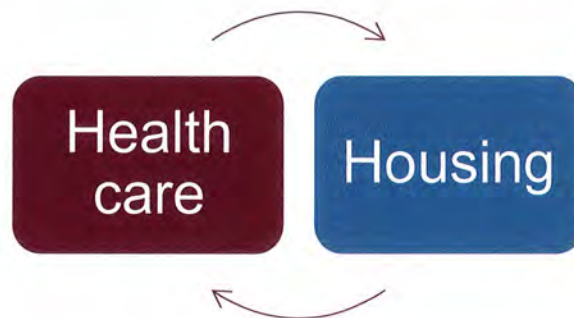




Plenary 10: Youth-oriented Comprehensive Health Care

Addressing the health-related needs of youth experiencing homelessness is key to their achieving and maintaining housing stability. Likewise, stable housing can support and promote positive health outcomes for youth.

Youth experiencing homelessness are a medically underserved population in the United States, despite being at risk of negative health outcomes. Homelessness can cause or exacerbate issues for youth across all sectors of health, including physical and oral health, behavioral health (addressing both mental health and substance use disorders), sexual and reproductive health, and social-emotional well-being. Poor health not only affects the physical, emotional, and mental well-being of youth, but also disrupts paths to housing stability, the ability to manage and cope with the challenges of homelessness, and overall quality of life.



Improving health outcomes for youth experiencing homelessness requires working with youth with lived experience to identify health needs, addressing barriers to accessing healthcare services, and developing strategies for bridging gaps in services or quality of care. Communities must also work with local healthcare partners to help overcome youth-identified barriers to care, improve the accessibility of healthcare services, and integrate youth-focused principles of care into the healthcare delivery system.

Note: This document was generated by technical assistance (TA) providers to support direct TA for the Forum on Ending Youth Homelessness, and it incorporates information from multiple sources without attribution to the original source material. References to original source material are provided in the relevant resource sections of this document. The information was collected from publicly available online sources and, therefore, not every piece of information may be completely accurate or up to date. Participants who notice incorrect or outdated information are encouraged to speak up so that everyone at the forum receives the most complete and current information available. This document is not endorsed by the U.S. Department of Housing and Urban Development (HUD), Substance Abuse and Mental Health Services Administration (SAMHSA), or any other federal agency, and it is not intended for distribution outside the Forum on Ending Youth Homelessness.



Healthcare Needs of Youth Experiencing Homelessness

Homelessness exposes youth to physical, mental, emotional, and social conditions that may negatively affect their overall health, safety, and wellness. The health impacts of homelessness are often exacerbated by prior or current experiences of neglect, exploitation, traumatization, violence, and substance use disorders.

Communities should work to stabilize housing and health concurrently, ensuring that youth receive wraparound services to meet their comprehensive health needs. This involves providing youth with access to a full continuum of care when they enter housing and service programs and extending this care through their transition.

In addressing the healthcare needs of youth experiencing homelessness, the importance of outreach cannot be overstated. Encouraging youth to access care may mean providing transportation vouchers or even telecommunications devices, the latter being important to most young people, but particularly valuable to youth experiencing homelessness.

PHYSICAL HEALTH¹

Need: Youth experiencing homelessness are at risk of many common acute problems, including the following:

- Respiratory problems such as tuberculosis (especially among youth with AIDS)
- Dermatological problems such as lice, scabies, acne, and staph infections
- Foot problems due to wet, cold, and exposed extremities
- Malnutrition due to food insecurity
- Injuries sustained from accidents or violence
- Infections due to improper wound care and exposure to bacteria
- Need for routine immunizations, including flu, Tdap, HPV, meningococcal conjugate, as well other vaccines unique to individual needs (e.g., hepatitis A and B)

Youth experiencing homelessness may also need care for chronic conditions, such as asthma, hypertension, obesity, diabetes, and epilepsy. These chronic conditions are more difficult to treat and manage without stable housing.

Interventions: Mobile clinic and street medicine teams can meet youth “where they are” to provide immediate medical care and referrals for continued care. Youth-serving health providers should strive to meet individual health and immediate care needs, while being understanding and flexible about follow-up care. In addition, healthcare providers need to use a strengths-based approach in their interactions with youth experiencing homelessness and to provide trauma-informed care. Health providers should also ask youth about their immunization status and administer the appropriate vaccines upon their consent.

¹ National Health Care for the Homeless Council (NHCHC). (2016, January). “Engaging youth experiencing homelessness: Core practices and services.”; Eliot, A. S. and the Canadian Paediatric Society. (2013, June-July). “Meeting the health care needs of street-involved youth.” *Paediatric Child Health*, 18(6), 317–321.



ORAL HEALTH²

Need: Youth experiencing homelessness may experience dental disease due to malnutrition, difficulties maintaining regular oral care habits, tobacco (cigarettes and smokeless tobacco) and alcohol use. Dental abscesses require urgent treatment and periodontal disease leads to significant halitosis and eventual tooth loss. Oral health conditions are not only common negative health outcomes but can also hinder youths' attempts to improve their life circumstances. Decayed, missing, or misaligned teeth can lower an individual's self-esteem and have an impact on social interactions, including attempts to find employment.

Interventions: Oral health services, including preventive and restorative services, should be incorporated into the comprehensive wraparound healthcare services available to youth experiencing homelessness.

SEXUAL HEALTH³

Youth experiencing homelessness are at heightened risk of sexually transmitted infections (STIs), including HIV, and pregnancy if they are engaged in voluntary sexual activity or survival sex,⁴ or are sexually assaulted. Risks increase with multiple partners, high-risk partners, survival sex, and inconsistent use of safer sexual practices. All youth experiencing homelessness are at risk of sexual violence and this risk increases among those who engage in survival sex. Levels of risk when engaging in survival sex are higher for unsheltered youth than sheltered youth.

Interventions: Youth-serving health providers can provide STI prevention, testing, and treatment services aimed at engaging youth through onsite and mobile clinics. Sexual education, including information on safer sex practices, should be offered (but not required) to youth receiving care. Sexual health services available to youth should be comprehensive, including preventive healthcare services such as Pap smears for youth age 21 or older, access to effective contraception, and access to reproductive health counseling for lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth.

REPRODUCTIVE HEALTH & PREGNANCY⁵

Rates of pregnancy correlate with housing status; data suggest about 50 percent of unaccompanied youth have had a pregnancy experience, and one study showed that both accompanied and unaccompanied young men experiencing homelessness were less likely to use contraception (30 percent) than their housed counterparts (60 percent).

² U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). (2001, January).

"Understanding the health care needs of homeless youth."; Eliot, A. S. and the Canadian Paediatric Society. (2013, June-July).

"Meeting the health care needs of street-involved youth." *Paediatric Child Health*, 18(6), 317-321

³ NHCHC. (2016, January). "Engaging youth experiencing homelessness: Core practices and services."; HRSA. (2001, January).

"Understanding the health care needs of homeless youth."

⁴ The term "survival sex" refers to engaging in sexual activities to secure basic needs, such as food, clothing, or shelter.

⁵ NHCHC. (2016, January). "Engaging youth experiencing homelessness: Core practices and services."



Interventions: Youth-serving programs and health providers can offer services that may help limit the number of unplanned pregnancies, including distributing condoms and making referrals for sexual education, contraception,⁶ and pregnancy termination services. Tailored services can also be provided for youth who are pregnant or already parents, including access to substance use disorder treatment, parenting classes, child care, transportation assistance, visiting nurse programs, and midwifery support groups. Pregnant youth using opioids have high-risk pregnancies and need referral to programs offering medication-assisted treatment, such as buprenorphine or methadone.

HIV/AIDS⁷

Youth experiencing homelessness, particularly youth engaged in street culture, are at a heightened risk of HIV infection. Two prominent risk factors for HIV infection are survival sex work and injection drug use.

Interventions: Youth-serving programs and health providers can increase the prevention and treatment of HIV infections among youth experiencing homelessness by offering educational outreach on HIV status, providing access to Pre-Exposure Prophylaxis (PreP) and other HIV prevention options, providing regular HIV testing services in mobile and onsite clinics, supporting treatment adherence for HIV-positive youth, and investing in supportive housing targeted to HIV-positive youth who are experiencing or at-risk of homelessness.

MENTAL HEALTH⁸

Youth experiencing homelessness are at a greater risk of developing mood disorders, bipolar disorder, conduct disorder, and posttraumatic stress disorder (PTSD), and of attempting suicide than housed youth. The prevalence of mental health conditions among youth experiencing homelessness increases with histories of sexual abuse, exploitation, traumatization, and violence, and may precede homelessness.

Interventions: Mental health screening and treatment for depression, anxiety, and other mood disorders; suicidality; and PTSD should be integrated into youth-serving healthcare settings and wraparound services. Youth-serving programs should post numbers for the local 24/7 crisis hotline and the National Suicide Prevention Lifeline to assist youth having mental health crises when health providers are not on call or available. Youth-serving health providers also need to provide additional support for medication management for youth experiencing homelessness who have mental health needs. It is helpful for youth-serving health providers to be able to refer youth to, and consult with, mental health specialists to ensure access to treatment services and skillful assistance in managing both crises and chronic conditions among youth experiencing homelessness.

⁶ For example, long-acting reversible contraceptive methods [LARC] are low maintenance and do not require user action.

⁷ Eliot, A. S. and the Canadian Paediatric Society. (2013, June-July). "Meeting the health care needs of street-involved youth." *Paediatric Child Health*, 18(6), 317–321.

⁸ NHCHC. (2016, January). "Engaging youth experiencing homelessness: Core practices and services."; Eliot, A. S. and the Canadian Paediatric Society. (2013, June-July). "Meeting the health care needs of street-involved youth." *Paediatric Child Health*, 18(6), 317–321.



SUBSTANCE USE & CO-OCCURRING DISORDERS⁹

Youth experiencing homelessness are significantly more likely to use alcohol, marijuana, and other potentially harmful substances, including illicit use of prescription medicines, than the general population. In addition, use of opioids, including prescription opioids and heroin, are increasing among older youth. Substance use is often a means of coping with the stress and instability of homelessness, although many youth also report substance use prior to becoming homeless. Additionally, substance use disorders frequently co-occur with mental health disorders such as depression, PTSD, and bipolar disorder. Youth identified as having a conduct disorder are at high risk of substance use disorders and depression; they may also be at higher risk of suicide.

Interventions: Using evidence-based tools designed for adolescents, youth-serving programs and health providers should screen all youth experiencing homelessness for substance use and determine the degree to which they are involved with harmful use. Providers should also screen for fetal alcohol syndrome disorders. They should offer youth-oriented substance use disorder treatment and support groups, using harm reduction and Motivational Interviewing to approach young people with substance use disorders to help them feel welcomed and accepted when receiving services. Recovery-oriented programs and peer recovery networks can also provide safe, nonjudgmental environments for youth to receive services.

TRAUMA¹⁰

Research suggests that most youth experiencing homelessness have experienced multiple traumatic events. While a large number experience trauma before leaving home, many are re-traumatized while experiencing homelessness, including by the trauma inherent in the experience of homelessness itself.

Common traumatic events include:

- Child physical and sexual abuse and neglect
- Witnessing community violence or violence at home between parents or caregivers
- Removal from home by child protective services
- Incapacitation of parents due to mental illness, substance use, or incarceration
- Experiencing violence in their own relationships
- Harassment or violence due to homelessness, sexual orientation, and/or gender identity
- Physical and sexual assault on the street
- Incarceration
- Engaging in survival sex or prostitution

Interventions: Programs should screen for histories of trauma and provide health, housing, and social services, and transportation to those services, in accordance with the principles of trauma-informed care and positive youth development. Youth-serving programs and health providers should consider implementing proven treatment modalities for trauma, such as narrative therapy, eye movement desensitization and reprocessing (EMDR) therapy, expressive arts, and acute therapy interventions.

⁹ NHCHC. (2016, January). "Engaging youth experiencing homelessness: Core practices and services."; National Network for Youth. (n.d.). "Consequences of youth homelessness"; U.S. Department of Health and Human Services, Family and Youth Services Bureau. (2016, April). "Street outreach program data collection study."

¹⁰ National Child Traumatic Stress Network. (2009). "Psychological First Aid for Youth Experiencing Homelessness."



Resources

- **[Ending Youth Homelessness Guidebook Series: Mainstream System Collaboration](#)**: August 2016 HUD publication for the YHDP on coordinating with mainstream systems to design and implement an effective system for preventing and ending youth homelessness
- **[Engaging Youth Experiencing Homelessness: Core Practices and Services](#)**: January 2016 report by the National Health Care for the Homeless Council (NHCHC) on the health needs of youth experiencing homelessness, barriers to services, and strategies for youth engagement in health care
- **[Street Outreach Program Data Collection Study, U.S. Department of Health and Human Services, Family and Youth Services Bureau](#)**: 2016 U.S. Department of Health and Human Services (HHS) report on the Street Outreach Program that includes data on mental health, substance use, sexual health, and more
- **[Youth Homelessness in San Francisco: 2014 Report on Incidence and Needs](#)**: 2014 publication by Larkin Street Youth Services detailing the comprehensive needs of youth experiencing homelessness in San Francisco and the United States, including health needs and challenges faced by youth
- **[Meeting the Health Care Needs of Street-involved Youth](#)**: 2013 research study identifying the healthcare needs of youth experiencing homelessness in the United States and Canada, including barriers to accessing healthcare services, and recommendations for improving services and outcomes of youth experiencing homelessness who are engaged in care
- **[Psychological First Aid for Youth Experiencing Homelessness](#)**: 2009 manual by the National Child Traumatic Stress Network (NCTSN) on homelessness and trauma among youth providing a framework and model for intervention by direct care staff working in drop-in centers, emergency and transitional shelters, and group homes
- **[Culture and Trauma Brief: Trauma Among Homeless Youth](#)**: 2007 issue brief by the NCTSN on the consequences of trauma and homelessness for youth
- **[Understanding the Health Care Needs of Homeless Youth: Program Assistance Letter](#)**: 2001 letter developed by the Health Care for the Homeless Branch addressing the healthcare needs of youth experiencing homelessness and published by the HHS Bureau of Primary Health Care
- **[Consequences of Youth Homelessness](#)**: Issue brief by the National Network for Youth (NN4Y) examining the consequences of youth homelessness for both youth and society, including the impact of homelessness on mental health, substance use disorders, and sexual practices
- **[The National Child Traumatic Stress Network's Featured Resources for National Homeless Youth Awareness Month](#)**: Numerous resources compiled to help communities, families, educators, mental health and child welfare professionals, policy makers, and advocates better understand youth experiencing homelessness



Disproportionate Health Outcomes for Populations of Focus

Health risks are disproportionately high among youth of color, as well as youth who are LGBTQ, victims of sexual trafficking and exploitation, and pregnant or parenting. Communities should work to increase the capacity of local healthcare providers to meet the healthcare needs of populations of focus among youth and institutionalize culturally appropriate, engaging, and inclusive care practices.

YOUTH OF COLOR¹¹

- Regardless of income level, Black and Latino adolescents experience disproportionate rates of HIV infections, STIs, and unintended pregnancies.
- Although rates of mental disorders for youth of color are similar to rates for all youth, mental health needs among youth of color are less likely to be identified and treated with prevention or early intervention services by healthcare professionals, resulting in more severe negative health outcomes.
- Youth of color are at an increased risk of trauma resulting from experiences of racism or ethnic discrimination, including racially motivated incidences of violence and abuse.

LGBTQ+ YOUTH¹²

- LGBTQ+ youth experiencing homelessness are at a higher risk of depression, PTSD, suicidal thoughts and attempts, and alcohol and substance use disorders as a result of trauma than any of their peers.
- LGBTQ+ youth are at a heightened risk of violence prior to and during homelessness, often due to homophobia, transphobia, or familial rejection and abuse.
- STIs and HIV are a heightened health concern for some LGBTQ+ youth populations, particularly men who have sex with men, transgender women, and youth engaged in survival sex. LGBTQ+ youth experiencing homelessness are more likely to engage in survival sex than their heterosexual peers.

PREGNANT AND PARENTING YOUTH¹³

- Pregnant youth experiencing homelessness are more likely to lack access to prenatal care than their housed counterparts. As a result, they experience an increased risk of low-birthweight babies and high infant mortality.
- Pregnant or parenting youth experiencing homelessness are significantly more likely than their non-parenting peers to report being diagnosed with either depression or

¹¹ National Association of Social Workers. (2001, November). "Adolescent health and youths of color." Practice Update from the National Association of Social Workers.

¹² LGBT Health Education Center. (2012). "Improving the health care of lesbian, gay, bisexual, and transgender people: Understanding and eliminating health disparities."; Walls, N. E., Hancock, P., & Wisneski, H. (2007, September). "Differentiating the social service needs of homeless sexual minority youths from those of non-homeless sexual minority youths"; Michelle Page (Winter 2017). "Forgotten Youth: Homeless LGBT Youth of Color and the Runaway and Homeless Youth Act." *Northwestern Journal of Law & Social Policy*, Vol. 12, Issue 2.

¹³ U.S. Department of Health and Human Services, Family and Youth Services Bureau. (2016). "Parenting and homeless: Profiles of young adult mothers and fathers in unstable housing situations."



bipolar disorder and to have experienced a significantly higher number of traumatic events during childhood.

VICTIMS OF SEXUAL TRAFFICKING AND EXPLOITATION¹⁴

- Youth who have been trafficked are at a heightened risk of physical and sexual health issues associated with exploitation and abuse, including broken bones and other untreated internal and external injuries; sexually transmitted diseases, including HIV; and malnutrition.
- Youth who have been trafficked are at a very high risk of trauma and complex mental and emotional health needs, including extreme anxiety, an inability to trust, self-destructive behaviors, profound shame or guilt, and despair and hopelessness.

INTERSECTIONALITY

Youth experiencing homelessness may be part of multiple populations of focus which can result in compounded health risks and potentially negative health outcomes. The intersectional health needs and the impact of concurrent health disparities for youth who belong to multiple populations of focus should be considered when developing youth-specific, culturally competent health services and interventions.

Resources

- [Forgotten Youth: Homeless LGBT Youth of Color and the Runaway and Homeless Youth Act](#): Winter 2017 report providing insight into the needs of youth of color experiencing homelessness from an intersectional perspective
- [Engaging Youth Experiencing Homelessness: Core Practices and Services](#): January 2016 report by the NHCHC on the health needs of youth experiencing homelessness, barriers to services, and strategies for engaging youth in health care
- [Parenting and Homeless: Profiles of Young Adult Mothers and Fathers in Unstable Housing Situations](#): 2016 research study identifying the health and social challenges faced by unstably housed pregnant and parenting youth
- [Human Trafficking and Child Welfare: A Guide for Case Workers](#): July 2017 bulletin by the Child Welfare Information Gateway and the Children's Bureau of the Administration for Children and Families addressing the needs of trafficking victims and the ways that child welfare caseworkers can address the trafficking of children
- [Children with Emotional Disorders in the Juvenile Justice System](#): 2015 position statement by Mental Health America on creating an effective system of care for youth with emotional disorders in the juvenile justice system, including a profile of the behavioral health characteristics of juvenile justice system-involved youth
- [Examining Homeless Outcomes Among Foster Care Youth in Wisconsin](#): 2014 profile of health and housing outcomes for youth involved in the foster care system in Wisconsin and nationwide

¹⁴ U.S. Department of Health and Human Services, Family and Youth Services Bureau, Children's Bureau. (2015, July). "Child welfare and human trafficking."



- **Improving the Health Care of Lesbian, Gay, Bisexual, and Transgender People: Understanding and Eliminating Health Disparities**: 2012 report by the LGBT Health Education Center on the health disparities affecting LGBTQ populations in the U.S.
- **Differentiating the Social Service Needs of Homeless Sexual Minority Youths**: 2007 research study on the disproportionate health risks experienced by homeless sexual-minority youths compared to non-homeless sexual-minority youths
- **Understanding the Health Care Needs of Homeless Youth: Program Assistance Letter**: 2001 letter developed by the Health Care for the Homeless Branch addressing the healthcare needs of youth experiencing homelessness and published by the HHS Bureau of Primary Health Care
- **Adolescent Health and Youths of Color**: 2001 research update from the National Association of Social Workers on the trends and health outcomes for youth of color



Risk and Protective Factors

Risk factors are characteristics at the individual, family, or community level that are associated with a higher likelihood of negative health, housing, and social outcomes for youth. **Protective factors** are characteristics that counteract the effects of risk and are associated with a lower likelihood of youth experiencing negative health, housing, and social outcomes. Risk and protective factors can inform screening and assessment methods and affect the development of system-level strategies and interventions as part of a community's coordinated response for preventing and ending youth homelessness.

STATIC VS. DYNAMIC RISK AND PROTECTIVE FACTORS



Static Factors

Static risk and protective factors, such as age, race, and histories of trauma and abuse, are factors that are not modifiable or changeable through intervention.



Dynamic Factors

Dynamic risk and protective factors are potentially changeable factors, such as connections with school and employment, that can be targeted through intervention.

Communities can target housing and service interventions toward increasing dynamic protective factors and decreasing dynamic risk factors for youth experiencing homelessness.

DYNAMIC RISK FACTORS FOR YOUTH EXPERIENCING HOMELESSNESS

Trauma

Experiences of trauma can lead to lasting emotional and psychological damage, potentially increasing risk-taking behavior and inhibiting youth from utilizing the psychosocial skills necessary to transition out of homelessness.

Emotional distress

Housing instability may create fear, anger, anxiety, or suffering for youth, which may cause or exacerbate mental illness, substance use disorders, or self-harming behaviors.

Sexual risk behavior

Sexual risk behaviors may include unprotected sex, sexual activity at an earlier age, having multiple partners, having sex with high-risk partners, and engaging in survival sex. These behaviors increase the risk of negative health outcomes such as STIs and HIV.

Family problems

Family problems can result in trauma, insufficient social and emotional support, and can make it unlikely or impossible for youth to exit homelessness through family reunification.

Substance use disorders

Drug and alcohol use can lead to negative and potentially fatal health outcomes related to dependency and addiction. Substance use disorders also causes impairment, which may decrease decision-making skills and increase the risk of interaction with law enforcement.



Justice system involvement Justice system involvement and homelessness are risk factors for each other. Youth who are involved with the justice system have high histories of abuse, risky behavior, and running away, and youth who have been incarcerated may exit the justice system to unstable housing conditions.

DYNAMIC PROTECTIVE FACTORS FOR YOUTH EXPERIENCING HOMELESSNESS

School engagement or employment

Education or employment can provide structure, stability, the development of life skills, and a connection with caring adults and a learning community. Education can also connect youth with short-term supports such as meals and counseling, and employment decreases the need for youth to engage in risky or illegal behaviors to address their financial needs.

Family cohesion and support

Family cohesion and support can provide a sense of connectedness, stability, and acceptance for youth, as well as opportunities for family reunification as a pathway out of homelessness or housing instability.

Survival skills

The ability to live independently and cope with problems or challenges as they occur supports resiliency among youth.

Positive connections

Positive connections with family, friends, peers, and caring adults facilitate the creation of a strong support system for youth. These connections can provide a “social safety net” to help youth achieve stability.

Positive future expectations

Hopefulness or optimism about the future support positive mental health and can help youth cope with challenges and stress related to their current circumstances.

Decision-making skills

Youth with good decision-making skills are more likely to avoid risky behaviors and adopt safe, healthy behaviors.

Self-esteem and self-efficacy

Believing in oneself and one’s ability to succeed can support positive mental health and encourage youth to engage with opportunities for stability to transition out of homelessness.

Good health

Good health supports the overall functioning and well-being of youth, including managing difficult physical, mental, and social conditions while unstably housed, as well as supporting pathways to stable housing and economic stability.



Resources

- [Ending Youth Homelessness Policy Summit](#): July 2016 USICH presentation detailing the role of risk and protective factors in developing a coordinated community response to ending youth homelessness
- [Framework to End Youth Homelessness: A Resource Text for Dialogue and Action](#): February 2013 report by USICH detailing a framework for ending youth homelessness
- [Unaccompanied Youth Intervention Model](#): Model developed in 2012 by the United States Interagency Council on Homelessness (USICH) that incorporates risk and protective factors into system planning efforts
- [Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle](#): 2011 HHS publication tracking risk and protective factors for mental, emotional, and behavioral disorders from infancy to early adulthood
- [Understanding the Health Care Needs of Homeless Youth: Program Assistance Letter](#): 2001 letter developed by the Health Care for the Homeless Branch addressing the healthcare needs of youth experiencing homelessness and published by the HHS Bureau of Primary Health Care
- [Consequences of Youth Homelessness](#): Issue brief by the National Network for Youth (NN4Y) examining the consequences of youth homelessness for both youth and society, including the impact of homelessness on mental health, substance use disorders, and sexual practices



Barriers to Accessing Healthcare Services

Youth experiencing homelessness face distinct challenges and barriers to accessing healthcare services. Age and housing status can create or exacerbate structural barriers to accessing healthcare services, which include financial and legal challenges to obtaining care. Youth also face distinct social barriers to accessing care, including discrimination, bias, and lack of cultural competency when seeking health services or interacting with healthcare providers.

Communities should engage both youth experiencing homelessness and local healthcare partners in identifying and addressing barriers to care and creating accessible, affordable, and appropriate service delivery options for youth.

BARRIER TO HEALTH CARE: DISCRIMINATION & BIAS¹⁵



When seeking access to healthcare services, youth experiencing homelessness may face discrimination or bias based on substance use, age, culture, racial or ethnic identity, sexual orientation, gender identity, weight, mental illness, and engagement in sexual activities.

Youth who are unstably housed may also experience discrimination or negative attitudes based on their housing status. Such experiences may discourage youth from seeking care or disclosing their housing status to healthcare providers.

Communities should work with youth with lived experience and local service providers to develop strategies for addressing discrimination and bias. Such strategies may include:

- Collaboration with youth with lived experience to assist in raising awareness in their social circles and communities to reduce external and internal bias.
- Training for local healthcare providers to ensure that staff at all levels provide culturally competent, appropriate, and nonjudgmental care with an awareness of and a sensitivity to the needs of youth experiencing homelessness.
- Public education campaigns for mental health that acknowledge the effects of compounded discrimination and bias for youth experiencing homelessness who have behavioral health needs.
- Psycho-education outreach to homeless shelters and drop-in centers.
- Collaboration between homeless service providers and juvenile justice systems to provide mental health assessments for youth experiencing homelessness as part of discharge or contingency planning.

¹⁵ Dee Balliet (May 24, 2018). Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Homeless and Housing Resource Network Youth Spotlight Series. "Creating and Strengthening Points of Connection to Better Serve Youth with Behavioral Health Needs Who Are Experiencing Homelessness – Intersections of Youth and the Experience of Homelessness."



STRUCTURAL & FINANCIAL BARRIERS TO HEALTH CARE

Lack of youth-oriented healthcare settings	Youth may feel intimidated or uncomfortable receiving care in traditional, adult-oriented healthcare settings. Youth-oriented healthcare settings (separate site or co-located with adult care settings) create a safer, more reassuring environment for youth to seek healthcare services among peers.
Inaccessible hours of operation	Standard hours of operation for health clinics may not accommodate youth. Offering hours of operation on evenings and weekends provides flexible opportunities for youth to access care.
Inaccessible locations	Affordable healthcare providers and clinics may not be in locations that are safe or easily accessible for youth. A lack of transportation can prevent youth from accessing health services, particularly if healthcare providers are not easily accessible via public transportation. Mobile health services and providing access on a regular basis to onsite medical care in housing services and shelters can help youth overcome transportation barriers.
Demanding processes for accessing services	Address requirements, lengthy waiting times, and detailed intake forms can be intimidating for youth and can discourage seeking treatment for non-urgent healthcare needs. Providing flexible hours that allow streamlined access to services for youth and employing knowledgeable staff to assist youth with intake can help alleviate the demands of accessing health services for youth.
Lack of financial resources	Youth experiencing homelessness often lack the financial resources to regularly access medical care. Communities can increase outreach to youth and promote awareness of local federally qualified health centers (FQHCs), rural health clinics, and clinics that provide free or sliding-scale health services.
Lack of health insurance	Unaccompanied youth often lack health insurance coverage due to lack of documentation to support their application for coverage. Youth who are experiencing or at risk of homelessness are likely to be eligible for Medicaid coverage in their state of residence; legal aid can be provided to help youth through the application and documentation process.
Lack of coordinated health services	Youth experiencing homelessness engage with and benefit from healthcare services the most when they are a component of a network of connected and coordinated service providers helping them with interrelated needs such as shelter, food, education, and life skills training.



Obtaining services without parental consent

Laws on the types of services that unaccompanied youth under age 18 can receive without parental consent vary state by state. Many states allow minors to consent to treatment in limited circumstances, including emergency treatment of life-threatening conditions, diagnosis and treatment of STIs, treatment related to a pregnancy, drug or alcohol treatment, and treatment of mental illness.

Lack of comprehensive healthcare options

Services that are accessible to youth may not include the full range of services needed to meet their comprehensive healthcare needs. Services should include primary and preventive care, sexual health, mental health, and substance use disorder treatment (and, when useful, access or referrals to complementary medicine).

Limited service capacity in rural areas

Service capacity and resource limitations may be particularly challenging in rural and sparsely populated areas. The National Alliance to End Homelessness (NAEH) suggests relying heavily on needs and asset assessments when planning for services and programs to overcome this barrier to youth engagement.

SOCIAL BARRIERS TO HEALTH CARE

Concerns over confidentiality of care

Youth may avoid accessing healthcare services due to concerns regarding confidentiality of care. Confidentiality is a particular concern for youth with child welfare status who have run away from their last placement, youth involved with the juvenile justice system, and youth who fear that they will be reported to authorities if they engage with the healthcare system. Outreach workers and healthcare providers should actively inform youth of their right to confidentiality and address any confidentiality issues before a health encounter.

Balancing health care with the realities of homelessness

Healthcare providers may not be aware of the realities of homelessness that complicate the health status of youth, including difficulty following through with referrals or purchasing and securely using medications. Healthcare providers can work to “meet youth where they are,” including making treatment regimens and referrals as simple and straightforward as possible and offering walk-in and evening appointments for follow-up care.

Lack of trust for medical care providers

Past experiences may make it difficult for youth experiencing homelessness to trust adults, including healthcare providers, and formalized systems of care. Outreach workers and healthcare providers should recognize this and work to build trust and respect. Offering opportunities for continuity of care can help youth build relationships and trust with providers.



Communication skills	Healthcare providers' tone and language can affect youth healthcare experiences. Healthcare providers should use easily understandable and accessible language to talk to youth regarding their health and recognize that communication is more effective in a compassionate, rather than lecturing, tone.
Lack of health education	Youth experiencing homelessness may lack health education, preventing them from accessing health services or practicing self-care. Outreach workers and providers can give youth information on healthy practices, using health insurance to access care, and navigating the healthcare system.
Lack of knowledge of available resources	Youth, especially individuals newly experiencing homelessness, may lack knowledge of available services and assistance. Communities should engage in youth-targeted outreach and marketing, informed by the advice of youth and the participation of community partners.
Non-prioritization of health	Youth experiencing homelessness may prioritize other basic needs, such as food and shelter, over health care, which can be more difficult to obtain and maintain. Outreach workers and health providers can work with youth to understand the impact of health on other aspects of their life and well-being.

Resources

- [**Creating and Strengthening Points of Connection to Better Serve Youth with Behavioral Health Needs Who Are Experiencing Homelessness:**](#) May 2018 Substance Abuse and Mental Health Service Administration (SAMHSA) webinar as part of the Homeless and Housing Resource Network's Youth Spotlight Series focused on developing and strengthening meaningful points of connection for youth with behavioral health needs
- [**Ending Youth Homelessness Guidebook Series: Mainstream System Collaboration:**](#) August 2016 HUD publication for YHDP on coordinating with mainstream systems to design and implement an effective system for preventing and ending youth homelessness
- [**Engaging Youth Experiencing Homelessness: Core Practices and Services:**](#) January 2016 report by the NHCHC on the health needs of youth experiencing homelessness, barriers to services, and strategies for youth engagement in health care
- [**Meeting the Health Care Needs of Street-involved Youth:**](#) 2013 research study identifying the healthcare needs of youth experiencing homelessness in the United States and Canada, including barriers to accessing healthcare services, and recommendations for improving services and outcomes of youth experiencing homelessness who are engaged in care
- [**Unaccompanied Youth's Rights to Consent for Medical Treatment:**](#) November 2011 issue brief from the National Association for the Education of Homeless Children and Youth (NAEHCY) on state laws regarding a youth's right to consent to medical treatment



- **Health-seeking Challenges Among Homeless Youth**: 2010 research study on the perspective of young adults experiencing homelessness regarding barriers and facilitators to accessing healthcare services
- **Quality of Health Care: The Views of Homeless Youth**: 2004 research study from Seattle, Washington, on factors and barriers influencing the quality of health care for youth experiencing homelessness
- **Health Coverage for Homeless and At-risk Youth**: Issue brief from the Office of The Assistant Secretary for Planning and Evaluation (ASPE) on providing health coverage under the Affordable Care Act (ACA) to youth experiencing and at risk of homelessness
- **Understanding the Health Care Needs of Homeless Youth: Program Assistance Letter**: 2001 letter developed by the Health Care for the Homeless Branch addressing the healthcare needs of youth experiencing homelessness and published by the HHS Bureau of Primary Health Care



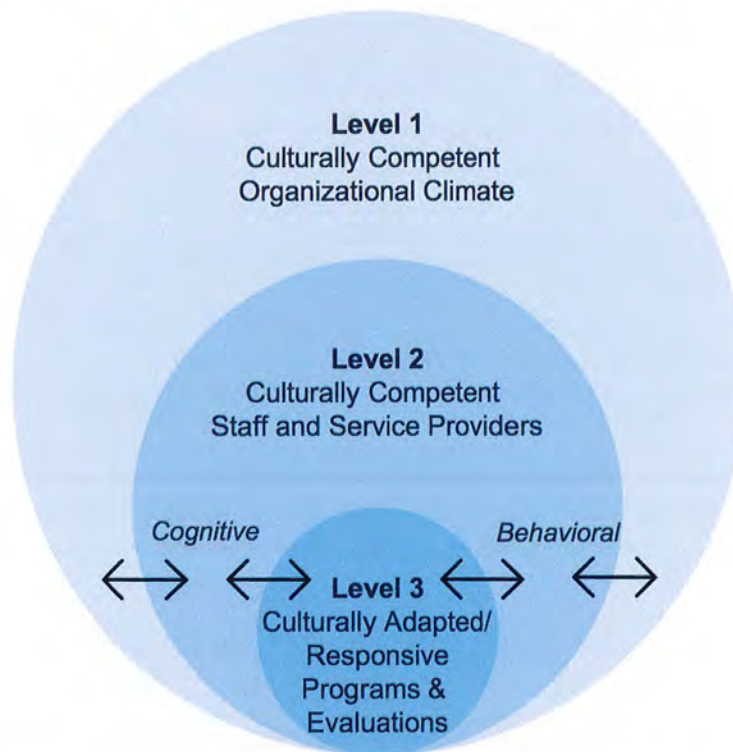
Youth-oriented Practice Frameworks

The practice frameworks used in service delivery are central to breaking down barriers to accessing services for youth experiencing homelessness. Communities should implement practice frameworks that reflect best practices for youth and that support a strengths-based, inclusive approach to comprehensive care.

CULTURAL COMPETENCE

Cultural competence is the ability of providers to effectively deliver services that meet the social, cultural, and linguistic needs of youth. Providers should be alert to their own cultural frameworks and presuppositions, to the cultures of youth, and to the ways in which the differences play out in the provider–client relationship. Nonjudgmental acceptance of youth and their respective cultures is key to developing a trusting client–provider relationship.

Cultural Competence Organizational Model



- **Cultural competence at the organizational level** promotes ongoing awareness, knowledge, and skill development among staff concerning diverse cultures.
- **Cognitive** (i.e., critical awareness, knowledge) and **behavioral** (i.e., skill-based) **cultural competence** among staff facilitates the delivery of culturally appropriate services and programs.
- **Culturally competent staff** are more effective at engaging and serving more diverse populations.
- **Diverse consumers** help staff advance and attune their cultural competency skills.



POSITIVE YOUTH DEVELOPMENT

Positive youth development is an intentional, pro-social approach that engages youth within their communities, schools, organizations, peer groups, and families; recognizes, utilizes, and enhances young adults' strengths; and promotes positive outcomes for youth through opportunities, positive relationships, and leadership development.

The Five C's of Positive Youth Development



Confidence

An internal sense of overall positive self-worth and self-efficacy.



Competence

Positive view of one's social, academic, cognitive, health, and/or vocational actions.



Connection

Positive bonds with people and institutions.



Character

A sense of right and wrong; respect and integrity.



Caring/Compassion

A sense of sympathy and empathy for others.

A youth with the five thriving characteristics is on the path to attaining a sixth "C": **Contribution** to self, family, community, and civil society. It is the sixth "C" that leads to positive adulthood.



HARM REDUCTION

Harm reduction refers to policies and practices that primarily aim to reduce adverse health, social, and economic consequences of high-risk behaviors and to benefit people engaging in high-risk behaviors. Harm reduction can help engage youth with the highest risks and greatest healthcare needs while respecting youth choice and independence.

Core Elements of Harm Reduction for Youth Experiencing Homelessness

Remove barriers to program entry and participation based on high-risk behaviors.	1	
	2	Engage with youth respectfully and non-coercively.
Provide information on risks, safer options, and strategies for harm reduction.	3	
	4	Allow youth to drive goal-setting and service planning.
Focus on the youth's immediate needs and attainable goals.	5	
	6	Prioritize building relationships with youth.
Emphasize personal responsibility for natural consequences of the youth's behavior.	7	
	8	Identify and connect with resources within the community.



TRAUMA-INFORMED CARE

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals. Youth pathways into homelessness and experiences with homelessness itself are commonly understood to be traumatic experiences, requiring that engagement efforts, treatment, and service responses be trauma informed.

The Four R's of a Trauma-informed Program, Organization, or System

Realizes the widespread impact of trauma and understands potential paths to recovery

Recognizes the signs and symptoms of trauma in clients, families, and others involved with the system

Responds by fully integrating knowledge about trauma into policies, procedures, and practices

Seeks to actively resist *re-traumatization*

MULTI-DISCIPLINARY TEAM MODEL

A **multi-disciplinary team model** involves professionals from a range of disciplines working together to deliver comprehensive care that addresses as many of the patient's needs as possible. Team members coordinate care through case conferencing while providing specialized care in their area of expertise.

Key Multidisciplinary Youth Homelessness Team Members

Youth shelter
case manager

Public health
nurse

Behavioral
health clinician

Independent
living skills
(ILSP)

Legal aid

Juvenile
probation

Office of
Education
homeless
liaison



Resources

- [**Creating and Strengthening Points of Connection to Better Serve Youth with Behavioral Health Needs Who Are Experiencing Homelessness:**](#) May 2018 Substance Abuse and Mental Health Service Administration (SAMHSA) webinar as part of the Homeless and Housing Resource Network's Youth Spotlight Series focused on developing and strengthening meaningful points of connection for youth with behavioral health needs *[note: this resource may require the creation of an Adobe Connect account for log-in access]*
- [**Engaging Youth Experiencing Homelessness: Core Practices and Services:**](#) January 2016 report by the NHCHC on the health needs of youth experiencing homelessness, barriers to services, and strategies for engaging youth in health care
- [**Enhancing Cultural Competence in Social Service Agencies: A Promising Approach to Serving Diverse Children and Families:**](#) March 2014 research brief summarizing the state of the field on cultural competence in social services
- [**Harm Reduction: Preparing People for Change:**](#) April 2010 fact sheet by the NHCHC that defines the key features of harm reduction and provides examples of the harm reduction principles in practice
- [**Shelter from the Storm: Trauma-informed Care in Homelessness Services Settings:**](#) 2009 research study on best practices and case studies for implementing trauma-informed care into health and housing programs and services for individuals experiencing homelessness
- [**Ways to Promote the Positive Development of Children and Youth:**](#) 2008 Child Trends brief on the elements and features that define positive youth development and highlights for supporting the positive development of children and youth
- [**Principles of Harm Reduction:**](#) Definition of the principles of harm reduction from the Harm Reduction Coalition
- [**Homeless Youth Online Course:**](#) An 11- lesson National Child Traumatic Stress Network course designed for direct care staff working with youth experiencing homelessness that covers a range of topics, including adolescent development and risk behaviors, HIV testing, resiliency, and trauma *[note: this resource requires participants to establish a free account to access online courses]*
- [**SAMHSA's Youth Engagement Guidance: Strategies, Tools, and Tips for Supportive and Meaningful Youth Engagement in Federal Government-sponsored Meetings and Events:**](#) Resources to support youth services, development, leadership, and organizing, as well as civic engagement



Evidence-based and Evidence-informed Interventions for Youth At-risk of or Experiencing Homelessness

Evidence-based and evidence-informed interventions should be utilized by youth-serving programs and health providers as part of their response to addressing the comprehensive care needs of youth at risk of or experiencing homelessness. The interventions below are youth-oriented, strengths-based, and supportive of the social-emotional well-being of youth. Many interventions also support strategies for addressing familial conflict and helping youth build social stability and supports, thus helping youth build pathways to long-term personal stability.

EVIDENCE-BASED AND EVIDENCE-INFORMED INTERVENTIONS

Community Reinforcement Approach (CRA)	A behavioral intervention that addresses substance use disorders, social stability, and physical and mental health issues. The Adolescent Community Reinforcement Approach (A-CRA) is tailored for use with youth. A-CRA uses behavioral and cognitive intervention strategies to influence behavior.
Ecologically Based Family Therapy (EBFT)	EBFT is a substance use reduction intervention that focuses on decision-making, emotional regulation, and other intrapersonal factors that may influence substance use and other risky behaviors.
Functional Family Therapy (FFT)	FFT is an empirically grounded, well-documented, and highly successful family intervention for youth ages 10 to 18 with behavioral, emotional, or substance use disorders. A hallmark of this intervention is its ability to fit an array of service delivery settings where at-risk youth are served.
Street Smart	An intensive program to prevent HIV/AIDS and other STIs among runaway and homeless youth ages 11 to 18 who engage in high-risk sexual behaviors. It is a multisession, manual-guided, small-group intervention that teaches effective behavior change, problem-solving skills, and strategies for increasing safer sexual behaviors.
Support to Reunite, Involve, and Value Each Other (STRIVE)	STRIVE is a family-based intervention for runaway and homeless youth ages 12 to 17 that aims to increase residential stability, decrease runaway episodes, and decrease HIV risk. It is a five-session, in-home program that works to repair youths' relationships with their families.
Cognitive Behavioral Therapy (CBT) for adolescent depression	This is an adaptation for youth of the classic cognitive therapy model, which assumes that people's moods are directly related to their patterns of thought. The goal of CBT is to help a person learn to recognize negative patterns of thought, evaluate their validity, and replace them with healthier ways of thinking.



Motivational Interviewing (MI)

This is a goal-directed, client-centered counseling style where the goal is to seek behavioral change by helping clients explore and resolve ambivalence.

Trauma-focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with parent–youth sessions increasingly incorporated over the course of treatment.

Resources

- [9 Evidence-based Guiding Principles to Help Youth Overcome Homelessness](#): February 2014 report developed by the Homeless Youth Collaborative on Developmental Evaluation on the guiding principles for providing services to youth experiencing homelessness
- [HHS ASPE Report on Family Interventions for Youth Experiencing or at Risk of Homelessness](#): 2016 report summarizing the existing evidence and common elements from 49 different interventions (prevention, reunification, reconnection) and what is most effective
- [Evidence-based Approach to Ending Youth Homelessness](#): March 2016 list of evidence-based screening and assessment tools that can be used with youth who are at risk of or experiencing homelessness



Health Care for Youth Experiencing Homelessness: Case Studies

The following case studies highlight innovative approaches to addressing the comprehensive healthcare needs of youth who are at risk of or experiencing homelessness in four distinct communities.

NEIGHBORCARE HOMELESS YOUTH CLINIC (SEATTLE, WASHINGTON)

Since 1993, Neighborcare's Homeless Youth Clinic (HYC) has provided a safe and supportive environment where youth experiencing homelessness ages 12 to 23 can receive medical, dental, and mental health care. HYC's goal is to provide youth experiencing homelessness with the resources they need to improve their health. Through improved health and connections with social services, HYC ultimately empowers young adults to take control of other aspects of their lives, such as continuing their education, finding employment, and getting into housing.

Two nights a week, on a drop-in basis, young adults can access medical, dental, and social work services, as well as naturopathic care, acupuncture, yoga, and meditation classes. The clinic is staffed by medical providers, a mental health counselor, a substance use disorder counselor, an insurance eligibility specialist, and an acupuncturist. The patients are served without regard to insurance status.

BRIDGE OVER TROUBLED WATERS (BOSTON, MASSACHUSETTS)

Bridge Over Troubled Waters (Bridge) conducts outreach and provides comprehensive care services to runaway, homeless, and high-risk youth in Boston. Bridge's continuum of health-related services includes the following:

- **Street outreach**—Trained outreach workers patrol daily to make regular, consistent contact with youth experiencing homelessness on the streets throughout a range of neighborhoods in Boston and Cambridge where youth experiencing homelessness are known to gather.
- **Mobile Medical Van**—The Mobile Medical Van (MMV), the first program of its kind in the nation, connects with the street outreach team each weeknight. The MMV is a national model for providing critical care: medical attention; survival kits; clothes; food; and referrals to in-depth, low-barrier, open-intake services at Bridge and other agencies as required. The van runs from 6:00 to 10:00 p.m.—the hours that they can reach the most teens experiencing homelessness—and stops at shelters, parks, and subway stops.
- **Runaway program**—Bridge is the local respondent for the national runaway hotline offering 24-hour access to a counselor and safe overnight accommodations for youth experiencing homelessness ages 14-17 for up to 72 hours.
- **Counseling and support services**—Licensed clinical counselors are trained and experienced in working specifically with youth experiencing homelessness, and they use a variety of counseling methods tailored to each youth, including trauma-informed and positive youth development approaches. Counselors “meet youth where they are” during their initial intake and set up appointments for follow-up counseling sessions or provide referrals to Bridge's in-house services or to outside agencies.



- **In-house medical and dental clinics**—Bridge offers weekly free medical and dental services staffed by healthcare professionals from Health Care for the Homeless and Tufts and Harvard dental schools at its West Street headquarters location.

Bridge works to meet the immediate needs of youth; provide referrals to additional housing, health, and social services as appropriate; and build trust with youth by respecting their privacy and confidentiality.

COVENANT HOUSE NEW YORK—UNDER 21, INC. (NEW YORK CITY)

Covenant House—Under 21 provides comprehensive primary healthcare services to youth experiencing homelessness up to age 21, as well as to their children. Services are offered at no cost or on a sliding-scale basis to anyone, regardless of age (up to 21), socioeconomic status, race, ethnicity, gender, religion, sexual orientation, physical ability, or language. Onsite services include pediatric and adult primary care, gynecological care, pre- and post-natal care, STI and HIV screening, mental health care, case management, health education, drug awareness and education, and substance use disorder assessments.

The Covenant House provides referrals to partner health providers for substance use disorder treatment, severe and persistent mental illness support, dental and vision services, and other specialized care, as appropriate. The program also has informal collaborations with several local hospitals to ensure access to emergency and specialized care for its patients.

CONTRA COSTA YOUTH CONTINUUM OF SERVICES HY-HOPE PROGRAM (CONTRA COSTA COUNTY, CALIFORNIA)

The Homeless Youth - Health, Outreach, and Peer Education (HY-HOPE) program offers three services – health care, outreach, and peer education – to engage runaway youth and youth experiencing homelessness, build trusting relationships, provide healthier alternatives to being on the streets, and assist youth in developing skills needed to support their well-being.

- **Health care** is provided through an adolescent health clinic on-site at Calli House, an interim housing and services program. Sponsored by Health Care for the Homeless, a Nurse Practitioner provides health assessments, physical exams, immunizations, STD testing, and family planning services. No appointment is necessary, and all services are provided confidentially and free of charge to youth experiencing homelessness.
- **Outreach** is conducted weekly to youth living on the streets and youth at-risk of homelessness. The team provides direct access to Calli House youth shelter; critical information and referral to services; health and safety education; crisis intervention; and counseling.
- **Peer education** is interwoven into all Contra Costa Youth Continuum of Services (CCYCS) programs and allows youth to provide support and education to each other. Current and former CCYCS youth have opportunities to lead support groups, life skills education classes, conduct outreach, and participate in community service activities.



Appendix A: Relevant Federal Health Care Resources to Help Communities End Youth Homelessness¹⁶

TARGETED RESOURCES FOR PREVENTING AND ENDING HOMELESSNESS	
Cooperative Agreements to Benefit Homeless Individuals (CABHI)	Enhances and/or expands the infrastructure and mental health and substance use treatment services for people experiencing homelessness, including permanent supportive housing.
Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States)	Enhances or develops the infrastructure of states and their treatment service systems to provide evidence-based treatment services, permanent supportive housing, and other recovery support services to people experiencing homelessness.
Grants for the Benefit of Homeless Individuals (GBHI)	Supports the development and/or expansion of community infrastructure that integrates behavioral health treatment and services for substance use disorders and co-occurring mental and substance use disorders, permanent housing, and other services for people experiencing homelessness.
Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSI)	Funds comprehensive treatment and recovery-oriented services for behavioral health to support individuals that have exited homelessness in permanent housing.
Healthcare for the Homeless (HCH) Program	Funds health centers that provide primary and preventive health care services to people experiencing homelessness.
Projects for Assistance in Transition from Homelessness (PATH)	Funds services for people with serious mental illness experiencing homelessness.
NON-TARGETED RESOURCES FOR PREVENTING AND ENDING HOMELESSNESS	
Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness	Funds states, counties, cities, and other eligible entities to implement and evaluate new Assisted Outpatient Treatment programs.
Children's Health Insurance Program	Funds states to provide health and behavioral health coverage to uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid.

¹⁶ U.S. Interagency Council on Homelessness. (2018, March). "Federal Homelessness Assistance Programs that Can Help Communities End Youth Homelessness." https://www.usich.gov/resources/uploads/asset_library/nontargeted-programs-for-ending-youth-homelessness.pdf and (2018, May). "Non-Targeted Federal Programs That Can Help Communities End Youth Homelessness." https://www.usich.gov/resources/uploads/asset_library/nontargeted-programs-for-ending-youth-homelessness.pdf



Community-Based Coalition Enhancement Grants to Address Local Drug Crises	Funds current or former Drug-Free Communities (DFC) Support Program recipients to prevent and reduce opioid, methamphetamine, and prescription medication use disorders among youth ages 12-18 in communities.
Community Mental Health Services Block Grant	Funds states and other eligible entities to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances.
Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis	Funds state, territory, tribal agencies, or local governments to identify youth and young adults at clinical high risk for psychosis and provide evidence-based interventions to prevent the onset of psychosis or lessen the severity of psychotic disorder.
Comprehensive Addiction and Recovery Act: Building Communities of Recovery	Funds nonprofit recovery community organizations to support the development, enhancement, expansion, and delivery of recovery support services, as well as the promotion of and education about recovery.
Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation	Funds state, territorial, and tribal entities to expand and enhance treatment services for adolescents and/or transition-aged youth with substance use disorders and/or co-occurring substance use and mental disorders.
Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances	Funds states and other eligible entities for widescale operation, expansion, and integration of the Systems of Care approach.
Cooperative Agreements for Tribal Behavioral Health (Native Connections)	Funds federally recognized tribes and tribal organizations to prevent and reduce suicidal behavior and substance use, reduce the impact of trauma, and promote mental health among American Indian/Alaska Native young people.
Drug-Free Communities Mentoring Program	Funds current Drug-Free Communities program recipients with a coalition that has been in existence for at least five years to assist newly forming coalitions in becoming eligible to apply for DFC funding on their own.
Drug-Free Communities Support Program	Funds community-based coalitions addressing youth substance use to establish and strengthen community collaborations to prevent and reduce substance use among youth.



Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families

Funds domestic public and private nonprofit entities to enhance and expand comprehensive treatment, early intervention, and recovery support services.

Garrett Lee Smith (GLS) Campus Suicide Prevention Grant

Funds public and private institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression and substance use/abuse, that put them at risk for suicide and suicide attempts.

Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts

Funds tribal, state, and local governments to expand and/or enhance substance use disorder treatment services in existing adult problem solving courts.

Grants to Expand Substance Abuse Treatment Capacity in Family Treatment Drug Courts

Funds tribal, state, and local governments to expand and/or enhance substance use disorder treatment services in existing family treatment drug courts.

Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program

Funds state, territory, and tribal agencies to improve access to treatment and support services for youth and young adults, ages 16-25, who have a serious emotional disturbance or a serious mental illness.

Historically Black Colleges and Universities (HBCU) Center for Excellence in Behavioral Health

Funds nationally recognized HBCU(s) to promote behavioral health, expand campus service capacity, and facilitate workforce development.

Law Enforcement and Behavioral Health Partnerships for Early Diversion

Funds tribal, state, and local governments to establish or expand programs that divert adults with a serious mental illness (SMI) and/or co-occurring mental and substance use disorder from the criminal justice system to community-based services prior to arrest and booking.

Linking Actions for Unmet Needs in Children's Health in American Indian and Alaskan Native Communities, U.S. Territories, and Pacific Jurisdictions Cooperative Agreements

Funds federally recognized tribes and tribal organizations to address the physical, social, emotional, cognitive, and behavioral aspects of wellness for young children from birth to eight years within tribes, territories, and Pacific Island jurisdictions.

Maternal and Child Health Services Block Grant

Funds state and territory maternal and child health agencies to provide low-income mothers and children access to quality maternal and child health services.

Medicaid

Funds states to provide health and behavioral health coverage to eligible individuals.

Mental Health Awareness Training Grants

Funds state, tribal, and local governments, and community-based public and private non-profit entities to prepare and train others on how to appropriately



and safely respond to individuals with mental disorders, particularly individuals with serious mental illness and/or serious emotional disturbance.

Minority AIDS Initiative—Service Integration

Funds local public and private nonprofit entities to integrate evidence-based, culturally competent mental and substance use disorder treatment with HIV primary care and prevention services for individuals living with or at risk for HIV and/or hepatitis in at-risk populations, including racial and ethnic minority communities.

Offender Reentry Program

Funds domestic public and private nonprofit entities to expand substance use disorder treatment and related recovery and reentry services to sentenced adult (18 years or older) offenders/ex-offenders who are returning to their families and community from incarceration in state and local facilities including prisons, jails, or detention centers.

Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities

Funds federally recognized tribes and tribal organizations to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families.

Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants

Funds State Education Agency or Education Agencies/Authorities serving children and youth residing in federally recognized American Indian/Alaska Native tribes, tribal organizations, and consortia of tribes or tribal organizations. The program supports the development and implementation of a comprehensive plan of activities, services, and strategies to decrease youth violence and support the healthy development of school-aged youth.

Promoting Integration of Primary and Behavioral Health Care

Funds states or state agencies to promote full integration and collaboration in clinical practice between primary and behavioral health care.

Residential Treatment for Pregnant and Postpartum Women

Funds public and private nonprofit entities to expand comprehensive treatment, prevention, and recovery support services for women and their children in residential substance use treatment facilities, including services for non-residential family members of both the women and children.

Resiliency in Communities After Stress and Trauma (ReCAST) Program

Funds local municipalities that have faced recent civil unrest for evidence-based violence prevention and community youth engagement programs, as well as linkages to trauma-informed behavioral health services.



Ryan White HIV/AIDS Program, Part A and Part B	Funds states to offer 13 core medical services and 17 support services for people with HIV/AIDS.
Ryan White HIV/AIDS Program (RWHAP), Part D	Funds public and nonprofit private entities that provide family-centered outpatient or ambulatory care for low income, uninsured, and medically underserved women, children, and infants living with HIV.
State Targeted Response to the Opioid Crisis Grants	Funds states and territories to increase access to treatment, reduce unmet treatment need, and reduce opioid overdose related deaths through prevention, treatment, and recovery activities for opioid use disorder.
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Funds public and private nonprofit entities to implement screening, brief intervention, and referral to treatment services for adolescents and adults in primary care and community health settings for substance misuse and substance use disorders.
Statewide Family Network	Funds family-controlled public and private non-profit organizations in states, territories, and tribes. The purpose is to better respond to the needs of children and adolescents with serious emotional disturbance and their families by providing information, referrals, and support, and to create a mechanism for families to participate in state and local mental health services planning and policy development.
Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities Ages 13-24 Cooperative Agreement	Funds community-based public and private non-profit entities and federally recognized tribes to provide services to youth at highest risk for HIV and substance use disorders.
Substance Abuse Prevention and Treatment Block Grant	Funds states and other eligible entities to plan, implement, and evaluate activities that prevent and treat substance use disorders and promote public health.
Targeted Capacity Expansion: Medication Assisted Treatment—Prescription Drug and Opioid Addiction	Funds states with the highest rates of admissions to expand/enhance access to medication-assisted treatment services for persons with an opioid use disorder.
Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-risk for HIV/AIDS	Funds local public and private nonprofit entities to link racial and ethnic minority individuals who are HIV positive or at high risk for HIV to housing, treatment, and support services.



Appendix B: Health Care Resources and Medicaid Coverage

A variety of health care resources for low-income people exist at the federal and state level. These resources can take the form of health care directly accessible by individuals or funding that flows through organizations that provide health care and related services. Accessing certain resources requires enrollment (and re-certification) based on specific, documented eligibility criteria. As with housing resources, many health care resources focus on particular populations, such as people experiencing homelessness, people living with HIV/AIDS, veterans, or people with disabilities.

Federally Qualified Health Centers (FQHCs)¹⁷

The Federal Health Center Program serves medically underserved populations or areas, works with special populations, and provides for enhanced Medicaid reimbursement. The four types of health centers are: (1) Community Health Centers; (2) Health Care for the Homeless; (3) Migrant Health Centers; and (4) Public Housing Primary Care Health Centers. Details about Community Health Centers and Health Care for the Homeless Programs are below.

Community Health Centers¹⁸

Community Health Centers (CHCs) deliver comprehensive, high-quality preventative and primary health care to patients regardless of their ability to pay. They also provide oral health and behavioral health care tailored to the needs of the communities they serve. CHCs offer a sliding fee discount based on income.

Health Care for the Homeless (HCH) Programs¹⁹

HCH Programs emphasize a multi-disciplinary approach to delivering care to people experiencing homelessness, combining aggressive street outreach with integrated systems of primary care, mental health and substance use disorder services, case management, and clinical advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

Rural Health Resources

Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) are the safety net providers for rural and remote communities.

Critical Access Hospitals (CAHs)²⁰

“Critical Access Hospital” is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential

¹⁷ National Association of Community Health Centers, “So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center,” July 2011: 1, <http://www.nachc.com/client/documents/Starting%20a%20FQHC%20Manual-September%202011.pdf>.

¹⁸ Idaho Primary Care Association, “What is a Community Health Center?”, 2015, <http://www.idahopca.org/community-health-centers#what-are-community-health-centers>.

¹⁹ National Association of Community Health Centers, “Health Care for the Homeless,” <http://www.nachc.com/homeless-healthcare.cfm>.

²⁰ Rural Health Information Hub, “Critical Access Hospitals (CAHs),” <https://www.ruralhealthinfo.org/topics/critical-access-hospitals>.



services in rural communities. This is accomplished through cost-based Medicare reimbursement.

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- 25 or fewer acute care inpatient beds
- Location more than 35 miles from another hospital
- Maintained annual average length of stay of 96 hours or less for acute care patients
- 24/7 emergency care services

Rural Health Clinics (RHCs)²¹

A Rural Health Clinic is a federally qualified health clinic (but not a part of the FQHC Program) that is certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement to increase rural Medicare and Medicaid patients' access to primary care services.

CMS reimburses RHCs differently than it does other facilities. CMS is required to pay RHCs using a prospective payment system (PPS) rather than a cost-based reimbursement system. RHCs receive an interim payment from Medicare, and at the end of the year, this payment is reconciled using the clinic's cost reporting. For services provided to Medicaid patients, states can reimburse using PPS or by an alternative payment methodology that results in a payment equal to what the RHC would receive under PPS. Regardless of whether the patient sees a mid-level provider or a physician, the RHC must receive the same amount for its services.

Indian Health Services²²

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states.

Veteran Health Resources

Veterans Health Administration²³

The Veterans Health Administration is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and

²¹ U.S. Department of Health and Human Services Health Resources and Services Administration, "What are Rural Health Clinics (RHCs)?", 2015, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html>.

²² Indian Health Services, "About IHS," <https://www.ihs.gov/aboutihs/>

²³ U.S. Department of Veterans Affairs, "Veterans Health Administration," www.va.gov/health/aboutVHA.asp and U.S. Department of Veterans Affairs, "Homeless Veterans – Health Care," http://www.va.gov/homeless/health_care.asp



1,053 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 8.9 million veterans each year.

The following programs may be offered at VA medical facilities, including community-based outpatient clinics, to provide healthcare to homeless veterans.

Health Care for Homeless Veterans (HCHV) Program

The HCHV program serves as the hub for a myriad of housing and other services which provide the VA a way to outreach and assist veterans experiencing homelessness by offering them entry to VA care. The central goal is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. HCHV's Contract Residential Treatment Program ensures that veterans with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services.

Homeless Patient Aligned Care Teams (H-PACTs) Program

The Homeless Patient Aligned Care Teams (H-PACTs) Program implements a coordinated homeless primary care model that focuses on improving access, care coordination, and quality of treatment for alcohol and other substance use for veterans experiencing or at risk of homelessness. H-PACTs provide a coordinated "medical home" specifically tailored to the needs of homeless veterans, integrating clinical care with the delivery of social services.

Health Care for Re-Entry Veterans Program

The Health Care for Re-Entry Veterans Program helps incarcerated veterans successfully rejoin the community through supports, including mental health and substance use treatment.

Homeless Veterans Dental Initiative

The Homeless Veterans Dental Initiative provides dental treatment for eligible veterans in a number of programs: Domiciliary Residential Rehabilitation Treatment, VA Grant and Per Diem, Compensated Work Therapy/Transitional Residence, Healthcare for Homeless Veterans (contract bed), and Community Residential Care.

HIV/AIDS Health Resources

Ryan White HIV/AIDS Program²⁴

The Ryan White HIV/AIDS Program provides a comprehensive system of care, including primary medical care and essential support services, for people living with HIV who are uninsured or underinsured. The program works with cities, states and local community-based organizations to provide HIV care and treatment services to more than 512,000 clients in the U.S. each year.

²⁴ U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Program, "Ryan White HIV/AIDS Program Parts," <http://hab.hrsa.gov/abouthab/partd.html>



Part A

Part A provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV epidemic.

Part B

Part B provides grants to State departments of health or other State and U.S. Territories which administer public health programs and services. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to State for Emerging Communities and an award for Minority AIDS initiative activities.

The AIDS Drug Assistance Program (ADAP) provides free medications for the treatment of HIV/AIDS and opportunistic infections. The drugs provided through ADAP can help people with HIV/AIDS to live longer and treat the symptoms of HIV infection. ADAP can help people with partial insurance and those who have a Medicaid spend down requirement.

Part C

The Part C Early Intervention Services (EIS) component funds comprehensive primary health care in outpatient settings for people living with HIV disease.

Part D

Ryan White HIV/AIDS Program Part D grant recipients provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

Behavioral Health Resources

Many community health centers and free clinics offer free or low-cost mental and behavioral health services.

Projects for Assistance in Transition from Homelessness (PATH)²⁵

The Substance Abuse and Mental Health Services Administration (SAMHSA) operates the grant program Projects for Assistance in Transition from Homelessness (PATH), which provides assistance to individuals who are homeless and have serious mental illnesses. PATH funds are distributed to states, which then contract with local public or non-profit organizations to fund services for homeless individuals.

Among the services eligible for funding under PATH are outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, alcohol and drug treatment services staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services.

²⁵ Benefit.gov, "Projects for Assistance in Transition from Homelessness (PATH)", <https://www.benefits.gov/benefits/benefit-details/728>



Other Health Resources for Uninsured Residents

Free Clinics²⁶

Free health and medical clinics offer services free of cost or for a nominal fee to persons who have limited income, no health insurance, or do not qualify for Medicaid or Medicare.

Medicaid

State Medicaid Plan²⁷

Historically, Medicaid eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low. The Affordable Care Act (ACA) extended Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about \$32,500 for a family of four in 2013). All states previously expanded eligibility for children through Medicaid and the Children's Health Insurance Program (CHIP).

Home and Community Based Services Waiver Programs²⁸

The 1915(c) waivers are one of many options available to states to allow the provision of long-term care services in home and community-based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Managed Care²⁹

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

²⁶ Mental Health America, "Paying for Care," <http://www.mentalhealthamerica.net/paying-care>

²⁷ The Henry J. Kaiser Family Foundation, "How Will the Uninsured Fare Under the Affordable Care Act?", April 7, 2014, <http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/>

²⁸ Medicaid.gov, "1915(c) Home & Community-Based Waivers," <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>

²⁹ Medicaid.gov, "Managed Care," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>



Appendix C: Current Research on the Intersection of Health and Youth Homelessness

The following articles present important and current research on the intersection between health and experiences of youth homelessness, including actionable findings and recommendations that can inform your approach to addressing the health needs of youth through your coordinated community plan to prevent and end youth homelessness.

Do Programs for Runaway and Homeless Youth Work? A Qualitative Exploration From the Perspectives of Youth Clients in Diverse Settings (April 2018)

Synopsis: Runaway and homeless youth (RHY) comprise a large population of young people who reside outside the control and protection of parents and guardians and who experience numerous traumas and risk factors, but few buffering resources. Specialized settings have developed to serve RHY, but little is known about their effects. This cross-sectional qualitative descriptive study, grounded in the positive youth development approach and the Youth Program Quality Assessment model, addressed this gap in the literature.

Results of the study indicated that because RHY are distrustful of service settings and professional adults and skilled at surviving independently, the population-tailored approaches found in RHY-specific settings are vital to effectively engage and serve RHY. Researchers found the following four major themes regarding the positive effects of settings:

1. Engaging with a RHY setting was emotionally challenging and frightening, and thus the experiences of safety and services tailored to RHY needs were critical;
2. Instrumental support from staff was vital and most effective when received in a context of emotional support;
3. RHY were skilled at survival on the streets, but benefited from socialization into more traditional systems to foster future independent living; and
4. Follow-through and aftercare were needed as RHY transitioned out of services.

With respect to gaps in settings, RHY highlighted the following:

1. A desire for better management of tension between youths' needs for structure and wishes for autonomy and
2. A lack of RHY input into program governance.

Emotional Health Among Youth Experiencing Family Homelessness (January 2018)

Synopsis: Youth who are homeless with adult family members comprise 37 percent of the U.S. homeless population, yet mental health among this group has not yet been well described. This study aimed to compare the risk of suicidality, and factors that may protect against it, between family-homeless and non-homeless youth.

The study found that youth experiencing recent family homelessness are at higher risk of suicidality than their non-homeless peers, suggesting homelessness itself as a marker of risk. Factors that protect emotional health are less impactful among youth experiencing recent family



homelessness. Thus, interventions among homeless youth may need to address social determinants of health such as stable housing and adversity in addition to developmental assets.

Counting All Homeless Youth Today So We May No Longer Need To Tomorrow (January 2018)

Synopsis: This editorial emphasizes the need to be able to count and characterize the population of youth experiencing homelessness nationally and longitudinally, including efforts to improve reporting of minors experiencing homelessness.

Prevalence and Correlates of Youth Homelessness in the United States (November 2017)

Synopsis: Unaccompanied youth homelessness is a serious concern. Response, however, has been constrained by the absence of credible data on the size and characteristics of the population and reliable means to track youth homelessness over time. This study sought to address these gaps in data.

The study found that over a 12-month period, approximately 3.0% of households with 13- to 17-year-olds reported explicit youth homelessness (including running away or being asked to leave) and 1.3% reported experiences that solely involved couch surfing, resulting in an overall 4.3% household prevalence of any homelessness, broadly defined. For 18- to 25-year-olds, household prevalence estimates were 5.9% for explicitly reported homelessness, 6.6% for couch surfing only, and 12.5% overall. Prevalence rates were similar across rural and nonrural counties. Higher risk of homelessness was observed among young parents; black, Hispanic, and lesbian, gay, bisexual, or transgender (LGBT) youth; and those who did not complete high school.

The prevalence and incidence of youth homelessness reveal a significant need for prevention and youth-centric systems and services, as well as strategies to address disproportionate risks of certain subpopulations.

"Housing First" for Homeless Youth With Mental Illness (October 2016)

Synopsis: "Housing First" has been shown to improve housing stability in abstract homeless individuals with mental illness but had not been empirically tested in youth experiencing homelessness. This study aimed to evaluate the effect of "Housing First" on housing stability in youth experiencing homelessness aged 18 to 24 years participating in At Home/Chez Soi, a 24-month randomized trial of "Housing First" in 5 Canadian cities.

The study found that "Housing First" was associated with improved housing stability in homeless youth with mental illness. Future research should explore whether adaptations of the model for youth yield additional improvements in housing stability and other outcomes.



Profiles in Preventing and Ending Youth Homelessness: Youth-oriented Health Care

The following profiles on youth-oriented health care have been curated from the Coordinated Community Plans of Round 1 YHDP grant recipients, as well as from information provided by communities that have accepted the 100-day Challenge to End Youth Homelessness, an initiative made possible through funding from the U.S. Department of Housing and Urban Development (HUD).

Seattle/King County, WA

YHDP-funded Project: Behavioral Health Crisis Response

- **Target Population:** Homeless young adults, ages 18–24 (existing services are targeted to youth under 18)
- **HUD Homeless Definition:** Categories 1, 2, and 4
- **Project Type:** Supportive services only, as a mobile crisis team
- **Staffing:** Funding will support staffing for the crisis team for both mobile crisis response and respite bed program services

King County's Department of Community and Human Services (DCHS) will expand and enhance the Children's Crisis Outreach Response System (CCORS) to ensure immediate access to young adults, families, law enforcement officers, youth and young adult housing providers (including transitional housing and rapid rehousing), and other community organizations to mobile crisis outreach 24/7 anywhere within the county. The crisis outreach team will work to de-escalate the current crisis and provide in-home and community-based supports for up to 8 weeks. When a crisis situation cannot be stabilized or calls for a more intensive stabilization response, the crisis team will have access to crisis stabilization beds, where young adults can stay for up to 14 days. Existing programming provides crisis outreach response for youth, supporting mediation and safe reunification of the youth with family. For those youth who do not have (or do not choose) family or other natural supports to return to, the crisis outreach team will work to transition the youth to find longer-term housing options.

Expanding the CCORS team increases capacity to extend services beyond the current focus on youth under 18 to serve young adults ages 18–24 living in housing programs within the youth and young adult homeless housing system. The need for all potential services and supports will be explored, including housing, education (GED programs and post-secondary resources) and mentoring, basic health care (e.g., ensuring healthcare coverage and preventive care), treatment for substance use disorders (local community-based nonprofit), employment programs (onsite housing case management), and mental health services (local community-based nonprofit).

CCORS provides training and support to the family and housing staff to prevent future crises, including repeated episodes of homelessness or potential involvement in the justice system. It is



anticipated that these programs will be able to stabilize more young people and support them moving to other programs in the continuum as their service needs change.

San Francisco, CA

Recent efforts by the San Francisco Department of Public Health have been dedicated to differentiating transition-age youth (TAY) behavioral health needs and services from the adult system of care. The department has led planning activities and stakeholder engagement to better understand the behavioral health needs of TAY and identify strategies and priorities for improving access to and quality of care for TAY. These activities have culminated in well-defined strategies in the areas of outreach, expanding program/system capacity and system coordination with future efforts focused on mapping out services and developing the proposed structure for the TAY behavioral health system of care.

Anchorage, AK

Medicaid Reform Package

In 2016, the Alaska Legislature passed Senate Bill 74 (SB 74). This multidimensional Medicaid reform package includes direction to apply for an 1115 demonstration waiver that will develop a comprehensive and integrated behavioral health system that partners with diverse providers and disciplines to provide evidence- and data-driven practices, with the goal of achieving positive outcomes for children, youth, and adults experiencing behavioral health conditions. SB 74 includes direction to reduce operational barriers, minimize administrative burden, and improve the behavioral health system's effectiveness and efficiency.

Project Funded by Non-YHDP funds: Full-time Behavioral Health Consultant at Wellness Center at CHA

Anchorage will use billing revenue and matching funds from Southcentral Foundation to locate one full-time equivalent (FTE) behavioral health consultant at the Youth Engagement Center of the Wellness Center. The Wellness Center is operated by the Southcentral Foundation, the Alaska native tribal health organization that serves Anchorage and Southcentral Alaska. The behavioral health consultant will provide triage, assessment, direct services, and consultation for the permanency navigators team.

Gaps Addressed: Youth who experience behavioral health issues often lack the knowledge or efficacy to navigate the appropriate behavioral health resources in the community. One barrier to accessing the proper services is the lack of an appropriate referral. The behavioral health consultant will address these barriers by conducting assessments and providing appropriate referrals.

Program Philosophy: Integrated behavioral health services should be available in a primary care setting that is accessible to any youth or young adult at risk of or experiencing homelessness. Both short-term crisis intervention services and longer-term assessment and individualized treatment, as well as referrals for treatment with other providers, will be available. The behavioral health consultant will also provide consultation and oversight for the team of permanency navigators.



Cincinnati/Hamilton County, OH

Cincinnati is service-rich and has a history of building innovative service partnerships to meet the needs of subpopulations and intersecting identities. One example of this is the Cooperative Agreement to Benefit Homeless Individuals (CABHI) program, which is a partnership between the Greater Cincinnati Behavioral Health Services and homeless service agencies that use the evidence-based practice critical time intervention (CTI). CABHI is a critical community partner that has helped Cincinnati/Hamilton County approach a true end to chronic homelessness.

Cincinnati will draw on this project and its strategies to specifically serve pregnant and parenting youth in a team-based service model. Young parents straddle the youth and family systems and are often involved in multiple systems with multiple service providers. Through a Youth Dedicated Service Team, the Cincinnati YHDP will further support pregnant and parenting young people in navigating complex systems and needs by helping reduce barriers and the number of contacts. This team will be trained and equipped to address the intersecting needs of young people and young families in an appropriate and family-centric way. This will ensure that the needs of both the head of household and the child are being comprehensively met, including social and emotional well-being.

Ohio Balance of State

Southeast Ohio is battling an opioid crisis that has greatly affected the region. From 2000 to 2014, the number of overdose deaths statewide increased by 200 percent. According to the Centers for Disease Control and Prevention (CDC), the state of Ohio's 4,329 overdose deaths in 2016 was the second highest number in the nation.

This epidemic has had a profound impact on the region's youth and child welfare system. As the number of parents who overdose or become incarcerated increases, so does the need for protective services, including foster care and kinship placement. This has had a significant impact on youth age 14–24. Minors are forced into foster or kinship care, whereas 18- to 24-year-olds are faced with leaving home with no safety net. According to Doug Stephens, Executive Director of Ohio Court-Appointed Special Advocate (CASA), without the parental support that other youth experience, they are more likely to drop out of school, become parents before they are ready, experience homelessness, fall victim to human trafficking, and be unemployed or incarcerated.

Mendocino County, CA (100-day Challenge)

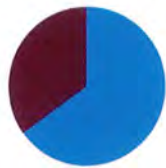
Mendocino County, in collaboration with Ukiah Valley Medicine Center, implemented a street medicine program that brings medical assistance directly to homeless encampments and staffs weekly clinics for youth experiencing homelessness. This endeavor has a client-centered practice that is key to outreach and engagement efforts and has provided a meaningful opportunity for involvement by persons experiencing homelessness, who accompany the medical teams and support their efforts.

San Diego, CA: Health Profile



#39

Rank



65% of youth with major depression did not receive any mental health treatment.

Youth Mental Health Ranking

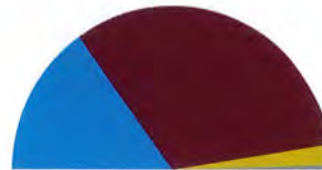
In 2018, Mental Health America ranked California **39th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.

- **12.28%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **7.8%** of youth experienced severe depression.
- **8.1%** of youth had private health insurance that did not cover mental or emotional problems.
- **4.23 per 1,000 students** in California were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Mental Health Among Youth Under Age 25 Experiencing Homelessness

The 2018 San Diego County Point-in-Time Count found that **30%** of youth under the age of 25 experiencing homelessness reported **at least one mental health issue**.

Youth were less likely than the general population of people experiencing homelessness in San Diego County to experience a mental health issue (**30% to 43% comparatively**).



● Mental Health Issue
● No Issue
● Don't Know
● Data Not Collected

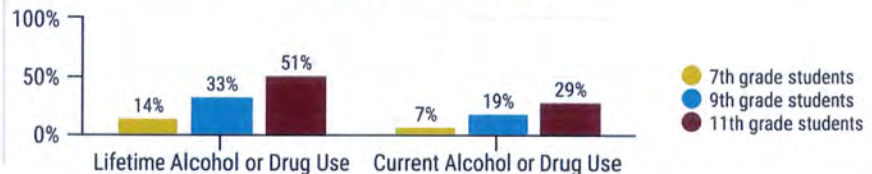
Teen Birth Rate



In 2016, there were **650** births to youth under the age of 20 in the city of San Diego. San Diego has the **3rd** highest teen birth rate among cities in California, behind Los Angeles and Fresno.

Alcohol and Other Drug Use Among School Aged Youth

The 2014-2015 California Healthy Kids Survey found that **14%** of 7th grade students, **33%** of 9th grade students, and **51%** of 11th grade students in San Diego County reported use of alcohol or drugs at any point in their life. **7%** of 7th grade students, **19%** of 9th grade students, and **29%** of 11th grade students reported current drug or alcohol use.



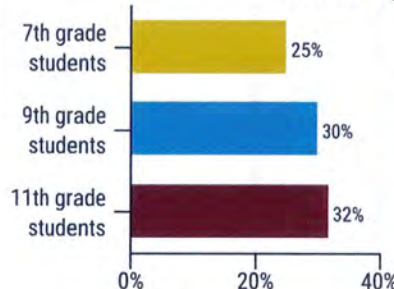
Uninsured Youth in San Diego County



In 2016, **19.7%** of youth aged 18 to 24 were uninsured in San Diego County, nearly the same as the average uninsured rate of **19.8%** for this age group in the state of California.

California **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Feelings of Sadness and Hopelessness Among School Aged Youth



The 2014-2015 California Healthy Kids Survey found that **25%** of 7th grade students, **30%** of 9th grade students, and **32%** of 11th grade students in San Diego County reported chronic feelings of sadness or hopelessness over the past 12 months.

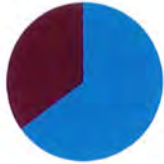
Louisville, KY: Health Profile



#15
Rank

Youth Mental Health Ranking

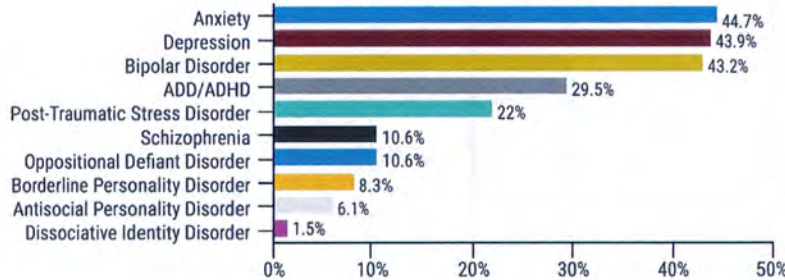
In 2018, Mental Health America ranked Kentucky **15th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



64.9% of youth with major depression did not receive any mental health treatment.

- **11.05%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **5.5%** of youth experienced severe depression.
- **5.8%** of youth had private health insurance that did not cover mental or emotional problems.
- **7.26 per 1,000 students** in Kentucky were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Mental Health Among Youth Experiencing Homelessness



A 2016 Youth Experience Survey (YES) of youth aged 12 to 25 experiencing homelessness in Louisville, Kentucky and Southern Indiana found that nearly **three-fourths (73.5%)** of youth surveyed reported having a current mental health issue/diagnosis, with **more than half (58.3%)** reporting more than one mental health issues/diagnoses.

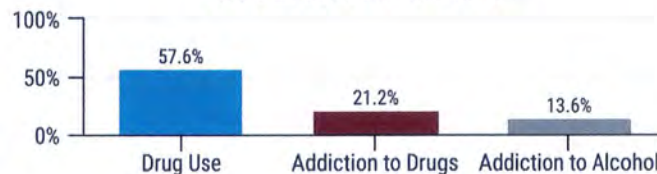
Teen Birth Rate



In 2016, there were **625** births to youth under the age of 20 in Louisville. There were **4,331** total births to youth under the age of 20 in the state of Kentucky, a rate of **31 births per 1,000 women** in this age group.

Alcohol and Other Drug Use Among Youth Experiencing Homelessness

A 2016 Youth Experience Survey (YES) of youth aged 12 to 25 experiencing homelessness in Louisville, Kentucky and Southern Indiana found that **57.6%** of youth reported **drug use**, while **21.2%** reported having an **addiction to drugs**, and **13.6%** an **addiction to alcohol**.



Uninsured Youth in Jefferson County



In 2016, **15.8%** of youth aged 18 to 24 were uninsured in Jefferson County, lower than the average uninsured rate of **17%** for this age group in the state of Kentucky.

Kentucky **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Medical Concerns Among Youth Experiencing Homelessness



A 2016 Youth Experience Survey (YES) of youth aged 12 to 25 experiencing homelessness in Louisville, Kentucky and Southern Indiana found that **57.6%** of youth reported a **current medical problem**, with **12.9%** reporting a current dental issue. Medical conditions reported included asthma, vision issues, chronic pain, sexually transmitted infections, open wounds, skin problems and broken bones.

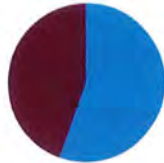
Boston, MA: Health Profile



#4
Rank

Youth Mental Health Ranking

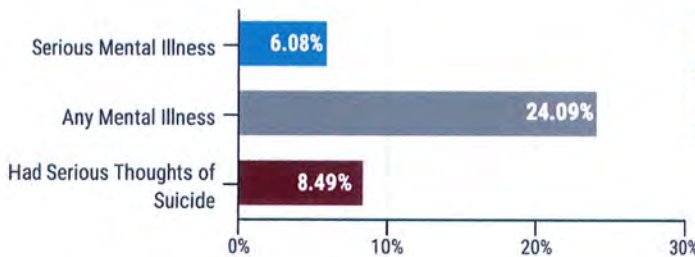
In 2018, Mental Health America ranked Massachusetts **4th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



55.5% of youth with major depression did not receive any mental health treatment.

- **12.37%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **8.3%** of youth experienced severe depression.
- **2.4%** of youth had private health insurance that did not cover mental or emotional problems.
- **17.61 per 1,000 students** in Massachusetts were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, **191,000** youth aged 18 to 25 in Massachusetts reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **48,000** youth (25% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

67,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

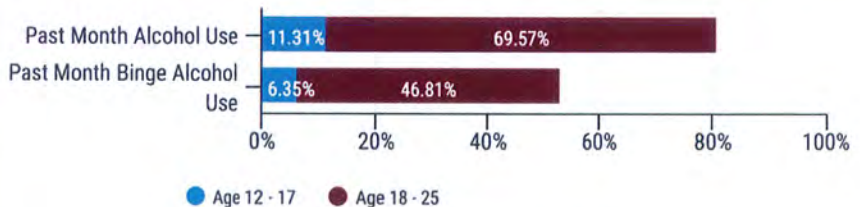
Teen Pregnancy & Parenting



In 2015, there were **249** births to youth under the age of 20 in Boston. Voices of Youth Count found that **28%** of young women experiencing homelessness in Suffolk County reported that they were pregnant or a parent.

Alcohol Use Among Youth

In 2016, **606,000** youth ages 12 to 25 in Massachusetts reported alcohol use in the past month, with **402,000** youth reporting binge alcohol use.



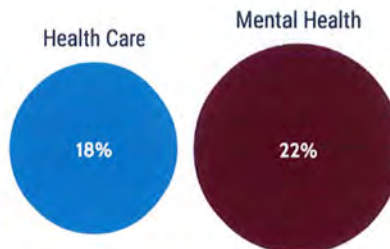
Uninsured Youth in Suffolk County



In 2016, **5.6%** of youth aged 18 to 24 were uninsured in Suffolk County, slightly higher than the average uninsured rate of **5.1%** for this age group in the state of Massachusetts.

Massachusetts **has** implemented Medicaid expansion for individuals with incomes below 13% of the Census Bureau's poverty threshold.

Health Services Sought by Youth Experiencing Homelessness



The Massachusetts 2017 Youth Count found that among youth experiencing homelessness, **18% had sought health care services** and **22% had sought mental health services** in the past 12 months.

Northwest Minnesota: Health Profile



#3
Rank

Youth Mental Health Ranking

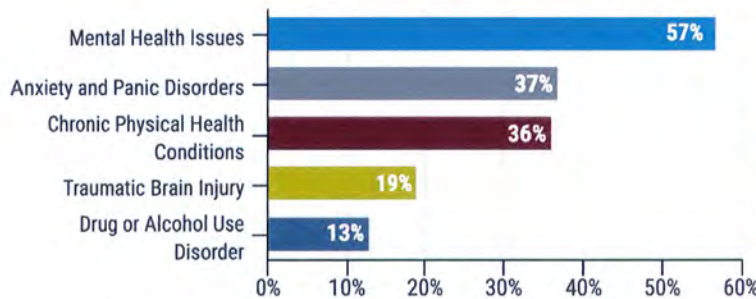
In 2018, Mental Health America ranked Minnesota **3rd** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



51.9% of youth with major depression did not receive any mental health treatment.

- **12.55%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **8.2%** of youth experienced severe depression.
- **5.4%** of youth had private health insurance that did not cover mental or emotional problems.
- **18.95 per 1,000 students** in Minnesota were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Health Concerns Among Youth Experiencing Homelessness



The 2015 Minnesota Homeless Study found that the majority of youth experiencing homelessness have serious health concerns. **57%** reported **significant mental health issues** and **36%** reported **chronic physical health conditions**. **Anxiety or panic disorders** were the most common mental health issues reported by youth (37%). **19%** of youth reported symptoms of a **traumatic brain injury**, and about **13%** reported a **drug or alcohol use disorder**.

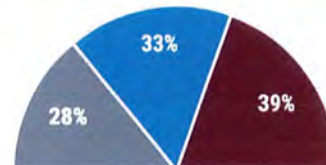
Health Insurance Among Youth in Minnesota



In 2016, **19%** of youth aged 18 to 24 were uninsured in Minnesota. The 2015 Minnesota Homeless Study found that 69% of youth experiencing homelessness had medical coverage, including 81% of youth with children.

Minnesota **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Co-occurrence of Health Issues Among Youth Experiencing Homelessness



- None of these four kinds of health conditions
- One of these four kinds of health conditions
- Two or more of these four kinds of health conditions

The 2015 Minnesota Homeless Study found that compared to adults, youth experiencing homelessness were significantly less likely to have multiple health issues.

According to the survey, **28%** of youth experiencing homelessness reported having **none of the four following kinds of health conditions** - mental illness, substance use, chronic physical health conditions, or traumatic brain injury. **33%** of youth reported having **one of these four health conditions**, and **39%** reported having **two or more of these health conditions**.

Health Access for Youth Experiencing Homelessness



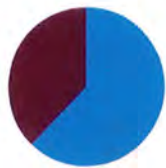
The 2015 Minnesota Homeless Study found that **60%** of youth experiencing homelessness said they have a **regular place to go for health care**. Their regular place was most often a clinic requiring fees or insurance (**71%**), a free clinic (**15%**), or the emergency room (**7%**).

Nebraska Balance of State: Health Profile



#21

Rank



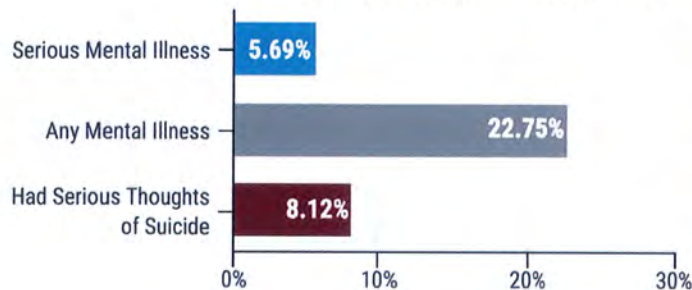
62.1% of youth with major depression did not receive any mental health treatment.

Youth Mental Health Ranking

In 2018, Mental Health America ranked Nebraska **21st** in the country for youth mental health based on prevalence of mental illness and access to care in the state.

- **12.25%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **7.6%** of youth experienced severe depression.
- **8.3%** of youth had private health insurance that did not cover mental or emotional problems.
- **8.46 per 1,000 students** in Nebraska were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, **48,000** youth aged 18 to 25 in Nebraska reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **12,000** youth (25% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

17,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

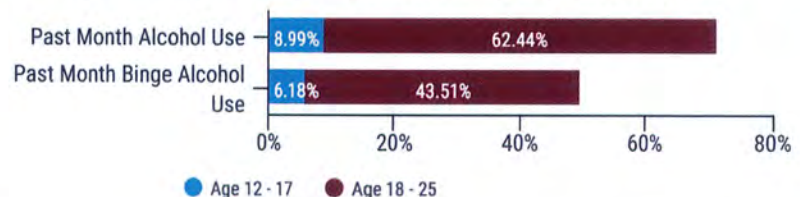
Teen Birth Rates



In 2016, there were **1,213** births to youth aged 15 to 19 in Nebraska, a rate of **19 births per 1,000 women** in this age group.

Alcohol Use Among Youth

In 2016, **147,000** youth ages 12 to 25 in Nebraska reported alcohol use in the past month, with **102,000** youth reporting binge alcohol use.



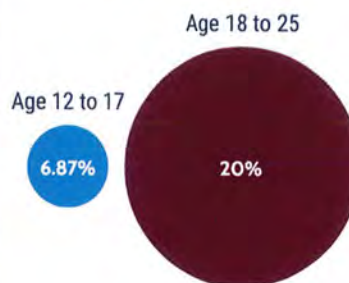
Uninsured Youth in Nebraska



In 2016, **16.1%** of youth aged 18 to 24 were uninsured in Nebraska, lower than the average uninsured rate of **19%** for this age group in the United States.

Nebraska **has not** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold, but may put a Medicaid expansion measure on the ballot in November.

Past Month Illicit Drug Use Among Youth



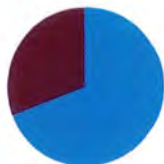
In 2016, **10,000 youth aged 12 to 17 (6.87%)** and **43,000 youth aged 18 to 25 (20%)** in Nebraska reported past month illicit drug use.

New Mexico Balance of State: Health Profile



#25

Rank



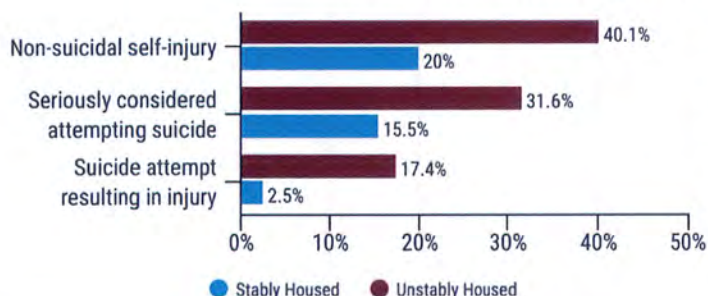
69.2% of youth with major depression did not receive any mental health treatment.

Youth Mental Health Ranking

In 2018, Mental Health America ranked New Mexico **25th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.

- **11.50%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **5.8%** of youth experienced severe depression.
- **4.7%** of youth had private health insurance that did not cover mental or emotional problems.
- **6.41 per 1,000 students** in New Mexico were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Mental Health Among Unstably Housed Students



New Mexico high school students who experienced housing instability were **two times** as likely to engage in non-suicidal self-injury than stably housed students, **two times** as likely to seriously consider attempting suicide, and **7 times** as likely to make a suicide attempt resulting in an injury that had to be treated by a doctor or a nurse.

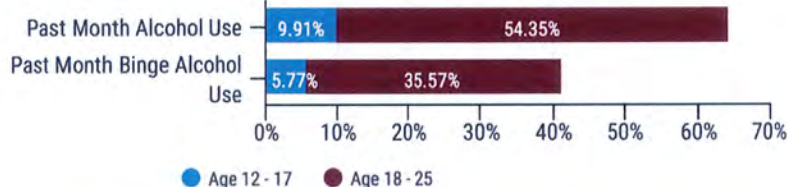
Teen Birth Rates



In 2016, there were **2,000** births to youth aged 15 to 19 in New Mexico, a rate of **29.4 births per 1,000 women** in this age group.

Alcohol Use Among Youth

In 2016, **138,000** youth ages 12 to 25 in New Mexico reported alcohol use in the past month, with **90,000** youth reporting binge alcohol use.



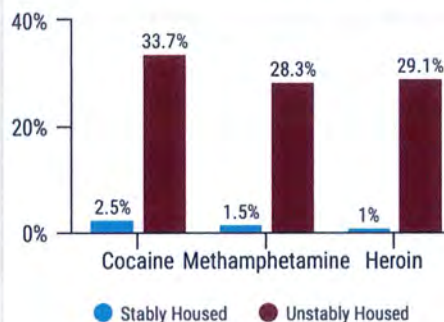
Uninsured Youth in New Mexico



In 2016, **25%** of youth aged 18 to 24 were uninsured in New Mexico, higher than the average uninsured rate of **19%** for this age group in the United States.

New Mexico **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Substance Use Among Unstably Housed Students



New Mexico high school students in unstable housing were **12.5 times** more likely to currently use cocaine, almost **19 times** more likely to currently use methamphetamine, and **29 times** more likely to currently use heroin than students in stable housing.

Columbus, OH: Health Profile



#11
Rank

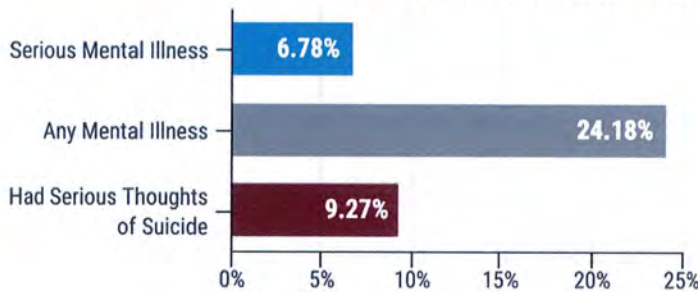
Youth Mental Health Ranking

In 2018, Mental Health America ranked Ohio **11th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



- **11.85%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **8.0%** of youth experienced severe depression.
- **8.1%** of youth had private health insurance that did not cover mental or emotional problems.
- **9.57 per 1,000 students** in Ohio were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, **295,000** youth aged 18 to 25 in Ohio reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **83,000** youth (28% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

113,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

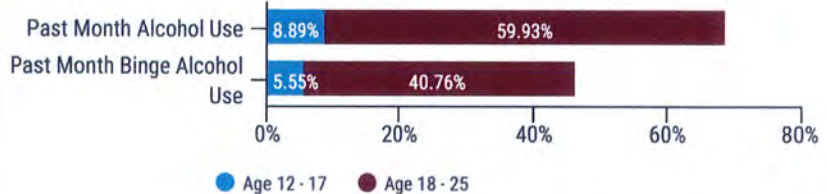
Teen Pregnancy Rates



In 2015, there were **699** births to youth aged 15 to 19 in Columbus. There were **8,755** total births to youth aged 15 to 19 in the state of Ohio, a rate of **23 births per 1,000 women** in this age group.

Alcohol Use Among Youth

In 2016, **812,000** youth ages 12 to 25 in Ohio reported alcohol use in the past month, with **548,000** youth reporting binge alcohol use.



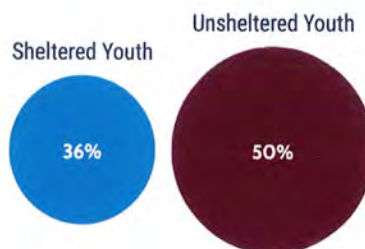
Uninsured Youth in Hamilton County



In 2016, **11.7%** of youth aged 18 to 24 were uninsured in Hamilton County, lower than the average uninsured rate of **13.7%** for this age group in the state of Ohio.

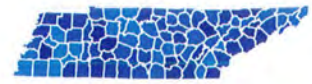
Ohio **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Healthcare Utilization Among Youth Experiencing Homelessness



A Central Ohio study on healthcare utilization found that **36%** of youth experiencing sheltered homelessness and **50%** of youth experiencing unsheltered homelessness **do not have a regular source of healthcare**, such as a medical home or primary care provider.

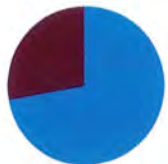
Nashville, TN: Health Profile



#32
Rank

Youth Mental Health Ranking

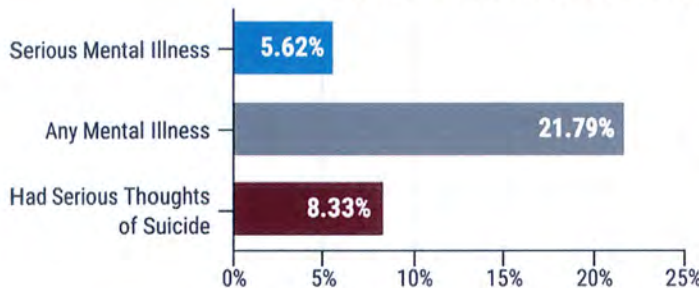
In 2018, Mental Health America ranked Tennessee **32nd** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



72.2% of youth with major depression did not receive any mental health treatment.

- **10.92%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **6.5%** of youth experienced severe depression.
- **7.4%** of youth had private health insurance that did not cover mental or emotional problems.
- **3.62 per 1,000 students** in Tennessee were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, **153,000** youth aged 18 to 25 in Tennessee reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **39,000** youth (25% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

58,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

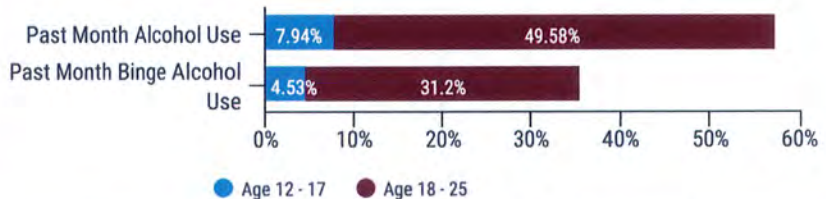
Teen Pregnancy Rates



In 2016, there were **137** births to youth aged 15 to 19 in Davidson County, a rate of **12.6 births per 1,000 women** in this age group. This is lower than the teen pregnancy rate for the state of Tennessee (**28 births per 1,000 women** aged 15 to 19).

Alcohol Use Among Youth

In 2016, **387,000** youth ages 12 to 25 in Tennessee reported alcohol use in the past month, with **242,000** youth reporting binge alcohol use.



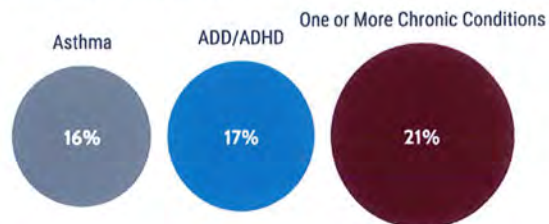
Uninsured Youth in Davidson County



In 2016, **17.7%** of youth aged 18 to 24 were uninsured in Davidson County, lower than the average uninsured rate of **18.4%** for this age group in the state of Tennessee.

Tennessee **has not** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Health Problems for Children At-Risk of Homelessness

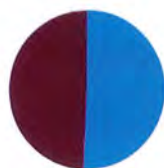


As of 2014, **one in every five youth** under the age of 18 in Tennessee who were at-risk of homelessness experienced **one or more chronic health condition**, including asthma (16%) and **ADD/ADHD (17%)**.

Vermont Balance of State: Health Profile



#2
Rank



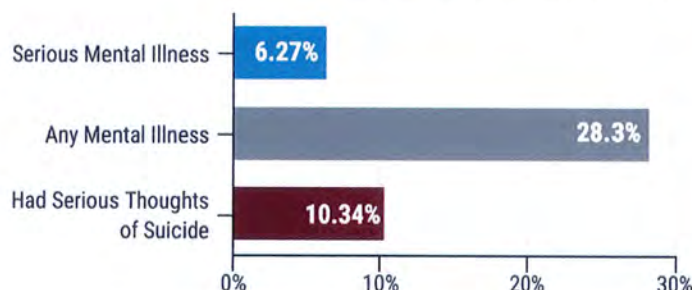
50.6% of youth with major depression did not receive any mental health treatment.

Youth Mental Health Ranking

In 2018, Mental Health America ranked Vermont **2nd** in the country for youth mental health based on prevalence of mental illness and access to care in the state.

- 12.06% youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- 8.5% of youth experienced severe depression.
- 4.7% of youth had private health insurance that did not cover mental or emotional problems.
- **26.05 per 1,000 students** in Vermont were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, 21,000 youth aged 18 to 25 in Vermont reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **5,000** youth (24% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

8,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

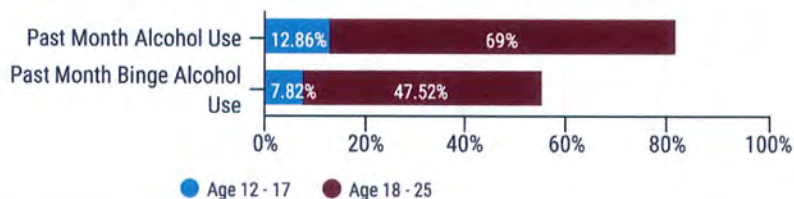
Teen Birth Rates



In 2016, there were **213** births to youth aged 15 to 19 in Vermont, a rate of **10 births per 1,000 women** in this age group.

Alcohol Use Among Youth

In 2016, **58,000** youth ages 12 to 25 in Vermont reported alcohol use in the past month, with **39,000** youth reporting binge alcohol use.



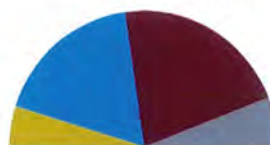
Uninsured Youth in Vermont



In 2016, **7.8%** of youth aged 18 to 24 were uninsured in Vermont, significantly lower than the average uninsured rate of **19%** for this age group in the United States.

Vermont **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Chronic Health Conditions Among Youth Experiencing Homelessness



- Physical Disability
- Developmental Disability
- Severe Mental Illness
- Other Chronic Condition

30% of youth identified as experiencing homelessness during the 2017 Vermont Point-in-Time Count reported chronic health conditions. Of these youth, **9%** had a **physical disability**, **36%** had a **developmental disability**, **43%** had a **severe mental illness**, and **12%** had an "other chronic health condition."

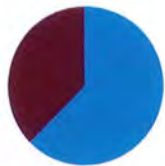
Washington Balance of State: Health Profile



#35
Rank

Youth Mental Health Ranking

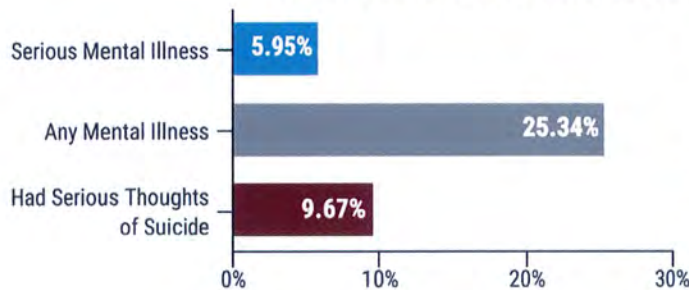
In 2018, Mental Health America ranked Washington **35th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



62.5% of youth with major depression did not receive any mental health treatment.

- **12.54%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **9.3%** of youth experienced severe depression.
- **6.1%** of youth had private health insurance that did not cover mental or emotional problems.
- **4.7 per 1,000 students** in Washington were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Past Year Mental Health Issues Among Youth Aged 18 to 25



In 2016, **189,000** youth aged 18 to 25 in Washington reported experiencing **any mental illness** (any diagnosable mental, behavioral, or emotional disorder) in the past year. **44,000** youth (23% of youth experiencing any mental illness) experienced a **serious mental illness** during this time period.

72,000 youth aged 18 to 25 reported having **serious thoughts of suicide** in the past year.

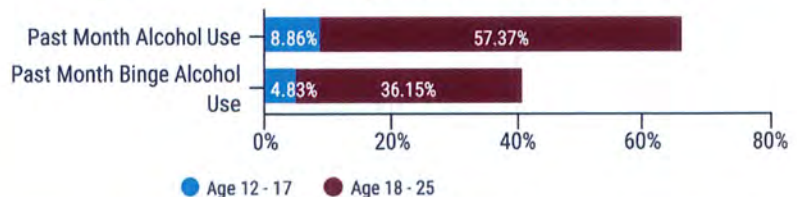
Teen Birth Rates



In 2016, there were **3,584** births to youth aged 15 to 19 in Washington, a rate of **17 births per 1,000 women** in this age group.

Alcohol Use Among Youth

In 2016, **475,000** youth ages 12 to 25 in Washington reported alcohol use in the past month, with **296,000** youth reporting binge alcohol use.



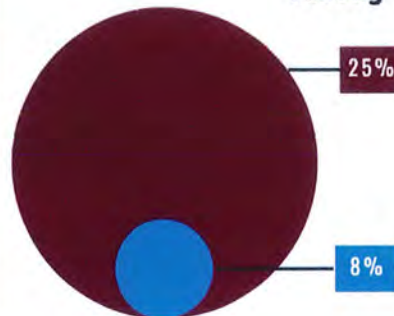
Uninsured Youth in Washington



In 2016, **17.6%** of youth aged 18 to 24 were uninsured in Washington, lower than the average uninsured rate of **19%** for this age group in the United States.

Washington **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Co-Occurring Disorders and Homelessness Among Youth



Youth in Washington with co-occurring substance abuse and mental health needs are **three times more likely to experience homelessness in high school** than those with no behavioral health needs (**25%** compared to **8%**).

Snohomish County, WA: Health Profile

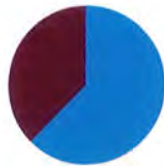


#35

Rank

Youth Mental Health Ranking

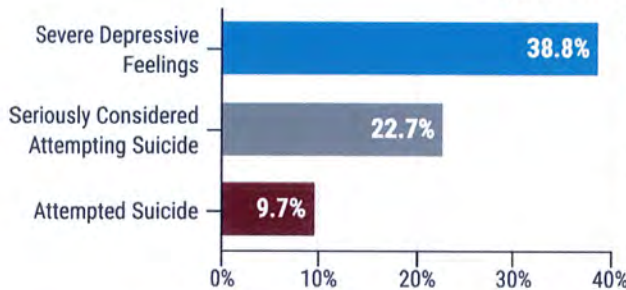
In 2018, Mental Health America ranked Washington **35th** in the country for youth mental health based on prevalence of mental illness and access to care in the state.



62.5% of youth with major depression did not receive any mental health treatment.

- **12.54%** youth (age 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.
- **9.3%** of youth experienced severe depression.
- **6.1%** of youth had private health insurance that did not cover mental or emotional problems.
- **4.7 per 1,000 students** in Washington were identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).

Depression and Suicide Among Youth



The 2016 Healthy Youth Survey found that **38.8%** of 12th grade students in Snohomish County reported **severe depressive feelings** for at least two weeks in a row during the past year.

12th grade students in Snohomish County were **more likely** to report that they had seriously considered suicide in the past year compared to the rest of the state (**22.7%** to **20%**, respectively). **9.7%** of 12th grade students reported **attempting suicide** in the past 12 months.

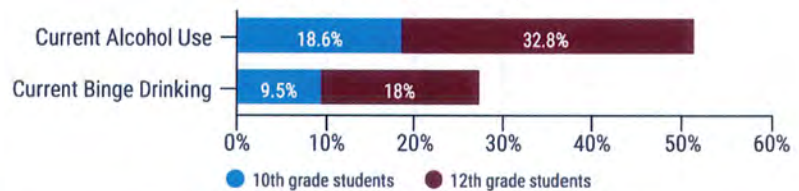
Teen Pregnancy Rates



In 2014, **507** youth aged 15 to 19 experienced a pregnancy in Snohomish County, a rate of **23 pregnancies per 1,000 women** in this age group.

Alcohol Use Among Youth

The 2016 Healthy Youth Survey found that **18.6%** of 10th grade students and **32.8%** of 12th grade students in Snohomish County reported current alcohol use, with **9.5%** of 10th grade students and **18%** of 12th grade students engaging in binge drinking.



Uninsured Youth in Snohomish County



In 2016, **14.8%** of youth aged 18 to 24 were uninsured in Snohomish County, lower than the average uninsured rate of **17.6%** for this age group in the state of Washington.

Washington **has** implemented Medicaid expansion for individuals with incomes below 138% of the Census Bureau's poverty threshold.

Substance Use Among Youth

The 2016 Healthy Youth Survey reported the percentage of 12th grade students in Snohomish County that have ever tried illegal drugs, including **methamphetamine (4.8%)**, **cocaine (6.9%)**, and **heroin (3.2%)**. **6.9%** of 12th grade students reported that they had used any illegal substance (excluding marijuana) to get high in the past 30 days.

