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# Health Issues in the Homeless Youth Population

Meera S. Beharry, MD, FAAP

Approximately 2 million youth in the US experience homelessness annually. A hidden and high-risk population, these youth have unique medical and psychosocial needs that contribute to or are a result of their homelessness.

Homeless youth often share temporary shelter with others, or congregate in secret locations due to fear of being discovered by parents, legal guardians, or law enforcement. Therefore, counts of homeless youth have yielded widely disparate numbers. The most commonly cited figure is that 1.5 million to 2 million American youth will experience homelessness each year.

Recent data from the Department of Housing and Urban Development (HUD) estimate that about 8,000 children younger than the age of 18 years and an additional 50,000 to 100,000 young people age 18 to 24 years are homeless on any given night.<sup>1</sup>

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## HOMELESS YOUTHS DEFINED

There are a variety of ways to define this population. Legal definitions of homelessness are provided by the McKinney-Vento Act and HUD. According to the McKinney-Vento Act, “homeless” people “lack a fixed, regular, and adequate nighttime residence.” This definition includes children and young people who are living in shelters, hotels, bus stations, and cars. It also includes children in migratory and homeless families.<sup>2</sup>

HUD defines youth who are “unstably housed” as “unaccompanied youth who have not had a lease or ownership interest in a housing unit in at least 91 days, have had three or more moves in the past 90 days, and who are likely to continue to be unstably housed.” While these definitions are helpful in program development, they are rather dry and of limited clinical use.

Clinicians and researchers who work with homeless youth have developed terms to reflect the etiology of homelessness. Youth who run away only for a few nights and return home are termed “situational runaways.” When these young people no longer return home, they are called “runaways.” “Throw-aways” are young people who were kicked out of their homes for any reason. Youth generally cite family discord and abuse; family financial problems; or social differences from their family, such as teen pregnancy or different sexual orientation, as a reason for being thrown out. “Systems youth” refers to young people who become homeless after exiting the foster care or juvenile justice system.<sup>3</sup>

Depending on the etiology of their situations, homeless adolescents will present with differing medical and psychosocial problems. However, for fear of being

stigmatized, they might not disclose their homelessness status. It is therefore up to the clinician to combine the elements of a patient's history and physical — hopefully obtained through a nonjudgmental, sensitive approach — to diagnose homelessness and best treat the patient, particularly in the context of their housing situation.

Karr and Kline<sup>4</sup> have suggested questions that can be used at various stages of an office visit to assess a youth's housing status and its role in the patient's health care provision. They suggest asking during the registration process, "Is this a permanent or temporary address?" Appropriate follow-up questions and responses should be used for those who answer "temporary."

On review of the medical records, immunization, or medical history, a provider can reflect, "It seems that you have moved a lot," and ask the patient about plans for staying at this address, reasons for the moves, and if there is anything that can be done to help. Clinicians may choose to ask, "Is having friends and family around good or bad for you?"<sup>4</sup> This creates an opportunity for the young person to share any past negative experiences, and for the provider to offer help.

Another helpful question is, "Would you like any help with getting food, clothing, or housing?" Current economic conditions have helped mitigate the potential sting of this question.

#### **MEDICAL PROBLEMS ASSOCIATED WITH YOUTH HOMELESSNESS**

Homeless youth have higher rates of the myriad medical problems that plague modern adolescents. Since many homeless youth have been victims of physical, emotional, or sexual abuse, they may be mistrustful of adults and may have had limited or no contact with medical professionals. When members of this population present for care, they are often in crisis. Frequently, they will present to the emergency department (ED), reproductive health clinics, or school-based clinics. However, some youth who feel a strong

connection to their primary care doctor will travel great distances to preserve continuity of care with a trusted adult.

#### **Sexually Transmitted Infections and Risks**

The average age of initial sexual intercourse among homeless youth is 12 to 13 years. Youth who are repeatedly positive for sexually transmitted infections (STIs) and diseases or those who report high numbers of sexual partners may be victims of sexual abuse and/or human trafficking, or may be engaging in "survival sex": exchanging sex for food, drugs, clothing, or shelter. By asking about this behavior, health care providers can help these patients meet their survival needs in safer ways, and potentially help victims of abuse escape their situations.

Rates of STIs among homeless youth vary greatly among studies, with a range of 8% to 40%.<sup>5</sup> Human immunodeficiency virus (HIV) is three to 30 times more prevalent among homeless youth.<sup>6</sup> These large ranges likely reflect differences in local prevalence of STIs, in addition to differences in the behaviors of youth who present to care. Homeless youth who present for care should be screened for HIV, syphilis, gonorrhea, chlamydia, and hepatitis B and C.

Twenty percent to 40% of homeless youth identify as lesbian, gay, bisexual, or transgender (LGBT).<sup>6</sup> In addition to being a common cause or contributing factor to youth homelessness, LGBT-identified youth can be at increased risk for victimization while homeless.<sup>7</sup>

Homeless young women are 2.3 to 7.8 times more likely than their nonhomeless peers to have ever been pregnant. While pregnancy can offer some youth a chance to receive housing benefits, the health risks to the adolescent and her fetus are considerable, resulting in a higher likelihood of the delivery of a low-birth-weight infant.<sup>5</sup>

#### **Malnutrition**

Rates of obesity among homeless youth are estimated to be 50%.<sup>8</sup> Homeless youth

are more reliant on fast food establishments and soup kitchens for their meals. While the food served at these venues alleviates the immediate problem of hunger, it is often high in fat, sugar, and salt content, presenting significant metabolic and cardiovascular risks. Access to fresh fruits and vegetables and high-fiber foods is very limited. This may prevent a homeless adolescent's adherence to any recommended lifestyle modifications for obesity treatment.

The nutritional challenges of being homeless can also present as anemia or more classic malnutrition.<sup>4</sup> Data regarding the prevalence of eating disorders among homeless youth are lacking.

#### **Respiratory and Infectious Diseases**

Medical problems associated with poor and crowded living conditions, such as asthma, tuberculosis, influenza, pneumonia, hepatitis A, lice, and scabies, are more common among homeless youth. Rates of tuberculosis are 20 times higher among homeless individuals than the general population.<sup>5</sup> Homeless youth who have asthma experience more exacerbations due to increased exposure to triggers like dust, smoke, mold, and cockroaches.<sup>4,5</sup>

Shelter-based youth were reported to have twice as many ED visits as their school-based peers.<sup>6</sup> Homeless children and youth are also more likely to be non-compliant with their asthma medications; frequent housing changes often mean losing medications or not having access to the electricity necessary to run nebulizers.<sup>4,6</sup> Lack of stable housing and poor record-keeping also contribute to this population's higher rates of inadequate immunization.<sup>4</sup>

#### **Mental Illness**

The lifetime prevalence of psychiatric disorders in homeless youth is almost twice that of their housed peers.<sup>6</sup> A young person's mental illness may have been a contributing factor in becoming homeless. Conversely, mental health problems may develop as a result of violence or other trauma experienced while homeless. Re-

## SIDEBAR

**Additional Resources for Homeless Youth**

- National Healthcare for the Homeless Council: [www.nhchc.org](http://www.nhchc.org).
- Covenant House: [www.covenanthouse.org](http://www.covenanthouse.org).
- National Safe Place: [nationalsafeplace.org](http://nationalsafeplace.org).
- National Center for Homeless Education: [center.serve.org/nche/index.php](http://center.serve.org/nche/index.php).
- National Alliance to End Homelessness: [www.endhomelessness.org](http://www.endhomelessness.org).

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ported rates of sexual abuse and physical abuse are as high as 35% and 82%, respectively.<sup>6</sup> These youth often report being victims of multiple forms of abuse,<sup>6</sup> and often present to medical care for treatment of the immediate effects or the sequelae of abuse.

Youth who present with trauma-related problems such as injuries from physical or sexual assault may be victims of street violence or, if housed, may be in an abusive situation that could result in homelessness. Adolescents may be savvy enough to avoid saying anything that would prompt a referral to child protective services, but may be receptive to accepting help or learning about safe housing arrangements. Building rapport and a therapeutic alliance are key components of helping a young person exit the abusive situation.

As many as one-third of homeless youth meet criteria for posttraumatic stress disorder (PTSD). Additionally, one study of 95 homeless youth accessing a mobile medical unit found that about 41% met criteria for bipolar disorder; 27.5% for PTSD; 41% for major depressive disorder (MDD); and 29% for attention-deficit/hyperactivity disorder (ADHD).<sup>9</sup>

Compared with school-based youth, shelter-based youth were almost four times as likely to report considering suicide. Reviews of the literature show that 40% to 80% of homeless youth reported having suicidal ideation and as many as two-thirds of such youth have attempted suicide.<sup>5,6</sup>

**Substance Use**

High rates of substance use are also associated with youth homelessness. Youth

may have been thrown out of their homes due to substance use issues, or may have begun using as a way to cope with homelessness. Substance use rates range from 70% to 90% among homeless youth, with tobacco and alcohol being the most commonly used substances.<sup>5,6</sup> Intravenous drug use rates have been reported to be as high as 33% in this population.<sup>5</sup> Older youth tend to report using heroin or crack at higher rates than younger adolescents.<sup>6</sup>

**INTERVENTION AND TREATMENT**

Auerswald and Eyre have suggested that those in the transitional states of the “life cycle of youth homelessness” are more open to intervention and outreach.<sup>10</sup> These transitional states refer to youth who are “first in the street” and those who are in “disequilibrium,” or in some conflict with their usual life of the street, such as having been robbed or assaulted.<sup>10</sup> At these times, youth are more likely to present to medical care and may be more receptive to strategies that will help them leave the street.

Practical ways of preparing for these opportunities include knowing what community resources exist prior to a patient presenting. Social workers are invaluable contacts for learning about homeless youth services. They can help get young people connected to shelters and can assist with any legal barriers to accessing care.

If social work services are not readily available, providers can contact local shelters, religious and community organizations directly. While services for homeless youth and homeless families are often kept separate from those for single adults,

shelters serving homeless adults will know which resources are available for youth.

**CONCLUSION**

Homeless youth who present for care are often in a state where they are more open to receiving care and exiting homelessness. While the stigma of homelessness may prevent a patient from disclosing his or her status, careful and compassionate questioning will provide an opportunity for intervention. Providers who are cognizant of community resources for homeless youth and who are willing to help can be useful allies and advocates for these vulnerable young people.

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