparison to the general U.S. population.(2,8-9)

Health Condition	Est. in Homeless Population	Est. in US
Hypertension	50%	29%
Diabetes	Up to 18%	9.3%
Myocardial infraction	35%	Up to 17%
HIV	Up to 21%	0.6%
Hepatitis C	Up to 36%	0.7%
Depression	Up to 49%	8%
Substance dependence	Up to 58%	Up to 16%

Concerns about Death

Although there is little research about the concerns of death among individuals experiencing homelessness, limited data suggests that they have unique fears and experiences about end-of-life. Frequently reported concerns about death include but are not limited to:

- Fear of anonymous, unacknowledged, and un-memorialized death, which is associated with being distant or alienated from family members;
- Fear or thoughts that providers would not deliver appropriate care including withdrawing life-sustaining support or withholding symptom control treatments (e.g. pain medication), due to stigma associated with homelessness;
- Fear of what will be done with their bodies after death such as being cremated or used for experimentation; and
- Fear of a violent sudden death or a prolonged, painful, and lonely death.(1,18-19)

People without homes have also reported being exposed to death at an early age as well as to sudden violent deaths during bouts of homelessness, adding to current fears around death.(19)

Advance Care Planning

According to the National Hospice and Palliative Care Organization, ACP is a process through which decisions are made about the care one would want to receive in the event of being unable to speak for oneself. It includes learning about options for life-sustaining/saving treatments, making those decisions ahead of time, letting loved ones know about advance care preferences, and documenting preferences, often in a legally binding document.(20)

Patients may document their preferences for advance care and surrogate decision-makers through advance directives such as living wills, durable power of attorney, do-not-resuscitate orders and Physician Orders for Life-Sustaining Treatment (POLST). However, these can also be consolidated into one “go-to” document for health providers.(9) This “go-to” document is generally stored in medical records at the site at which it was completed and, with the patient’s permission, can be filed elsewhere such as at county and Veteran Affairs hospitals. For this marginalized population, this type of documentation has been demonstrated to be very valuable.(21)

Palliative and End-of-life Care

The terms “palliative” and “end-of-life care” are often used interchangeably, as both provide patient- and family-centered care that aims to alleviate symptoms and optimize quality of life. However, palliative care may be given alongside curative treatment plans to individuals with life-threatening or complex illnesses; whereas end-of-life care is given without curative treatment to individuals with a life-limiting prognosis (i.e., given a life expectancy of six months or less).(9,22)

Although the number of advance care programs has increased over the years, these services remain mostly inaccessible to individuals experiencing homelessness.(9,15) Research has established four major categories of barriers to advance care: personal, structural, financial, and provider willingness and knowledge (see Table 2). Combined, these barriers too often result in persons experiencing homelessness dying without appropriate health care support and without ever accessing advance care programs.(15)

Table 2: Barriers to advance care planning for individuals experiencing homelessness.(12,14,17,22,24)

PERSONAL

- Prioritization of meeting basic needs for day-to-day survival
- Denial of death and dying and/or discomfort in discussing topic
- Spirituality and religion shapes perceptions of life and death; feeling that end-of-life is in the hands of a higher power
- Reluctance to access advance care services due to prior negative experiences with the health care system, or fear of being burdensome or undeserving of care
- Lack of understanding or misconceptions of key terminologies (e.g., palliative care, surrogate decision-making, vegetative states, and heroic treatments)

STRUCTURAL

- Lack of housing
- Strict rules and regulations of existing housing programs exclude those not functionally independent and who are ongoing substance users
- Strict rules and regulations of hospice and hospital-based end-of-life care programs exclude ongoing substance users
- Lack of continuity of care (i.e., lack of follow-up and poor discharge planning)
- Limited number of palliative and end-of-life programs for those who have low-incomes and/or are uninsured

PROVIDER

- Lack of clear process of advance care planning
- Lack of sufficient reimbursement
- Lack of knowledge of providing palliative or end-of-life care
- Discomfort in discussing end-of-life topics with patients
- Concerns about legal implications of advance care documents and interpretation
- Preconceptions or stereotyping of persons without homes

FINANCIAL

- Insufficient funds to pay out-of-pocket for end-of life care or burial plan
- Limited or no insurance coverage
- High cost of providing palliative and end-of-life care

Advance Care Preferences and Attitudes

Few studies have assessed the end-of-life preferences of people experiencing homelessness and the effect of ACP interventions on patient attitude. Participants in these limited studies were able to identify: surrogate decision-makers and preferences for symptom control, life-saving/sustaining treatments, and care of their bodies after death.(13,21,24) For example, a recent study by Leung et al. (2015) revealed that most participants prefer to receive cardiopulmonary resuscitation (CPR) if they had a chance of returning to their current state of health. However, preference to receive CPR declined when presented with hypothetical situations of returning to dementia or permanent comas. In the same study, a majority of participants reported that completing an advance directive helped them feel at peace and think more about their health, family and friends.(24)

Despite being distant or alienated from family members, participants without homes across two studies identified a family member as a surrogate decision-maker.(21,24) However, in other studies some participants preferred not to have family members involved in making decisions or even to be contacted in the event of death or unconsciousness, instead listing friends and medical and non-medical homeless service providers as surrogates.(1,18) In a qualitative study by Ko et al. (2014), older adults without homes reported having a preference for physicians to be surrogate decision-makers because they trusted their medical expertise in the absence of family and social support. These studies demonstrate that preferences for advance care can vary greatly. Whether one prefers closure and comfort care, aggressive treatment up to the time of death, or involving medical providers or family members in final decisions, written documentation is key to preserving control over care.(9)

Implications

This literature review demonstrates a high level of adverse outcomes (premature mortality and insufficient care at end-of-life), especially for adults age 50 and older as well as those with complex or life-threatening illnesses. The inability to pay out-of-pocket for palliative and end-of-life care is also common and may contribute to a death without comfort and dignity. More intensive, tailored approaches to advance care may be needed for individuals who have difficult histories and minimal family and social support.

Practice implications

A number of promising practices for advance care have emerged over the past few years, including shelter-based palliative care and medical respite programs.(25,26) In addition, various strategies in advance care planning have been suggested to address the unique circumstances of this marginalized population. One of these strategies is the utilization of trained staff to provide guidance through the ACP process, as studies have shown that participants experiencing homelessness are more likely to complete ACP activities if intensive support is provided.(21,24) Additionally, these participants have suggested a number of ways in which the ACP process can better meet their needs including:

1) Increasing positive interaction between the health care system and individuals experiencing homelessness;
2) Considering unique issues confronting individuals experiencing homelessness;
3) Diversifying care delivery methods; and
4) Increasing availability of advance care services (see Table 3)

In regards to policies around ACP, the Patient Self-Determination Act passed in 1990 requires Medicare and Medicaid providers to be educated about patient self-determination and advance directives and to periodically inquire about any existing advance directive or other form of document regarding their patients' medical care wishes. However, it does not require providers to assist in completing an advance directive.(9) Starting in 2016, Medicare will reimburse providers for ACP services(27,28), and while this helps alleviate the financial barriers for providers, it should be noted that only a small percentage of people who are homeless are Medicare beneficiaries.(29)

Table 3: Suggestions to better meet the needs of individuals experiencing homelessness in advance care.[1,12,18,22]

Issue	Suggestion	Examples of solutions
Many individuals experiencing homelessness mistrust the health care system due to past negative experiences	Increase positive interaction between health care system and individuals experiencing homelessness	Train health care staff on providing compassionate care and remove preconceptions and stereotypes
Individuals face a number of competing priorities **Without family and social support, some fear an anonymous death**	Consider unique issues confronting individuals experiencing homelessness	Coordinate with other social services to better meet needs Use body features like scars and tattoos to help in recognition and removing anonymity
Limited availability of palliative and end-of-life care services **Those existing have strict rules and regulations that seem to exclude this population** **Individuals experiencing homelessness may want to access advance care in different settings**	Increase availability and diversify advance care delivery methods	Meeting individuals where they are such as in shelters, on the street, in medical respite programs, or in permanent supportive housing Adapting a low threshold strategy-having minimal admission requirements Integrating harm reduction strategies for substance users

Recommendations

To better understand the effectiveness of ACP on homeless populations and to ensure positive outcomes, the following actions are recommended:

- It is important for providers to acknowledge the realities faced by patients experiencing homelessness and introduce ACP in a safe context and over repeated visits, building rapport and trust;
- It is important for stakeholders to consider and agree to a location within the patient medical record where ACP will reside, and establish procedures for when it is to be used and/or shared;
- Studies are needed to increase understanding of the clinical outcomes, cost-effectiveness, and implementation of advance care programs tailored for people experiencing homelessness such as those that exist in medical respite and permanent supportive housing programs; and
- Improvements in Medicaid and Medicare coverage of advance care (palliative and end-of-life care) are needed for people experiencing homelessness with terminal or complex illnesses.

inFOCUS
A Quarterly Research Review of the National HCH Council
Volume 3, Issue 4 | October 2015

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)

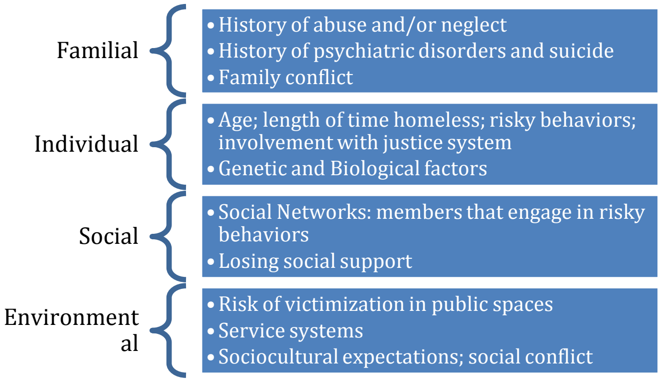


Figure 1: Multifactorial influences on behavioral health outcomes

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)

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

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)

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)

Claudia Davidson. National Health Care for the Homeless Council. (2016, April). Vital Role of Case Management for Individuals Experiencing homelessness: A Quarterly Research Review of the National HCH Council, 4:1.

Claudia Davidson. National Health Care for the Homeless Council. (2016, June). Advance Care Planning for Individuals Experiencing Homelessness: A Quarterly Research Review of the National HCH Council, 4:2.

Claudia Davidson. National Health Care for the Homeless Council. (2015, October). Behavioral Health among Youth Experiencing Homelessness: A Quarterly Research Review of the National HCH Council, 3:4.

Quantum Units
Education
Affordable. Dependable. Accredited.

www.quantumunitsed.com