# Review Notes

# Chapter 23: Homelessness, Poverty, Mental Illness, and Teen Pregnancy

I. Defining and understanding *poverty*

A. *Poverty* refers to having insufficient financial resources to meet basic living expenses for food, shelter, clothing, transportation, and medical care. It is estimated that more than 40 million people have incomes below the federal poverty level.

B. Types of poverty. *Persistent poverty* refers to individuals and families who remain poor for long periods and pass it on to their descendants. *Neighborhood poverty* refers to geographically defined areas of high poverty, characterized by dilapidated housing and high levels of unemployment.

C. Causes of poverty are complex and interrelated. The following are identified causes of poverty: decreased earnings, increased unemployment rates, changes in the labor force, increase in female-headed households, inadequate education and job skills, inadequate antipoverty programs, inadequate welfare benefits, weak enforcement of child support statutes, dwindling Social Security payments to children, and increased numbers of children born to single women.

# D. Poverty and health across the life span. Poverty directly affects health and well-being. Persons living in poverty experience higher rates of chronic illness, higher infant morbidity and mortality, shorter life expectancy, and more complex health problems; hospitalization rates are three times more than for persons with higher incomes. These poor health outcomes are often secondary to barriers that impede access to health care, such as inability to pay for health care, lack of insurance, geographical location, language, inability to find a health care provider, transportation difficulties, inconvenient clinic hours, and negative attitudes of health care providers toward poor clients.

1. Women of childbearing age. Women living in poverty have lower levels of physical functioning and higher reported levels of bodily discomfort than do women in higher socioeconomic groups. Prevalence rates for ulcer disease, asthma, and anemia are significantly higher in this group.

2. Adolescent women. Poor teens are more likely than nonpoor teens to have below-average academic skills, to drop out of school, and to have children. Poor pregnant women are more likely than other women to receive late or no prenatal care and to deliver low-birthweight babies, premature babies, or babies with birth defects.

3. Children. Many American childrenare members of the 5H club. They are hungry, homeless, hugless, hopeless, and without health care. The 2000 poverty rate of 16.2% for children is higher than that for any other age-group. Poverty among children (newborn to age 5 years) has increased in all racial and ethnic groups and in all urban, suburban, and rural geographic areas.

4. Young children (0 to 5 years of age) are at highest risk for the most harmful effects of poverty especially in regard to adequate nutrition and brain development. Other risk factors include maternal substance abuse or depression; exposure to environmental toxins, trauma, and abuse; and poor-quality daily care.

5. Older adults. In 2000, an estimated 10.2% of older adults (65 years and over) lived in poverty. This is a decrease in the poverty rate for this age-group largely because of improvements in Social Security and the Supplemental Security Income Program. However, poor elders are at greater risk for chronic illness and chronic illness with complications, poor dental health, and an overall higher mortality rate than are older adults in general.

II. Concept of homelessness

A. Poverty can lead to homelessness. Homelessness is estimated to be growing by 5% per year. It is hard to determine the exact number of homeless people. People who live on the street are the poorest of the poor, and they may be viewed as faceless, nameless, invisible, inaudible entities. A homeless person is one who lacks a fixed, regular, and adequate personal nighttime residence.

B. The concept of homelessness includes two broad categories:

1. Crisis poverty

a. Lives are generally marked by hardship and struggle.

b. Homelessness is often transient or episodic.

c. The homeless person may resort to brief stays in shelters or other temporary accommodations.

d. Homelessness may result from lack of employment opportunities, lack of education, obsolete job skills, or domestic violence.

e. These issues lead to persistent poverty and need to be addressed along with efforts to find stable housing.

2. Persistent poverty

a. Chronically homeless men and women, many of whom have mental or physical disabilities

b. The group most frequently identified with homelessness in the United States

c. Physical and mental disabilities often coexist with alcohol and other drug abuse, severe mental illness, other chronic health problems, and/or chronic family difficulties.

d. Lack money and family support

3. Often end up living on the streets; they need economic assistance, rehabilitation, and ongoing support.

C. Today’s homeless include people of every age, sex, ethnic group, and family type.

1. They are rural and urban people.

2. The single homeless tend to be younger and better educated than stereotypes would suggest.

3. Two trends have influenced homelessness over the past 25 years: a growing shortage of affordable rental homes and a simultaneous increase in poverty.

4. Families with children are the fastest-growing segment of the homeless population.

## D. Causes of homelessness

1. Most people move into homelessness gradually. Once they give up their own homes, they move in with family or friends. Only when all other options are exhausted do people go to shelters or seek refuge on the streets.

2. Many factors contribute to the increasing numbers of homeless persons:

a. More people living in poverty

b. A decrease in the number of affordable housing units and gentrification of neighborhoods and consequential increased costs for housing

c. Loss of single-room occupancy buildings where people could rent a room on a long-term basis

d. Emergency demands on income

e. Alcohol and drug addiction

f. Limited numbers of transitional treatment facilities for deinstitutionalized mentally ill individuals

E. Effects of homelessness on health

1. Homelessness is correlated with acute and chronic illness, acquired immunodeficiency syndrome (AIDS), trauma, and difficulty accessing health care services. Health care is usually crisis oriented and sought in emergency departments; those who access health care have a hard time following prescribed regimens.

2. Homelessness also affects psychological, social, and spiritual well-being. Becoming homeless also means losing friends, personal possessions, and familiar surroundings. Homeless persons live in chaos, confusion, and fear, experiencing loss of dignity, low self-esteem, lack of social support, and generalized despair.

## F. Homelessness and at-risk populations

1. Homeless pregnant women are at high risk for complex health problems. They have higher rates of sexually transmitted diseases, higher incidences of addiction to drugs and alcohol, poorer nutritional status, and a higher incidence of poor birth outcomes. Severity of homelessness significantly predicts lower birthweight and preterm births.

2. Homeless children have poorer health than do children in the general population, and they experience more symptoms of acute illness, such as fever, ear infection, diarrhea, and asthma than do their housed counterparts. Homeless children living on the streets in urban areas are at greatest risk for poor health because of poor nutrition, inconsistent health care, high levels of anxiety, and an inability to practice good health behaviors. Homeless children also experience higher rates of school absenteeism, academic failure, and emotional and behavioral maladjustments.

3. Homeless adolescents exhibit greater risk-taking behaviors including earlier onset of sexual activity, poorer health status, and decreased access to health care than do teens in the general population. Homeless teens often have histories of runaway behavior, physical abuse, and sexual abuse. Once on the streets, many homeless adolescents exchange sex for food, clothing, and shelter.

4. Homeless older adults generally have lived in long-standing poverty, have fewer supportive relationships, and are likely to have become homeless as a result of catastrophic events. Permanent physical deformities, often secondary to poor or absent medical care, are common among homeless older adults. Homeless older adults suffer from untreated chronic conditions, including tuberculosis, hypertension, arthritis, cardiovascular disease, injuries, malnutrition, poor oral health, and hypothermia.

III. Adolescent sexual behavior and pregnancy

A. Many teens who become pregnant get caught in a cycle of poverty, school failure, and limited life options, and some become homeless. Each year 800,000 to 900,000 teens become pregnant, and more than half go on to have babies. Births to teenagers make up 12% of all births in the United States.

1. In 1996, 35% of pregnancies to teenagers were ended by elective abortion. Elective abortion rates for teenagers increased from the time of legalization in 1973 until 1986. From 1986 to 1994, there was a 21% decrease in abortions to teens, caused in part by decreases in the pregnancy rate but may also have resulted from laws that required parental notification or consent for minors requesting abortion.

a. Adolescents who terminate their pregnancies by abortion differ from those who give birth in that they are more likely to complete high school, are more successful in school, have higher educational aspirations, and are more likely to come from a family of a higher socioeconomic status.

# B. Background factors

1. Teens often feel invincible and therefore do not recognize any risk related to their behaviors or anticipate the consequences. They may not believe that sexual activity will lead to pregnancy.

2. The first experience with intercourse and use of birth control for a teen affects pregnancy risk. Half of all first-time pregnancies occur within 6 months of initiating intercourse. One-half to two-thirds of all teenage girls in tenth to twelfth grades are sexually active; 78% of adolescent girls report use of birth control at first voluntary coitus. Male teens use condoms with increasing frequency but not consistently. The earlier the sexual debut, the less likely a birth control method will be used, as younger teens have less knowledge and skill related to sexuality and birth control.

3. Teens are more likely to be sexually active if their friends are sexually active.

4. Pregnant teenagers have a greater likelihood of having been sexually abused during their lifetime. Adolescent girls with a history of sexual abuse are at risk for earlier initiation of voluntary sexual intercourse, are less likely to use birth control, are more likely to use drugs and alcohol at first intercourse, and are more likely to have older sexual partners.

5. Family structure can influence adolescent sexual behavior and pregnancy. Adolescents raised in single-parent families are more likely to have intercourse and to give birth than are those raised in two-parent families. Parenting styles can influence a young woman’s risk for early sexual experiences and pregnancy. Children of parents who are neglectful are the most sexually experienced, followed by children of parents who are very strict.

# C. Young men and paternity

1. One in 15 males becomes a father during the teen years. Teen fathers face special challenges because of their own social problems including delinquency, alcohol or substance use, school problems, and limited future plans or ability to provide support. Paternity is legally established at the time of the birth for a married teen. It is more difficult to establish paternity among nonmarried couples.

2. Young men react differently when they learn that their partner is pregnant. The reaction often depends on the nature of the relationship before the pregnancy. Many young men will accompany the young woman to some prenatal visits and may even attend the delivery.

3. Nurses can acknowledge and support the young man as he develops in the role of father. His involvement can positively affect his child’s development and provide greater personal satisfaction for himself and greater role satisfaction for the young mother. Immediate concerns are his financial responsibility, living arrangements, relationship issues, school, and work. Establishing an opportunity to meet with the young man and both families is helpful to clarify these issues and identify roles and responsibilities.

# D. Early identification of the pregnant teen

1. Some teens delay seeking pregnancy services because they do not recognize such signs as breast tenderness and a late period. A teen also may delay seeking care to keep the pregnancy a secret from family members.

2. Once the nurse identifies the specific concern, information can be provided about how and when to obtain pregnancy testing. If the pregnancy test is positive, the next step is to perform a physical examination and pregnancy counseling. Pregnancy counseling should include the following:

a. Information on adoption, abortion, and childrearing

b. Assessment of support systems for the young woman

c. Identification of the immediate concerns she might have

# E. Special issues in caring for the pregnant teen

1. Pregnant teenagers are considered high-risk obstetric clients. Pregnancy complications can result from poverty, late entry into prenatal care, and limited self-care knowledge. Teens are more likely to get no prenatal care or to begin the care later in the pregnancy than are their older counterparts. Nursing interventions through education and early identification of problems may dramatically alter the course of the pregnancy and the birth outcome.

2. Violence. Teens are more likely to experience violence during their pregnancies than are adult women. Violence in pregnancy has been associated with an increased risk for substance abuse, poor compliance with prenatal care, and poor birth outcome. Eliciting this history from an adolescent is not easy. The nurse must ask about and observe for violence at each visit. Frequent routine assessments are more revealing than a single inquiry at the first prenatal visit.

3. Nutrition. Teens often do not have good nutrition patterns. The nutritive needs of both pregnancy and the concurrent adolescent growth spurt require the adolescent to change her diet substantially. The growing teen must increase caloric nutrients to meet individual growth needs and allow for adequate fetal growth. Poor eating patterns of the teen and her current growth requirement may leave her with limited reserves of essential vitamins and minerals when the pregnancy begins. The nurse can assess the pregnant teenager’s current eating pattern and provide creative guidance.

## F. Infant care

1. Few teens are ever prepared for the reality of 24-hour care of an infant. The nurse can help prepare the teen for the transition to motherhood while she is still pregnant. The nurse can enlist the support of the teen’s parents in education about infant care and stimulation. Young fathers-to-be would benefit from this education as well.

2. After the birth of the baby, the nurse should observe how the mother responds to infant cues for basic needs and distress. It is important to begin parenting education as early as possible. Adolescents who feel competent as parents have enhanced self-esteem, which in turn positively influences their relationship with their child.

G. Schooling and educational needs of pregnant teens. Teen parents may have had limited school success before the pregnancy. Coping with the demands of childrearing coupled with the immaturity of the young mother may make school even less of a priority. Legislation passed in 1975 prohibits schools from excluding students because they are pregnant. Greater emphasis is placed on keeping the pregnant adolescent in school during the pregnancy and having her return as soon as possible after the birth.

IV. Mental illness. Definitions and context

A. Mental health and illness can be viewed as a continuum. *Mental health* is defined in *Healthy People 2010* as being able to engage in productive activities and fulfilling relationships with other people, to adapt to change, and to cope with adversity. Mental disorders are conditions characterized by alterations in thinking, mood, or behavior that are associated with distress and/or impaired functioning. *Mental illness* refers collectively to all diagnosable mental disorders.

B. Mental disorders can occur across the life span and affect persons of all races, cultures, sexes, and educational and socioeconomic groups. In the United States, approximately 40 million adults, or 22% of the population, have a mental disorder. In addition to diagnosable mental conditions, there is increasing concern regarding the public health burden of stress, especially after the terrorist attacks in 2001 and the war in Iraq. Strengthening the public health sector to respond to terrorism involves developing mental health responses and other defenses.

# C. Deinstitutionalization

# 1. Deinstitutionalization involved moving many people from state psychiatric hospitals to communities to improve the quality of life for people with mental disorders by providing services in the communities where they live rather than in large institutions.

# 2. However, the community-based services were not often in place when persons were released to the community, and continuity of care became a problem. Families were not prepared for the treatment responsibilities they had to assume. Some clients found themselves in independent settings, such as rooming houses and single-room occupancy hotels, with little or no supervision. Clients, families, communities, and the nation suffered as poor living and social conditions were associated with mental disorders.

# 3. These types of issues prompted additional legislation and advocacy efforts, one of which was the development of community mental health centers (CMHCs). CMHCs were based partially on the principle that persons with mental disorders had a right to treatment in the least restrictive environment. Although CMHCs did prove less restrictive than institutions, they lacked necessary services.

D. At-risk populations for mental illness

## 1. Children and adolescents. Children are at risk for disruption of normal development by biological, environmental, and psychosocial factors that impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults. For example, children may develop depression after a loss or behavior problems from abuse or neglect. Examples of environmental factors include crowded living conditions, violence, separation from parents, and lack of consistent caregivers.

## a. Types of mental health problems typically diagnosed during childhood are depression, anxiety, and attention-deficit disorders. Suicide is the third leading killer of young persons between the ages of 15 and 24, and in 90% of cases, there was a mental or substance abuse disorder.

## b. Effective service for children, particularly for those with serious emotional disturbances, depends on promoting collaboration across critical areas of support, including schools, families, social services, health, mental health, and juvenile justice. Children and adolescents require a variety of mental health services, including crisis intervention and both short- and long-term counseling. Nurses working in community settings, well-child clinics, and home health can help to offset this problem through prevention and education.

## 2. Adults

## a. Stress contributes to adults’ mental health status. Sources of stress include multiple role responsibilities, job insecurity, and unstable relationships. These and other conditions can undermine mental health and contribute to serious mental illness, depression, anxiety disorders, and substance abuse.

b. Major depressive disorder differs both in intensity and duration from normal sadness or grief. Depression disrupts relationships and the ability to function and can be fatal. Anxiety disorders are common both in the United States and elsewhere. An alarming 24% of the population will experience an anxiety disorder, many with overlapping substance abuse disorders. Anxiety disorders may have an early onset and are characterized by recurrent episodes of illness and periods of disability.

c. The lifetime rates of cooccurrence of mental disorders and addictive disorders are high. About one in five persons in the United States experiences a mental disorder in the course of a year, and nearly one in three adults who have a mental disorder in their lifetime also experiences a cooccurring substance (alcohol or other drugs) abuse disorder.

## 3. Adults with serious mental illness

## a. Brief hospital stays and inadequate community resources have resulted in an increased number of persons with serious mental illness living on the streets or in jail. At present, many people with severe mental disorders live in poverty because they lack the ability to earn or maintain a suitable standard of living.

## b. Rehabilitation services, intensive case management, and persistent patient outreach and engagement strategies have been shown to be effective in helping persons with serious mental illness.

## 4. Older adults

## a. As the life expectancy of individuals continues to grow, the number experiencing mental disorders of later life will increase. Although many older people maintain highly functional lives, others have mental health deficits associated with normal sensory losses related to aging, failing physical health, difficulty performing activities of daily living, and social deprivation or isolation. Life changes related to work roles and retirement often result in reduced social contacts and support. Other losses are associated with the death of a spouse, other family members, or friends.

b. The presence of a physical or chronic illness increases rates of depression in older people. Depression rates for older adults in nursing homes range from 15% to 25%. Such healthy aging activities as physical activity and establishing social networks improve the mental health of older adults. Older adults underutilize the mental health system and are more likely to be seen in primary care or to be recipients of care in institutions. The nurse can reach them by organizing health promotion programs through senior centers or other community-based settings. Stress management for caregivers and respite day care programs for an older adult family member can increase coping and prevent abuse. Nurses can advocate with health authorities and localities to increase awareness of the importance of meeting the mental health needs of this growing population.

## V. Levels of prevention

## A. Primary prevention

## 1. Primary preventive services for all four of these special populations include affordable housing, housing subsidies, effective job training programs, employer incentives, preventive health care services, multisystem case management, birth control services, safe sex education, needle-exchange programs, parent education, and counseling programs.

## 2. Nurses can provide education about stress-reduction techniques to seniors attending a health fair as primary prevention for mental health problems. They also can form networks with other health professionals to educate policymakers and the public about the value of these preventive services. These programs could prevent homelessness from occurring at all.

B. Secondary prevention

1. Secondary preventive activities are aimed at reducing the prevalence or pathological nature of a condition. They involve early diagnosis, prompt treatment, and limitation of disability. Examples include supportive and emergency housing, targeted case management, housing subsidies, soup kitchens and meal sites, and comprehensive physical and mental health services.

2. Nurses can work with homeless and near-homeless aggregates to provide education about existing services and strategies for influencing public policy that will provide more comprehensive services for homeless and near-homeless persons.

C. Tertiary prevention

1. Tertiary prevention efforts attempt to restore and enhance functioning. On a community level, these might include support of affordable housing, promotion of psychosocial rehabilitation programs, and involvement in advocacy groups for the mentally ill or homeless population. Tertiary prevention of homelessness includes comprehensive case management, physical and mental health services, emergency shelter housing, needle-exchange programs, and drug and alcohol treatment.

2. It is important to know about the social and political environments in which problems occur. Nurses can influence politicians and other policymakers at the federal, state, and local levels about the plight of vulnerable populations in their community.

# VI. Role of the nurse

A. Nurses have a critical role in the delivery of health care to poor, homeless, mentally ill, and other high-risk people. Nurses need to be able to work with their clients to promote, maintain, and restore health. Nurses must be prepared to look at the whole picture: the person, the family, and the community interacting with the environment.

B. Important strategies to consider when working with at-risk individuals, families, and aggregates:

1. Create a trusting environment.

2. Show respect, compassion, and concern.

3. Do not make assumptions.

4. Coordinate a network of services and providers.

5. Advocate for accessible health care services.

6. Focus on prevention.

7. Know when to walk beside the client and when to encourage the client to walk ahead.

8. Develop a network of support for yourself.