Investing in What Works: How Social Workers Can Influence Policy to Reduce Pregnancies among Homeless Youth

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Abstract

Numerous factors make homeless youth one of the most highly vulnerable youth populations. One such challenge is pregnancy, as homeless youth pregnancy rates are far higher than those of their housed peers. Policies such as the Personal Responsibility Education Program's Innovative Strategies competitive grant mechanism, have been implemented to explore how evidence-based approaches may ameliorate pregnancy prevalence among various groups of high-risk youth. To date, however, no programs have been adopted to specifically target pregnancy reduction among homeless youth, a high-risk youth population that often displays unique causes and risks regarding pregnancy. This overview examines how social workers and other individuals involved in the policy-making process may work to further adapt and promote Innovative Strategies for use with homeless youth populations. In doing so, promising health and life outcomes could be afforded to one of the most vulnerable and underrepresented, while least visible youth populations.

Keywords: unintended pregnancies; homeless youth; health policy; high-risk youth

Overview

As part of the Patient Protection and Affordable Care Act (2010), the Personal Responsibility Education Program (PREP) was created to provide grants for comprehensive, age-appropriate, medically accurate sex education programs to reduce pregnancies and sexually transmitted infections [STIs] (Patient Protection and Affordable Care Act of 2010). To qualify, grantees must replicate evidence-based programs that also emphasize life skills, responsible decision-making, both abstinence and contraception for pregnancy and STI prevention, and conduct culturally responsive programming (Patient Protection and Affordable Care Act of 2010). PREP funding totals $75 million annually, and is jointly administered within the U.S. Department of Health and Human Services (HHS) by the Administration on Children, Youth, and Families (ACYF), and Family and Youth Services Bureau (FYSB).

Within PREP, $10 million of annual funding was designated for an *Innovative Strategies* (PREIS) grant program, which aims to reduce pregnancies specifically among high-risk, vulnerable, and culturally under-represented youth populations (ages 10 to 20), including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women under the age of 21, and youth residing in areas with high birth rates for young parents (Patient Protection and Affordable Care Act of 2010). For organizations that are awarded competitive grants, one of 31 evidence-based curriculum models identified through an HHS-conducted systematic review must be implemented (FYSB, 2012a). To date, 13 programs in 12 states have been allocated grants ranging from $400,000 to $934,000, respectively, to explore innovative strategies within high-risk youth populations (FYSB, 2012a). PREIS is overseen by FYSB in collaboration with the Office of Adolescent Health's (OAH) Teen Pregnancy Prevention Research and Demonstration Program (FYSB, 2012a).

While a serious need exists for programs that reduce pregnancies among vulnerable youth, the commitment of $10 million in annual funding is inadequate. The competitive grant allowance has been fully disbursed, and merely a dozen programs have received support to engage in PREIS approaches. Since there are many categories of high-risk youth included in PREIS eligibility parameters, insufficient funding means that programming may not be adequately implemented (or implemented at all) in each vulnerable population category. For example, none of the existing grantee programs specifically target homeless youth, a group that experiences some of the gravest risk factors regarding pregnancies (FYSB, 2012b). This evaluation thus explores the following hypothesis: *If PREIS funding is increased for purposes of implementing and testing evidence-based programs to reduce pregnancies specifically among homeless youth—a group that faces some of the highest risk factors and likelihoods for pregnancy—then pregnancies within this population will decrease.* In addition to improving this group's health and life outcomes through pregnancy reduction, additional positive outcomes will occur, such as improved maternal-child health outcomes and health care cost savings. Social workers could play an important role in raising awareness among policy decision-makers regarding the unique prevention needs and risks specifically faced by homeless youth. While also advocating for increased PREIS funding for use with homeless youth, social workers could promote the importance of implementing and adapting programs for more relevant and practical use within this population. Social workers could also educate and encourage agencies and organizations that work with homeless youth regarding PREIS funding opportunities as means by which promising pregnancy prevention interventions may be implemented and tested.

Pregnancies Among Homeless Youth

Homeless youth have been defined in different ways by governmental agencies and private services. For the purposes of this evaluation, the broadest federal definition of youth homelessness is used and includes, "an individual who is less than 21 years of age, for whom it is not possible to live in a safe environment with a relatives, and who has no other safe alternative living arrangement" (42 U.S.C. § 5732).

Approximately 1.6 million youth are homeless in the United States (Ringwalt, Greene, Robertson, & McPheeters, 1998). Homeless youth pregnancy rates are five times higher when compared to their housed peers (Greene & Ringwalt, 1998). National and regional studies report that over 50% of female homeless youth indicate past or current pregnancies (Anderson, Freese, & Pennbridge, 1994; Halcón & Lifson, 2004; Tucker et al., 2012; Winetrobe et al., 2013), and at least 10% of female homeless youth are pregnant at any given time (Herndon et al., 2003). Moreover, approximately 73% of pregnancies to homeless youth are unintended (Gelberg, Leake, & Lu, 2001). Repeat pregnancies are also a challenge, as approximately 30% of one study's sample showed that young homeless women participants had been pregnant two or more times (Halcón & Lifson, 2004), with a separate study indicating that about 50% of the women in the sample had been pregnant four or more times (Bassuk & Weinreb, 1993).

Homeless youth often have few legal means to earn sufficient money to meet their basic needs, and many homeless youth view their exchange of sex for food, clothing, and shelter as one of their only viable options for survival on the streets (Anderson et al., 1994; Halcón & Lifson, 2004). In addition to increased risks for unintended pregnancy, homeless youth are thus

also at greater risk of contracting HIV and other STIs (Gangamma, Slesnick, Toviessi, & Serovich, 2008; Solorio et al., 2008), and exhibit higher rates of HIV compared to their housed peers (Beech, Myers, Beech, & Kernick, 2003).

While the vast majority of homeless youth pregnancies are unintended, studies suggest that some homeless youth intentionally seek to become pregnant, as pregnancy and parenthood are viewed as solutions to obstacles they face. As such, pregnancy is perceived as a conduit toward accessing health care and other social services that they often lack (Tucker et al., 2012). In addition, pregnancy and parenting have been described as motivating factors for positive life changes, and create bonds in lieu of relationship voids and feelings of abandonment that homeless youth have often experienced in their respective families of origin (Thompson, Bender, Lewis, & Watkins, 2008; Tucker et al., 2012). For example, in a large representative survey of homeless youth, 21% of the respondents agreed that they would like to become pregnant within the next year, and an additional 25% of youth reported indifference regarding the possibility of pregnancy within the next year (Winetrobe et al., 2013). Pregnancy and pro-pregnancy attitudes, however, are associated with longer homelessness duration (Halcón & Lifson, 2004; Milburn, Rotheram-Borus, Rice, Mallet, & Rosenthal, 2006; Slesnick, Bartle-Haring, Glebova, & Glade, 2006; Thompson et al., 2008; Tucker et al., 2012), and youth who have been homeless for longer timeframes are more likely to show pro-pregnancy attitudes (Tucker et al., 2012).

Furthermore, pregnancy risks are amplified as homeless youth are more likely to begin sexual intercourse at younger ages, and are more likely to have multiple sex partners (Greenblatt & Robertson, 1993). As many as 70% of all homeless youth disclose that they have engaged in unprotected sexual intercourse (De Rosa, Montgomery, Hyde, Iverson, & Kipke, 2001; Rice, Milburn, & Rotheram-Borus, 2007; Tevendale, Lightfoot, & Slocum, 2009; Tucker et al., 2012), with substance use prior to sex also commonly reported (Kral, Molnar, Booth, & Watters, 1997; Tucker et al., 2012). Incidents of rape and sexual victimization are frequent occurrences in homeless populations, thereby increasing pregnancy risks (Stewart et al., 2004), and such victimizations are predictive of repeated experiences of sexual and other physical re-victimization (Whitbeck, Hoyt, & Ackley, 1997). Homeless youth also experience high rates of intra-familial incest prior to leaving home, which sometimes results in pregnancy (Haley, Roy, Leclerc, Boudreau, & Bolvin, 2004). Other youth enter homelessness after becoming pregnant, as they are forced out of their homes by parents or guardians as a result (Meadows-Oliver, 2006).

Homeless youth pregnancy is an important concern for a myriad of reasons. First, the mental and physical stresses of both pregnancy and raising a child(ren) have been found to make women's departures from homelessness more difficult (Webb, Culhane, Metraux, Robbins, & Culhane, 2003). Also, life on the streets has been shown to exacerbate mental health problems (Cauce et al., 2000), particularly in a population that is more likely to screen positive for challenging mental health diagnoses (Bassuk, Buckner, Perloff, & Bassuk, 1998).

Additionally, homeless women of any age are less likely to receive prenatal care and other reproductive health screenings compared to housed women (Chau et al., 2002). Pregnancies that occur while homeless are more likely to result in increased birth complications, and newborns are more likely to be born preterm, at low birth weights, and with neurological and physical problems resulting from prenatal nutritional deficits (Chapman, Tarter, Kirisci, &

Cornelius, 2007; Little et al., 2005; Oliveira & Goldberg, 2002; Stein, Lu, & Gelberg, 2000). While pregnancy may also result in negative health consequences for any homeless woman, the ramifications are particularly pronounced in younger women, as they have been shown to suffer from more acute as well as chronic health problems resulting from pregnancy (Bassuk & Weinreb, 1993; Crawford, Trotter, Sitter Hartshorn, & Whitbeck, 2011).

There are many negative externalities associated with pregnancies to youth in general, whether housed or homeless. Pregnancies to teens and young adults are frequently accompanied by many personal and social costs, and such inequalities experienced by teen mothers are often also intergenerationally reflected in their children. According to the Centers for Disease Control and Prevention [CDC], teen mothers are 50% less likely to complete high school, and are more likely to become single parents (CDC, 2012). Teen mothers are also more likely to remain in poverty and rely on public assistance for longer periods of time (Terry-Humen, Manlove, & Moore, 2005). Children born to teen mothers are less likely to be educationally prepared for kindergarten, and are more likely to have behavioral problems and chronic medical conditions, drop out of high school, give birth as a teenager, become incarcerated at some point during adolescence, and become unemployed or underemployed as an adult (CDC, 2011).

Such pregnancies are also costly, particularly those that are unintended. The total medical cost to taxpayers related to unintended pregnancies (to all women, whether housed or homeless) totals between $9.6 and $12.6 billion annually (Monea & Thomas, 2011); and the costs of prenatal care, labor and delivery, postpartum care, and one year of infant care associated with births resulting from unintended pregnancies totals $11.1 billion in publicly-funded costs to Medicaid and CHIP programs (Sonfield, Kost, Benson Gold, & Finer, 2011). The same study found that 51% of births paid for through such programs were the result of unintended pregnancies. A Brookings Institution (2011) study further examined prenatal, postpartum, and infant care costs associated with publicly-funded unintended pregnancies, and the direct costs of each pregnancy ranged between $7,764 and $10,056. Efforts toward reducing such pregnancies are not only endorsed by leading scientific organizations, but program outcomes are highly measurable through public health markers, such as numbers of live births, maternal-child health outcomes, the number of pregnancies that are voluntarily terminated, and consumer usage of contraceptive methods. Outcomes are also easily measured through cost savings. For example, research indicates that for every $1 spent on contraceptive or pregnancy prevention services, almost $6 in medical costs are saved (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2012).

Using Evidence-Based Programs as Blueprints for Success

Because programs that have received PREIS funding are still in their infancy, limited information exists regarding the impacts they are having so far. However, logical parallels and predictions may be drawn from preliminary successes observed in some of the 31 evidence-based curriculum models that were approved for use in PREIS programs. These precedents may be used by social workers as advocacy tools regarding the need to implement such approaches and adaptations to existing models in homeless youth populations and by potential grantee organizations that serve homeless youth.

For example, *It's Your Game: Keep it Real* is a community-based, culturally-relevant, evidence-based curriculum model that has found, through longitudinal and experimental research design, that teens in the intervention group were significantly less likely than teens in the control group to initiate sex over the course of a 24 month study (Suellentrop, 2011). This model is currently in use with foster care youth who participate in a PREIS-funded program in Nebraska (FYSB, 2012b). As traditional school-based youth pregnancy prevention models are not typically the most practical fit for work with populations that frequently fluctuate between state care or among placements, such as foster youth, *It's Your Game, Keep it Real* was chosen as an intervention approach to be further explored through PREIS funding (FYSB, 2012b). Because of transience and unstable housing status, preliminarily promising results obtained from the Nebraska-based intervention should be highlighted as a potentially compelling and transferrable fit for use with homeless youth, who display similar challenges in terms of effective service delivery and outreach because of transience, unstable housing, and a lower likelihood of being present in school-based settings (Ringwalt et al., 1998).

Another possibility of applying PREIS-approved evidence-based programs to interventions with homeless youth is through the use of *Andersen's Behavioral Model of Health Service Use*, a long-standing theoretical model that has been tested in a multitude of ways with vulnerable populations regarding their use of health services and engagement in health-promoting behaviors (FYSB, 2012b). Gelberg, Andersen, and Leake (2000) tested the model in a study with homeless individuals, and found they are significantly more likely to obtain care if they believe it is important, and most notably if they have access to health-related resources to do so. Furthermore, *Teen Options to Prevent Pregnancy* (T.O.P.P.), which is based directly on Andersen's model, is currently being used in an Ohio-based PREIS grant program. T.O.P.P. is a randomized trial that further assesses the efficacy of a combination of telephone-based care coordination and mobile contraceptive services to reduce educational, attitudinal, and logistic barriers to contraceptive use and adherence (FYSB, 2012b). While this initiative aims to reduce pregnancies, it also has goals of preventing repeat pregnancies among parenting, low-income women, ages 10 to 19 (FYSB, 2012b). Because Andersen's model has been shown to be effective elsewhere in work with homeless populations, and its derivative, T.O.P.P. is being employed among vulnerable youth who are transient and who have previously been pregnant, this is another intervention that should be considered for use with homeless youth. Because homeless youth are often considered a *hidden* population and lack stable contact information (Ringwalt et al., 1998), and because of the aforementioned repeat pregnancy rates among homeless youth (Bassuk & Weinreb, 1993; Halcón & Lifson, 2004), such programming demonstrates logical and potentially compelling relevance to homeless youth.

While myriad critiques of evidence-based practice exist, in this case, it's plausible that an erosion of trust in evidence-based practice could be an unintended consequence of having promising programs in place and simply failing to comprehensively use them with their intended audiences. For instance, homeless youth are one of the highest-risk demographic groups regarding pregnancies, while current PREIS-funded programs focus on pregnancy reduction within other eligible vulnerable youth groups. As such, nothing innovative is being tested to reduce pregnancies specifically among homeless youth through federally-funded, evidence-based approaches. It is thus unlikely to see a decline in homeless youth pregnancies, and reduced support for both evidence-based curricula as well as government-funded competitive grant

programs could be the unfortunate outcome of PREIS when considered from a homeless youth pregnancy issue-perspective. This outcome could yield funding stream reductions for evidence-based approaches, in addition to further problem prevalence and its associated ramifications.

Furthermore, homeless youth comprise perhaps the only high-risk youth category (as defined by PREP *Innovative Strategies* eligibility) that does not otherwise have some level of guaranteed health care access and coverage through Medicaid, CHIP, and/or Title IV-E funding, that for example, youth in foster care or vulnerable youth who still live with their family of origin or legal guardians typically possess (National Association for the Education of Homeless Children and Youth, 2011). As such, expanding coverage of PREIS grant opportunities for programs regarding homeless youth does not suggest taking resources from one vulnerable group to give to another. Rather, as success stories continue to emerge from current grantee programs, agencies such as Medicaid, CHIP, and Title IV-E programs could contribute to funding further prevention-based PREIS programs. In doing so, the individualized needs of the many groups of vulnerable youth that fall under such auspices, respectively, could be more narrowly targeted while more comprehensively served.

Conclusion

An important onus exists upon social workers to advocate for homeless youth, who experience some of the gravest experiences and outcomes associated with pregnancy. By illuminating the unique factors that make this population particularly vulnerable to such outcomes, policy-makers as well as agencies who serve homeless youth may become more educated about and encouraged to fund, implement, adapt, and test PREIS pregnancy prevention programs specifically for homeless youth. In doing so, pregnancies among homeless youth may be reduced, maternal-child health outcomes improved, health care costs saved, and homeless youth may be afforded tools by which their health and life outcomes are optimized.

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