Homelessness Among Special Populations: Elderly, Incarcerated, Rural, and Transgender Individuals

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IN FOCUS

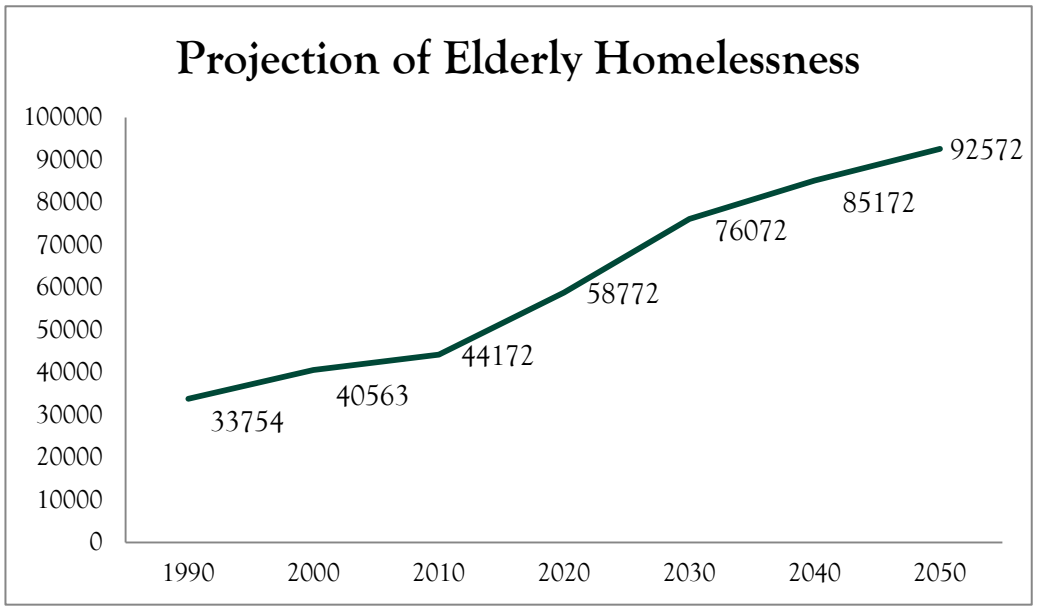
Aging and Housing Instability: Homelessness among Older and Elderly Adults

A Quarterly Research Review of the National HCH Council: Vol. 2, Issue 1 **Sep. 2013**

The September issue of *In Focus* provides a synthesis of recent literature on homelessness among older (age 50-64) and elderly (age 65 and older) adults in the United States. Much of the recent literature and policy focus has been placed on the plight of unstably housed youth and families. However, strong demographic trends, economic insecurity, and lack of affordable senior living have contributed to increased housing instability among those over age 50. Differences in pathways into homelessness, health care utilization, and age-specific clinical issues necessitate further consideration of the graying homeless population and will be discussed in this publication.

Aging Demographics

The homeless population in the United States is aging, mirroring general population trends.[1-6] The U.S. Census Bureau projects that the current elderly population will double by 2050, resulting in approximately 89 million people over the age of 65.[5] Similar trends are expected for those experiencing homelessness, according to projections by the Homeless Research Institute.[5] It is estimated that elderly homelessness will increase by 33% in 2020 (44,172 in 2010 to 58,772 in 2020). By 2050, the elderly homeless population is projected to more than double, with 95,000 elderly persons expected to be living without stable housing. The age composition of the homeless population has shifted significantly over the past two decades, with the median age of single adults increasing from 35 years in 1990 to 50 years in 2010.[7, 8] Still, the majority of unstably housed adults over 50 are between 50 and 64 years old, with only 5% age 65 and over. Looking specifically at sheltered individuals from 2007 to 2011, the age distribution has experienced an increase in individuals age 51 to 61 (from 19% to 23%); in total, 27% of sheltered individuals were age 51 or older in 2011.[6]



Data Source: Sermons, M.W., & Henry, M. *Demographics of Homelessness Series: The Rising Elderly Population.* Washington, D.C.: Homelessness Research Institute; 2010.

Pathways into Elder Homelessness

Although a number of safety net programs exist for the elderly, those between ages 50 and 64 often fall through the cracks despite having similar physical health to those much older due to daily stress, poor nutrition, and living

conditions.[9] In 2011, almost one-quarter of U.S. individuals below the poverty level were over the age of 62, demonstrating the financial instability of older and elderly adults.[6]

Existing research has established two predominant pathways into homelessness for this population: the aging of chronically homeless adults and first-time homelessness among older/elderly adults.[5, 10-12] In the first pathway, the aging trends affecting the general population are mirrored among those experiencing chronic homelessness. Unable to break the cycle of homelessness due to a myriad of issues, these individuals continue to age beyond 50 without stable housing. This pathway was confirmed in a study of the Los Angeles area's largest shelter, which revealed that the majority of older and elderly adults came to their current shelter from the streets or other shelters, not stable housing.[12]

In the second pathway, older and elderly individuals with a history of housing stability experience a first-time period of homelessness. Living on limited, fixed incomes—including Social Security and/or Supplemental Security Income—elderly persons experience severe housing cost burden more frequently than the general population, potentially resulting in housing loss (26% of elderly households were "severely cost-burdened" versus 20% of all households in 2007).[5] Compounding this, access to affordable senior living can be challenging, with an average wait time lasting approximately three to five years.[9] Two prominent studies have confirmed the prevalence of first-time homelessness among older and elderly adults.[10, 11] The first, a study of three international cities (including Boston), found the majority of elderly participants to be newly homeless with a history of stable adult employment and private living accommodations. Among these individuals, common causes of homelessness included: financial problems, mental health problems, relationship breakdown, physical health problems, and issues related to work.[10] A second study in Chicago reiterated this pathway into homelessness and identified three non-overlapping reasons for homelessness: "36% said they lost a job and could not find another and/or had problems with drinking; 39% reported discontinued or inadequate public assistance and/or a disagreement with family or friends with whom they were staying; and 25% reported inadequate income and/or illness."[11]

Health Care Utilization

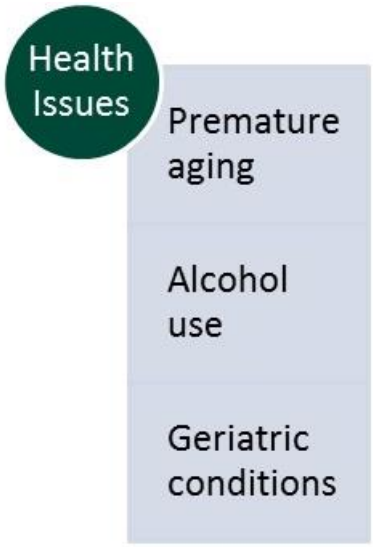
Lack of stable housing has been associated with increased Emergency Department (ED) utilization.[13] Compounded with older age and the burden of health conditions associated with aging, unstably housed adults over 50 use the ED at rates nearly four times the general population.[3, 14-16] A study comparing older and younger ED patients without stable housing found that older patients accounted for more than a third of the visits by all homeless adults and were more likely to arrive by an ambulance and be admitted to the hospital following an ED visit.[3] Another study of 250 unstably housed adults age 50 or older in 8 Boston shelters found that 64% had at least one ED visit in the past 12 months, 29% had at least four ED visits in the past 12 months, and 34% were hospitalized in the past 12 months.[17] Additionally, certain factors among these older patients were associated with making at least four ED visits in the past 12 months: female sex, white race, no usual source of primary care, at least one outpatient visit during the past year, alcohol problem, at least one fall during past year, executive dysfunction, and sensory impairment.

Health Issues

Due to prolonged exposure to stress, those living in poverty often experience weathering, or premature aging.[1, 18] Weathering has been shown to dramatically impact those without stable housing, causing individuals to age prematurely by 10 to 20 years beyond their chronological age.[1, 19] In addition to premature aging, the stress of homelessness affects morbidity and mortality. In a study comparing 40 homeless individuals with stress-related disorders and 40 housed controls in Madrid, the homeless participants had an altered immune function, which the authors stated could contribute to increased morbidity and mortality in this population.[20]

The consequences of weathering on health status emerge with age. Unstably housed adults over 50 experience higher rates of geriatric syndromes at younger ages than the general population of older adults, such as falls and memory loss.[3, 21] Geriatric syndromes are "conditions that occur in older adults and across discrete disease

categories;" examples include falls, cognitive impairment, frailty, major depression, sensory impairment, and urinary incontinence.[2] Factors associated with geriatric syndromes among older unstably housed adults include having less than a high school education, medical comorbidities (especially diabetes and arthritis), alcohol and drug use, and difficulty performing one or more daily living activities.[2]



A major geriatric condition, frailty is defined as the "...accumulation of deficits in physical, psychological, and social domains leading to adverse outcomes such as disability and mortality."[1] Factors that are significantly correlated with frailty in the older homeless population include chronological age, being female, increased health care utilization, and poorer nutrition scores.[1] Additionally, adverse life events including trauma, drug and alcohol use, and incarceration are other factors that can place those without stable housing at greater risk for hospitalizations, falls, and premature mortality.[1]

Alcohol use is another health concern among the older homeless population.[3, 4] In a study comparing ED use among older and younger homeless adults, the older population more frequently received alcohol-related diagnoses, while drug-related diagnoses were less common.[3] Older adults often experience more severe intoxication due to age-related changes in the metabolism of alcohol[4], but those in the study were still unlikely to request detoxification services.[3] The same study found that older adults were less likely than their younger counterparts to have psychiatric complaints or receive a psychiatric diagnosis discharge. Another age comparison study examined mental health, substance use, physical health, and social support among young, middle-aged, and older homeless adults before and after participation in intensive case management services.[4] At the baseline, older adults had fewer severe mental health and substance abuse problems than the other age groups, though their score improvement was slower or did not change after the intervention. Meanwhile, the youngest age group had the lowest scores for the substance use and psychiatric variables after the intervention, demonstrating a greater capacity for change.

End-of-Life Planning

Advance care planning is important at any age, but is especially vital for older and elderly adults. It allows individuals to document their end-of-life preferences with their social support systems and health care professionals in case they are unable to make decisions in the future.[22] For unstably housed adults, advance care planning can be challenging due to a lack of personal, social, and structural resources including poor health, limited medical access, high risk behaviors, and lack of social/family support.[22] To explore perceptions, needs, and concerns regarding advance care planning in the older homeless population, Ko et al. conducted a qualitative study of 21 older adults residing at a transitional housing facility.[22] The study found that end-of-life planning was an uncomfortable topic for participants to discuss, and the spirituality/religiosity of many defined and controlled perceptions of life and death, making advance care planning less relevant for them to consider. Physicians were largely the preferred decision-makers for end-of-life matters due to trust in their expertise and a lack of family/social support available for the surrogate decision-maker role. Finally, end-of-life planning was not a priority for participants in comparison to pressing basic needs.

To explore ways to improve end-of-life care and advance care planning among older adults without stable housing, Song et al. conducted a randomized trial comparing self-guided completion of an advance directive with professionally assisted advance care planning among 262 participants.[23] An advance directive is a legal document that allows patients to document what medical treatment they want to receive in different situations. The study found that one-on-one counseling and assistance significantly increased the completion rate of advance directives

(counseling completion rate of 38% versus self-guided completion rate of 13%), demonstrating that planning for end-of-life care can be accomplished more effectively if counseling and assistance are provided.

Implications and Recommendations

If demographic trends follow current projections, older and elderly homelessness will increase dramatically.[5] In addition to major prevention efforts, systems of care must be improved to accommodate the unique needs of older and elderly adults without stable housing. The research identifies a number of clinical implications that can be considered. First, focus should be placed on modifiable factors prevalent among this population, including alcohol use and common geriatric conditions.[17] To reduce avoidable ED utilization and improve health status, Brown et al. recommended routine screening and counseling on alcohol abuse, addressing common risk factors for falls, increasing access to eye glasses and hearing aids, and connecting patients with housing to decrease acute care use.[17] Salem et al. proposed three models of care to consider for this population, including having frontline geriatric nursing triage, shelter-based convalescence or medical respite facilities, and nurse case management utilizing a chronic disease self-management program.[1] With regard to end-of-life planning and care, Song et al. recommended counseling and assistance completing advance directives to improve the completion rate among the elderly homeless population. Due to negative perceptions of advance care planning, staff should approach clients with great sensitivity and assess their unique views of death and dying, while also addressing their basic and immediate needs.[22]

From a policy standpoint, Sermons et al. emphasized the need for an increased supply of subsidized affordable housing set aside for seniors.[5] With limited fixed incomes, housing cost burden can lead to first-time homelessness, one of two major pathways among older and elderly adults. For the second pathway, those who are above 50 and chronically homeless, Sermons et al. recommended permanent supportive housing to address intensive housing and service needs to break the cycle of long-term homelessness.

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IN FOCUS

Incarceration & Homelessness: A Revolving Door of Risk

A Quarterly Research Review of the National HCH Council: Vol. 2, Issue 2 **Nov. 2013**

The November issue of *In Focus* provides a synthesis of recent literature on the connections between incarceration and homelessness in the United States. The relationship between these topics is an intricate one, as both are risk factors for the other. Some homeless sub-populations are at increased risk for incarceration, including those with mental health issues, youth, and veterans without stable housing. Considerations for these special populations, as well as the health impact of incarceration; the role of housing first, jail inreach, and re-entry programs; and additional policy implications, will be discussed in this publication.

Rates of Incarceration and Homelessness

Incarceration and homelessness are mutual risk factors for each other.[1, 2] Study currency and methodologies vary, but researchers generally estimate that 25-50% of the homeless population has a history of incarceration.[3-5] Compared to adults in the general population, a greater percentage of inmates have been previously homeless (5% of general population versus 15% of incarcerated population with history of homelessness), illustrating that homelessness often precipitates incarceration.[2, 6, 7] Greenberg and Rosenheck found that homelessness was 7.5 to 11.3 times more prevalent among jail inmates than the general population.[2] Exiting homelessness is daunting regardless of one's criminal record. However, individuals with past incarceration face even greater barriers to exiting homelessness due to stigmatization, policies barring them from most federal housing assistance programs, and challenges finding employment due to their criminal records.[4] To meet basic necessities amidst these barriers, previously incarcerated individuals sometimes engage in criminal activities to get by, perpetuating the cycle of homelessness, re-arrest, and incarceration.

History of homelessness is
7.5 to 11.3
times more prevalent among inmates than the general population

Incarceration of Special Populations

Individuals without stable housing are already at greater risk for incarceration than the general population. However, sub-groups within the homeless population—namely individuals with mental health issues, veterans, and youth—have even more widespread incarceration histories.

Mental health issues are prevalent among incarcerated populations. Nearly one million adults with a serious mental illness are booked into jails annually,[8] and many of these individuals have histories of homelessness. Severe mental illness is prevalent among the homeless population and is associated with increased risk of criminal justice system involvement.[2] A study of 6,953 jail inmates found that individuals with homelessness in the year prior to incarceration had symptom clusters associated with mania, depression, psychosis, and substance use at 10-22% higher rates than inmates without prior homelessness.[2] Constantine et al.[9] completed a longitudinal study of 3,769 arrestees and jail inmates with serious mental illness and found that being male, being homeless, not having outpatient mental health treatment, and having an involuntary psychiatric evaluation were independently associated with significantly increased odds of misdemeanor arrests and a longer period of incarceration. The most common diagnoses among this population were major depression, bipolar I disorder, and psychotic disorders; 67% had a substance use disorder diagnosis.

Runaway/homeless youth (RHY) is another sub-population that experiences high rates of incarceration. An estimated 20-30% of unstably housed young people have arrest histories, equating to about 150,000 entering the criminal justice system annually.[10, 11] A cluster analysis of unstably housed youth identified four typological groups based on their use of homeless services: 1) basic survival service use, 2) multiple service use, 3) incarceration experience, and 4) minimal service use.[12] Youth in the group with incarceration experience had high histories of abuse, running away, and risky behavior on the streets in comparison to the other groups. Two-thirds of the previously incarcerated group had been kicked out of their housing compared to less than half of youth in the other three groups. Finally, the previously incarcerated youth were the lowest utilizers of homeless services despite their traumatic histories and high needs.

The unstably housed veteran population also experiences disparate rates of incarceration compared to the general homeless population.[4] Veterans who served during 1973-1980 are especially vulnerable, as they are overrepresented in both the homeless and prison populations.[4, 13-15] In a study of 14,557 veterans in the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program—which provides rental assistance, case management, and clinical services to unstably housed veterans—66% reported incarceration histories.[4] Before entering HUD-VASH, veterans with incarceration histories displayed greater psychiatric symptoms, received more substance abuse diagnoses, and were more likely to be chronically homeless than unstably housed veterans without prior incarceration. Additionally, having served in the Vietnam Theater of operations was associated with a greater history of incarceration, while service in Iraq/Afghanistan was associated with a reduced history of incarceration, demonstrating the diversity among unstably housed veteran cohorts. In a study of previously incarcerated veterans in the Health Care for Re-Entry Veterans Program, 30% were homeless.[6] Among incarcerated veterans who were homeless, three-fourths were episodically or chronically homeless and all reported significantly more mental health problems, more substance abuse, more arrests, and a greater likelihood of incarceration for non-violent offenses than previously incarcerated veterans with stable housing.

Health Impact of Incarceration

In addition to contributing to risk of homelessness, incarceration can also have significant effects on health. Brinkley-Rubinstein and Turner developed a model depicting the intersections of incarceration and health, including risk factors associated with incarceration and proximal predictors of health (see figure 1).[16] In a National Institute of Health manuscript, Dumont et al. describe incarceration as a public health epidemic.[17] Although previously thought to be a protective health influence, incarceration is actually a health risk based on the surge in mortality following release.[17] Overcrowded conditions, high-risk sexual behaviors, and shared needles for drug use and tattoos create ideal conditions for infectious disease outbreaks, although incarceration has even

Source: Brinkley-Rubenstein, L., & Turner, W.L. (2013). Health impact of incarceration on HIV-positive African American males: A qualitative exploration. AIDS Patient Care and STDs, 27(8), 450-458.

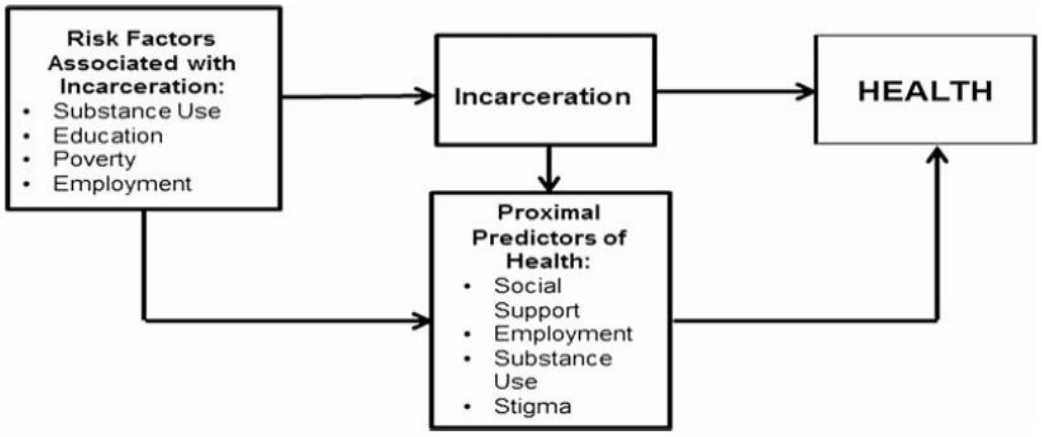

FIG. 1. The hypothesized impact of incarceration on health.

greater adverse effects on addiction and mental illness following release.[17] While the criminal justice system provides a steady source of health care during incarceration, continuity of care is disrupted upon release, particularly for those returning to unstable housing situations. Sudden discontinuation of medications and services, paired with lack of access to services, puts previously incarcerated individuals at risk to cycle among the streets, shelters, emergency rooms, and criminal justice system.[18] In addition to health challenges upon release, previous incarceration can even increase the risk of adult physical and sexual victimization among women.[19]

Re-Entry Programs Targeting the Homeless Population

With high rates of recidivism on top of the deleterious circumstances faced by those without stable housing, several programs have been implemented with much success. These programs connect formerly incarcerated individuals with stable housing, clinical, and support services to break the cycle of recidivism. An overview of these programs and supporting outcome data is presented below.

Jail Inreach

Jail inreach programs build relationships with inmates at risk of homelessness prior to their release, laying the groundwork for continuity of care. Healthcare for the Homeless-Houston operates a Jail Inreach Project that provides intensive medical case management to individuals with behavioral health diagnoses.[18, 20] Eligibility for the program is contingent upon: 1) being incarcerated in the Harris County Jail, 2) having a behavioral health diagnosis(es), 3) expecting to be homeless upon release, and 4) being a "frequent flyer," meaning high arrest rates and utilization of mental health services while incarcerated. Since 2009, the program has worked with over 492 individuals, 22% of which experienced multiple encounters resulting from re-arrest and incarceration. Of first-encounter clients, 56% had successful linkage to services after release, 5% declined services, 11% were transferred to another correctional facility, and 29% did not follow through with the program upon release.[20] The project attributes its success to developing patient-centered release plans with clients and promoting daytime release so that services are immediately accessible, often with case managers accompanying clients directly to the clinic.[18] Immediate linkage reduces missed first appointments and overall loss of clients, reducing arrest rates, number of days in jail, and costs of incarceration to the community.[18]

AHCH Re-Entry Program

The Re-Entry Collaborative (REC), facilitated by the Albuquerque Health Care for the Homeless (AHCH), uses an integrated primary care and social services treatment model to assist with the re-entry of homeless individuals released in the past 90 days with opiate dependency.[21] The program seeks to reduce the human suffering of opiate-addicted individuals without stable housing while also reducing societal damage and system costs of recidivism and overdose deaths. REC is a collaborative among the New Mexico Department of Health, Bernalillo County Substance Abuse Treatment Services, the New Mexico Department of Corrections, and the University of New Mexico Health Sciences Center (Project ECHO). The treatment model includes: 1) opiate replacement therapy using Suboxone, 2) care coordination, 3) stages of change and motivational interviewing for risk reduction, 4) Housing First philosophy, 5) trauma-informed care, and 6) a collaborative model for Systems Integration and Enhancement. REC has produced positive outcomes, including decreased drug use, associated risky/unhealthy behaviors, and mood disorders. Additionally, arrests decreased by 3% over the first six months and 11% after the first 12 months.

Supportive Housing and the Housing First Approach

The Housing First approach, which provides permanent supportive housing without sobriety or treatment requirements, has demonstrated its efficacy among the general homeless population. However, a building body of research has also revealed the model's success in preventing future incarceration and creating housing stability for those with histories of incarceration.

A study of unstably housed adults with medical illnesses and high prior acute care utilization found that the group engaged in Housing First had greater reductions in hospital admissions and jail bookings than the comparison group.[22] Additionally, a study of 95 chronically homeless individuals with severe alcohol problems found that the number of months of Housing First exposure predicted significant decreases in jail days and bookings compared to their incarceration histories in the past two years.[23] Of note, 91.3% of the participants' prior convictions were misdemeanors.

Exposure to
Housing First
predicted significant decreases in jail days and bookings

The supportive housing approach used by the HUD-VASH program has also demonstrated its effectiveness among those with incarceration histories. HUD-VASH does not exclude veterans with past criminal offenses from its permanent supportive housing and clinical services. Tejani et al. completed a study of 14,557 veterans in the HUD-VASH program and found that history of incarceration did not impede therapeutic alliance or housing success. The previously incarcerated population was equally successful at obtaining housing even though it had a higher incidence of chronic homelessness, substance abuse, and alcohol abuse/dependence prior to entering the program.[4]

Conclusion

The mutual risk between homelessness and incarceration necessitates greater attention from clinicians, administrators, researchers, and policymakers. In particular, special considerations should be made for the homeless population subsets at an even greater risk: youth, veterans, and those with mental health issues. A number of effective approaches exist to break the cycle of homelessness and recidivism. Supportive housing/Housing First, jail inreach, and integrated treatment for opiate-dependent individuals are three evidence-based examples. For a policy perspective on the topic, see the National HCH Council's Policy Statement on "Criminal Justice, Homelessness & Health" at http://www.nhchc.org/wp-content/uploads/2011/09/Criminal-Justice-2012.pdf.

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IN FOCUS

Gender Minority & Homelessness: Transgender Population

A Quarterly Research Review of the National HCH Council: Vol. 3, Issue 1 **September 2014**

The September issue of *In Focus* provides a synthesis of recent literature on transgender individuals and experiences of homelessness in the United States. Very little literature exists specifically addressing this homeless minority group. Literature that does address this group also includes lesbian, gay, bisexual, and sometimes queer/questioning individuals (LGBTQ). The use of 'Q' has been a recent addition for those questioning their sexual orientation and/or gender identity or individuals that identify as being queer. The LGBTQ group is often times grouped together on its commonality as being a marginalized "other" part of society. Despite the paucity of research findings specifically on unstably housed transgender individuals, it is clear that persistent societal, economic, cultural, and institutional discrimination and stigmatization, contribute to a disproportionate risk of housing instability and inequities in health for this population. Challenges in identifying unstably housed transgender individuals, pathways into homelessness, prevalent health issues, and service access barriers will be discussed in this publication.

Transgender Terminology

In contrast to lesbian, gay and bisexual men and women, transgender individuals are defined by their gender identity and how they present themselves, not by sexual orientation. Transgender is a term that encompasses gender variant identities, expressions, and non-conformity. [1] There is a general consensus that the term "transgender" refers to persons whose gender identity and/or gender expression is different from the sex they were assigned at birth and the expected gender role of that sex. [2, 3] However, due to the varying ideas of who should be embraced by this term, knowing how an individual self-identifies is the best guideline for classifying that person. [4, 5]

Identifying the Transgender Homeless Population

There are major challenges in capturing LGBTQ population data, especially among those who are unstably housed. Challenges include the transient and hidden nature of the homeless population, sensitivity in asking about sexual orientation and gender identity, concerns of confidentiality, lack of consensus regarding transgender definitions, and lack of standardized research methodology. [1, 6, 7] Some research studies include questioning/queer individuals while some do not. This will be seen throughout this publication.

It is estimated that

1 in 5

Transgender persons have unstable housing, or are at risk or in need of shelter services

A recent Gallup poll estimated the LGBT population of 51 states to range from1.7%-5.1%, with a national average of 3.5%. [8] Looking specifically at this gender minority group, an analysis done by the Williams Institute approximated that 0.3% of the U.S population are transgender. [1] Of the general population of transgender individuals, it is estimated that "one in five transgender persons have unstable housing or are at risk or in need of shelter services." [9 p. 321] Despite a lack of unstably housed transgender population estimates, it is believed that many have had some experiences of homelessness as demonstrated by the disproportionately large percentage (20%-40%) of unstably housed youth that identify as LGBTQ. [10]

Pathways into Homelessness

Relative to others, transgender individuals have an increased risk for experiences of homelessness. A number of contextual factors can thrust transgender youth and adults into homelessness including: family rejection and/or conflict, running away from or aging out of the foster care system, violence/victimization, and institutional discrimination (e.g., in schools, housing, and workplaces). As with other populations, substance use disorders and psychiatric illnesses also precipitate homelessness for some transgender individuals.

Family rejection and/or conflict, are the most common causes of homelessness amongst transgender youth [5, 11, 12], demonstrating the family's role as a primary protective network for youth.[13, 14] Transgender individuals are increasingly 'coming out' at an early age as transgender and sexual minority role models become more publicly visible and accepted. [5, 13] Prior to publicly 'coming out,' individuals may display signs of gender non-conformity. [12] Familial relationships can become strained and injurious if family members are not supportive. Reactions may manifest in avoidance, financial and emotional rejection, neglect, and abuse. [15] Transgender youth may opt to run away from home or be pushed out/expelled from the home because of non-affirming or abusive behaviors from their families.

Some transgender youth who leave home become a part of the foster care system. [12, 16] Once placed in foster care, youth may run away or simply age out of the system. [16,17] Young adults who age out of the system are suddenly faced with difficulties in acquiring financial support, maintaining relationships, and accessing social resources needed to survive on their own. [18, 19]

In a study of 381 LBGT youth service providers, three of the top reported reasons for LBGT youth becoming homeless were: running away due to family rejection (46% of respondents), being forced out or expelled from the home by their parents (43% of respondents), and aging out of the foster care system (17% of respondents).[20]

In a National Transgender Discrimination Survey (NTDS) of 6,450 transgender and gender non-conforming adults, 19% of participants became homeless at some point in their lives due to family rejection and discrimination, 2.5 times the rate of the general population. [21]

Violence/victimization is both a consequence and a contributing factor of homelessness amongst LGBT youth. Domestic violence by family members was found to be the second most common type of violence reported by unstably housed LGBT youth in a study conducted by Marsiglia, et al.[22] In the NTDS study mentioned above, 48% of transgender individuals who experienced some form of domestic violence also had a history of homelessness.[21] Both of these studies demonstrate that a large portion of transgender individuals experiencing emotional, physical, and/or sexual abuse, do so in their homes at the hands of people whom they know [23], resulting in many choosing homelessness or seeking shelters as a safer alternative.

Substance abuse and psychiatric illnesses are also both a consequence and contributing factor to homelessness. According to the United States Conference of Mayors, both substance abuse and mental health issues were reported as contributing factors to unaccompanied individual experiences with homelessness. [24] Numerous studies have shown that there is a high prevalence and heightened risk of substance abuse and other mental health issues such as depression, anxiety, and suicidal ideation within the transgender population [25, 26], putting them at

greater risks of becoming unstably housed. Violence/victimization and psychiatric illnesses will be discussed below as prevalent health issues in the transgender community.

Lastly, research suggests that housing discrimination and economic insecurity, attributable to workplace discrimination, increases the risk of adult transgender homelessness. [27] In the NTDS study, participants reported being denied (19%) or evicted (11%) from housing at some point in their lives because of gender non-conformity. In addition, a large portion of respondents reported adverse employment outcomes (47%) and some form of mistreatment or harassment on the job (90%). Adverse outcomes included being fired, denied a promotion, or not being hired because of gender non-conformity. Forty percent of those who reported job loss due to discrimination also had experiences of homelessness. [21]

Transgender Health

Prevalent Health Issues

Experiences of homelessness and transgender identity have been associated with higher rates of psychiatric illnesses, trauma, and HIV infection—compared to the general population. [9] Combined, these health risks are magnified. Psychiatric illnesses—including anxiety, depression, suicidal ideation, and substance abuse—have been attributed to self-hatred due to external exposures to abuse, and the oppressive and contemptuous behaviors of individuals around them.[9, 28, 29] Three recent studies, of various sample sizes of transgender individuals demonstrated the high prevalence (44-54%) of depression in this minority group, a rate 6-8 times greater than the general population (6.4%).[26, 30-32] In the NTDS, reports of attempted suicide were drastically higher than the general population (41% vs 1.6%). Of those who reported having attempted suicide, 69% had experienced homelessness. [21]

The second health issue of concern is trauma, from events of physical, emotional, and sexual abuse in the transgender community. Because unstably housed transgender individuals spend more time in public spaces, they are at an increased risk of victimization. Identified as one of the most impacted groups of victims compared to "cisgender" victims, transgender individuals were found to be 1.66 times more likely to experience threats and intimidation, and 3.32 times more likely to experience police violence, according to the National Coalition of Anti-Violence Programs. A Cisgender individual, as described by the NCAVP, refers to a person that expresses their gender identity in accordance to their sex-at-birth and expected gender role of that sex. [33]

Lastly, based on the NTDS, HIV rates amongst transgender individuals (2.64%) were found to be four times higher than the general population (0.6%).[21, 34] The HIV rate for those that had a history of homelessness was 7.12%—compared to a rate of 1.97% of those who did not.[17] Research suggests that the rate of infection is higher for those experiencing homelessness because of exposure to communities that have a high prevalence of HIV cases and high risk behaviors including un-safe sex and shared needle practices.[9] A survival strategy for some homeless transgender individuals is to participate in “sex work.” Sex work is the trading of sex or sexual acts for money, food, shelter,[9] and in some instances for gender affirmation [31], thus increasing their risk of HIV transmission.[35] The NTDS demonstrates this association, where 61% of those who reported that they were HIV positive also reported having participated in sex work for money.[21]

Transitioning Health

It is important to note that not all individuals who identify as transgender actually want to physically transition to another sex. However, for those that do, the process is long, often difficult, and costly. [9] Desire to transition or receive gender-confirming treatments can add to the emotional stress and mental instability (depression, anxiety, and suicidal ideation) of transgender individuals, especially in cases of limited access to treatment. [26] Access is especially limited for those who are unstably housed. As a result, many pursue illegal services, such as non-prescribed hormones and surgical procedures from untrained or unlicensed individuals. Without proper procedures and monitoring, transgender individuals are at increased risk for deleterious health outcomes, such as hepatitis through unsterile equipment or physical disfigurement through surgical procedures. Sex work may also be pursued in order to finance gender-confirming treatments or procedures [9], noted previously as a risk factor of HIV transmission. [35]

Homeless Service Access Barriers

Though the number of organizations that serve unstably housed transgender individuals has increased over the past ten years [20], large gaps in and barriers to social, housing, and medical services still remain. Research has established four categories of barriers to service access for the transgender population: personal, structural/systematic/legal, provider education, and financial. Personal barriers include reticence to disclose gender identity out of fear of rejection and compromising safety, internalized transphobia, and perceptions that providers lack transgender-specific knowledge. [9, 36] Collectively, mistrust of providers prevents individuals from seeking services or from receiving appropriate considerations to meet their needs.

Structural, systematic, and legal barriers include a lack of appropriate accommodations (e.g. gender neutral/fluid restrooms and shelter accommodations), limited gender choices of male or female in legal documents and service records (e.g. electronic medical records, shelter forms, and billing and coding records), and limited or no access to spousal/partner benefits.[36] In addition, there are insufficient laws protecting the rights of transgender individuals and existing laws go unenforced, which can reinforce personal fears of rejection and safety concerns.[9]

A lack of knowledge of trans-affirmative care as well as cultural sensitivity amongst service providers constitutes the third barrier. As demonstrated in the NTDS, there is both a perception by transgender individuals that health providers lack trans-affirmative care knowledge and a lived reality where 50% of the sample reported having to teach their health providers about transgender care. [21]

Financial barriers stem from a high prevalence of unemployment and on-the-job discrimination within the transgender population [9, 14], especially among those who experience homelessness. Combined, experiences of limited income and the current high costs of health care may make health services seem unattainable.

Conclusion

As the literature review suggests, transgender persons face an exorbitant amount of social and health disparities due to pervasive stigma and discrimination encountered in varying cultural contexts and social structures. [13] However, much is still unknown about the specific needs of unstably housed transgender individuals. Congruent with Healthy People 2020, studies have identified three predominant issues to be addressed in order to improve the circumstances of LGBTQ individuals: 1) collecting accurate data on the number, demographics, social influences, and health inequities of unstably housed LGBTQ persons [13]; 2) developing wellness and intervention models to manage/end transgender homelessness; and 3) offering training and technical assistance to providers on culturally appropriate care and trans-specific resources.[7]

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IN FOCUS

Rural Homelessness: Identifying and Understanding the "Hidden Homeless"

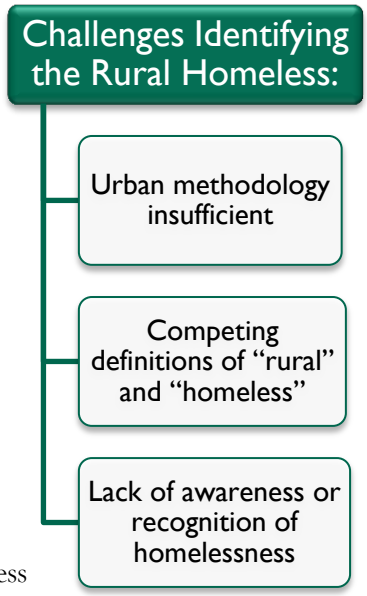
A Quarterly Research Review of the National HCH Council: Vol. 1, Issue 4 **June 2013**

The June issue of *In Focus* provides a synthesis of recent literature on rural homelessness. Homelessness is often conceptualized as an urban issue, which is reflected by the dearth of research on homelessness in rural areas. In reality, homelessness is pervasive in rural communities due to high rates of poverty, unemployment or under-employment, lack of affordable housing, and geographic isolation. This issue of *In Focus* will address the changing rural landscape, challenges to identifying the homeless population, patterns of homelessness, service access and delivery barriers, and promising practices in service delivery in the context of rural settings. A few limitations exist regarding the literature shared, namely the specificity of studies to certain rural communities and some outdated references due to a lack of recent literature on the topic.

Changing Rural Landscape

In the United States, a number of trends have altered the character and culture of rural communities, many of them at odds with the idyllic image of small town life. Corporate takeovers of family farms, restructuring of industries, in-migration of ethnically diverse populations, out-migration of young people, and the rising average age of the rural population are all factors that have changed the rural landscape.[1] Along with these trends, social problems stereotypical of urban areas have emerged, including poverty, adult and youth homelessness, increasing crime rates, drug addiction, and minority-majority group conflicts in places with new immigrant populations.[1, 2] A number of factors have contributed to rural poverty and homelessness, including a lack of affordable housing, especially in proximity to employment opportunitiues; prevalence of low-wage service occupations; lack of infrastructure to support employment (e.g. child care and public transportation); inadequate treatment opportunities for medical and behavioral health problems; natural disasters; and domestic violence.[1, 3-5]

Identifying the Rural Homeless Population

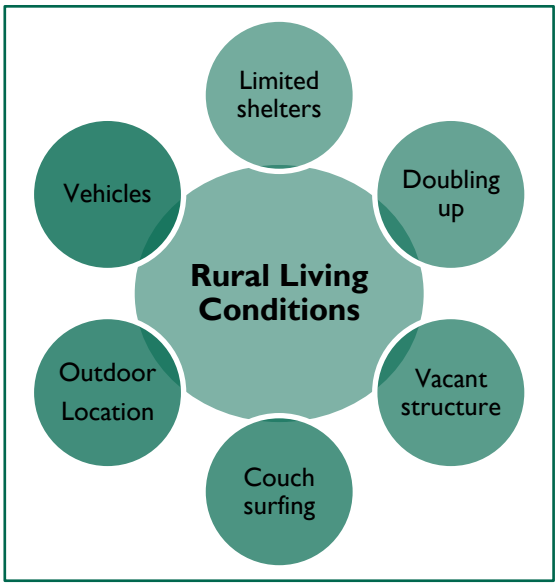


A major challenge in the study of rural homelessness is the inability to accurately identify and quantify the population. One issue is the prevalent lack of awareness or recognition of homelessness in rural areas.[1, 5-7] Recognition of rural homelessness is limited for a few reasons: rural landscapes camouflage homelessness through expansive geography with low population density, unstably housed individuals reside in less visible locations than in urban areas (wilderness, substandard housing, doubling up, etc.), and cultural norms deny that homelessness can exist in the idealized rural setting and aim to rid communities of this "social problem."[1, 6] Methodological concerns also exist in the identification of the rural homeless, including competing statutory definitions of "homeless" and "rural" held by federal agencies, issues in locating this "hidden population," and challenges accurately sampling the population.[5, 7] Methods used to enumerate the urban homeless are not as effective in rural areas. For example, urban counts have often been based upon the number of homeless service users in an area, but this method likely undercounts the homeless

population in rural communities due to the lack of service sites.[5] Another method has been to extrapolate rural homeless estimates from rates in urban areas.[5] Because of these methodological issues and data limitations, comparing the prevalence and variation in characteristics of homeless populations in rural and urban areas can be problematic.[5, 7]

Patterns of Rural Homelessness

Patterns of rural homelessness are often less visible than those in urban areas, with individuals spread out in remote locations.[8] Due to a desire to remain in rural communities or few options to leave, individuals often settle for substandard living conditions.[6] Common places of residence include a limited number of shelters; doubling up with family or friends, including in units on tribal lands; severely substandard structures that would likely be condemned in urban areas; couch surfing, especially among youth; outdoor locations; vehicles; and abandoned buildings.[7] For those doubling up in rural areas, it is a common cultural norm based upon the belief of taking care of one's own; however, severely overcrowded living situations have been associated with domestic violence and child abuse.[7] For those residing in less visible locations, it may be a conscious desire to remain hidden from abusers, parents, creditors, or police.[7] Although some unstably housed individuals remain in the same community, families with children often become hypermobile due to economic insecurity and inadequate housing, leading to social isolation.[9] Children in unstably housed rural families often experience academic struggles and difficulty obtaining services.[10] Levels of perceived visibility, local status, and mobility can dictate the community perceptions and anti-homeless rhetoric that unstably housed individuals face in rural areas, with the most preferential type being someone who is local, settled, and invisible.[6] This mentality speaks to the lack of awareness and acceptance of homelessness in rural areas.



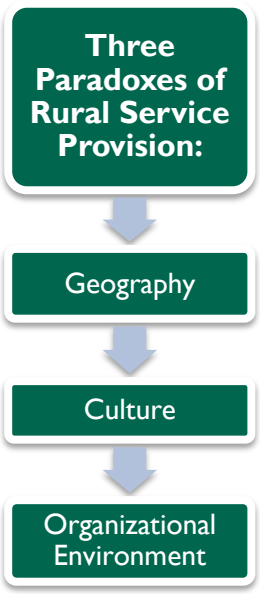
Service Access and Delivery Barriers

Rural areas are far from homogenous. Their unique, local dynamics can shape the experiences of unstably housed individuals and the way in which homeless services are designed and delivered.[1, 6] Geography can affect the type of viable living conditions in a community. Rural social structures and attitudes toward homelessness can even influence community responses between the extremes of marginalization and generosity, resulting in resource-rich and resource-poor rural areas.[6] A number of structural barriers inhibit the access to and provision of services across rural settings, including a limited number of homeless-specific services, lack of institutional capacity and staff, provider shortages, limited shelter beds, lack of affordable housing, large service areas, dispersed populations, lack of public transportation, lack of outreach to engage individuals in services, individuals' reluctance to seek outside assistance, and individuals' desires for privacy.[5, 7, 8, 11]

Organizations encounter many challenges in service delivery due to the unique rural dynamics in which they operate. Edwards et al. [1] identified three paradoxes in the provision of services in rural communities, demonstrating how local dynamics influenced community responses to homelessness. The first paradox was geography. In some areas, geographic isolation mobilized small towns to provide resource-rich environments for those experiencing homelessness through a collaborative response. However, Edwards et al. found this to rarely be the case, with poorer subsets of the population actually becoming more isolated at the remote margins of town. Geography also hindered residents from service utilization, created transportation issues, and produced issues of efficiency and scale for providers serving a geographically dispersed population.

The second paradox, culture, was demonstrated by competing values that influenced residents' levels of awareness, approval or disapproval, and solutions to addressing homelessness. On the one hand, rural communities demonstrated a commitment to taking care of one's own, which improved community responsiveness, while simultaneously valuing the individuation of problems, self-reliance, and privacy, which hindered community action.

The final paradox, organizational environment, demonstrated how state and local government agencies affected the service infrastructure in rural areas. Most agencies operated autonomously, providing singular services (e.g. food stamps), with little integration, coordination, or awareness of each other, disputing the rural stereotype of a tight-knit community. A report by the U.S. Government Accountability Office (GAO) found a similar lack of integration among programs funded by the Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) in rural communities.[7] Given the breadth of geographic and cultural barriers rural communities already face, the effects of limited collaboration are especially detrimental.



Promising Practices in Rural Service Delivery

Although limited research exists regarding effective rural service models[5], some emerging practices have been identified. These strategies, which are not limited to rural settings, include the integration of behavioral health and primary care to reduce stigma of behavioral health issues, the provision of transportation assistance, coordinated service delivery to maintain continuity of care, increased outreach in remote areas, use of community networks and peer navigators to facilitate mobile outreach, the continuum of care approach to increase awareness of complementary services in community, the promotion of cultural competence among staff, development of community coalitions and rural service teams, regionalized services, the housing-plus-services model, and employment initiatives to train the local workforce.[4, 5, 12] In addition to increasing access to services, Probst et al.[13] found that the presence of community health centers[1] and rural health clinics in rural communities limited county-level rates of hospitalization for ambulatory care sensitive (ACS) conditions, especially for older adults.

Promising Practices:

- *Behavioral health and primary care integration*
- *Transportation assistance*
- *Continuity of care across community providers*
- *Increase outreach in remote areas*
- *Use of community networks/peer navigators for outreach*
- *Promotion of cultural competence among staff*
- *Development of community coalitions/rural service teams*
- *Regionalized services*
- *Housing-plus-services model*
- *Employment initiatives to train local workforce*

Implications

The field of rural homelessness merits further study, as homelessness is not an exclusively urban problem. The patterns in which homelessness unfolds in rural settings differ from urban settings, necessitating tailored approaches in public policy and service design. New methodology is needed to effectively identify and enumerate the rural homeless population so that more accurate comparisons can be made with the urban homeless population. Once population characteristics and needs are identified, service infrastructures can be evaluated and

[1] The term "Community Health Center" is not defined in the section 330 statute, and there is no universal agreement on its meaning. It is commonly used to refer to the subset of Health Center Program grantees that receive funding to target a general underserved community or population.

redesigned to more effectively match rural settings, taking into consideration geography, culture, and organizational environment.

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