

Health-Seeking Challenges Among Homeless Youth

Angela L. Hudson ▼ Adeline Nyamathi ▼ Barbara Greengold ▼ Alexandra Slagle
Deborah Koniak-Griffin ▼ Farinaz Khalilifard ▼ Daniel Getzoff

- ▶ **Background:** Approximately 1.5 to 2 million homeless young persons live on the streets in the United States. With the current economic situation, research is needed on quality of services geared toward homeless young adults.
- ▶ **Objectives:** The objective of this study was to explore homeless young adults' perspectives on barriers and facilitators of health-care-seeking behavior and their perspectives on improving existing programs for homeless persons.
- ▶ **Methods:** This article is a descriptive qualitative study using focus groups, with a purposeful sample of 24 homeless drug-using young adults.
- ▶ **Results:** Identified themes were failing access to care based on perceived structural barriers (limited clinic sites, limited hours of operation, priority health conditions, and long wait times) and social barriers (perception of discrimination by uncaring professionals, law enforcement, and society in general).
- ▶ **Discussion:** Results provide insight into programmatic and agency resources that facilitate health-seeking behaviors among homeless young adults and include implications for more research with providers of homeless health and social services.
- ▶ **Key Words:** health care · health-seeking behaviors · homeless · young adults

Adolescent homelessness is a distressing social problem. Approximately 1.5 to 2 million homeless adolescent persons live on the streets in the United States (Bucher, 2008); homelessness among young persons is more common than homelessness among older adults (Ensign, 2004). Young persons often leave their family of origin due to parental conflict; violence between family members; or physical, sexual, or emotional abuse by a family member (Johnson, Rew, & Sternglanz, 2006; Rosenthal, Mallett, & Myers, 2006). Consequently, they leave homes of risk to encounter risky living situations on the streets.

Homeless young adults are highly vulnerable to negative health consequences because of the realities of street life, which include substance use, risky sexual behavior, unhygienic living conditions (Ensign & Bell, 2004), and poor access to health care (Ensign & Panke, 2002). Homeless young persons also are at risk for sexual and physical abuse (Alexander & Schrauben, 2006), both of which have been associated with poorer health (Wenzel, Hambarsoomian,

D'Amico, Ellison, & Tucker, 2006). In a survey of homeless adolescents, over 60% of the participants reported a history of sexual abuse, 56.3% had injected drugs, and 12.3% had attempted suicide at least once (Rew, Taylor-Seehafer, & Fitzgerald, 2001).

Other negative health consequences experienced by homeless young adults include sexually transmitted infections, poorly controlled chronic mental illness, and lack of immunization for conditions, such as hepatitis A and hepatitis B (Hudson, Nyamathi, & Sweat, 2008). Homeless young adults also are at increased risk for the development of respiratory disease, thought to be related to exposure to tuberculosis and influenza (Haldenby, Berman, & Forchuk, 2007). In addition to the mentioned problems, homeless young adults often experience posttraumatic stress disorder, skin disorders (Rew et al., 2001), foot problems, and lice (Kelly & Caputo, 2007).

Homeless persons are more likely to be admitted to the hospital and have increased durations of hospitalization than those of nonhomeless persons due to negative health consequences associated with street living. Despite their high burden of illness, homeless persons have fewer ambulatory care encounters than those of nonhomeless persons (Kushel, Vittinghoff, & Haas, 2001). Nearly half of all homeless young persons have no regular source of health care (Sneller et al., 2008).

There are several reasons homeless young adults may not receive regular health care; these include fear of social service agency notification, fear of legal intervention, lack of familiarity with respect to how to access health care resources, and lack of affordable health insurance (Klein et al., 2000). Lack of insurance, transportation problems, and lack of respect from providers were some of the barriers to health care identified in a study of the perceptions of homeless women living in Seattle (Ensign & Panke, 2002). Lack of insurance and lack of a regular source of care have been associated with poor access to health care among homeless women (Lim, Andersen, Leake, Cunningham, & Gelberg, 2002).

Angela L. Hudson, PhD, RN, FNP-C, is Assistant Professor; Adeline Nyamathi, PhD, ANP, FAAN, is Associate Dean for Academic Affairs; Barbara Greengold, PhD, RN, is Research Collaborator; Alexandra Slagle, is Research Assistant; Deborah Koniak-Griffin, EdD, RNC, FAAN, is Professor and Section Chair, Primary Care; and Farinaz Khalilifard, MA, BS, is Project Director, School of Nursing, University of California, Los Angeles. Daniel Getzoff, BA, is Director, Common Ground, Los Angeles, California.

Carlson, Sugano, Millstein, and Auerswald (2006) reported that homeless youth and young adults access targeted services depending on their stage of homelessness. When homeless young persons are in stasis or well integrated into street culture, accessing health-related services is not a priority; however, in the stage of disequilibrium, crises are frequent, and it is in crisis mode that the homeless seek mental health, drug abuse, and medical services. Therefore, their perspectives about quality of services might be less than ideal.

In addition to the barriers mentioned earlier, studies to address health care utilization specifically among homeless young adults have revealed other barriers—lack of knowledge regarding use of insurance (for those who have insurance), confidentiality issues, and the perception that health care systems have restrictive rules and regulations—that have been associated with poor service utilization (De Rosa et al., 1999). Lack of appropriate providers, lack of health care facilities, cultural and spiritual barriers, language barriers, and distrust of health care providers have been identified also as barriers by homeless young persons (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008). In another study, lack of insurance, lack of the ability to pay for services, stigmatization, and the sense of disrespect toward the homeless condition have been identified as barriers to health care delivery (Martins, 2008). Martins (2008) suggested that there are two separate, but not equal, health care delivery systems and that a homeless person does not receive the same degree of respect that is given to nonhomeless persons.

The perceptions of how homeless persons view the health care system have not been well studied. In one study, participants reported that when they felt discrimination relative to their homeless status, they were not likely to seek health care (Wen, Hudak, & Hwang, 2007). These authors concluded that homeless persons' perceptions of discrimination determine whether or not they access a health care system. An ethnic difference exists, such that homeless young persons, who were White, acknowledged homelessness as stigmatizing but did not reject the label of *homeless*, unlike African American youth (Hickler & Auerswald, 2009). White youth and young adults embraced their slovenly appearance, poor hygiene, tattoos, and body piercings. They congregated to form social networks, establish shared identities, and share knowledge regarding street life among themselves. They knew supportive professionals, resources, and services.

Thus far, several barriers faced by homeless persons (in particular, young homeless persons) have been identified. To improve health care access among homeless young adults, it is also important to address factors that might facilitate health care delivery. Barkin, Balkrishnan, Manuel, Andersen, and Gelberg (2003) showed that the possession of public health insurance improved health care utilization among homeless adolescents and young adults. In another study, the relationship between homelessness and health care access was examined, with the conclusion that strategies to improve health outcomes among emancipated youth should address issues such as lack of health insurance and housing instability (Kushel, Yen, Gee, & Courtney, 2007). It has been suggested also that Medicaid and the State Children's Health Insurance Program, in conjunction with financing from other public programs, should be used to facilitate health

care access to young adults leaving foster care (English, Morreale, & Larsen, 2003).

Some other facilitators which may improve health care access for the homeless population include the provision of needle exchange programs, vaccination prevention, and assertive outreach within the community (Wright & Tompkins, 2006). Behavior-oriented interventions of health promotion using counseling to help homeless adolescents reduce risky behaviors may result in improved health among this group (Flick & Rohnsch, 2007). There is a growing assertion that improvements should be made with respect to the provision of quality care for the homeless young adults living in the United States (Ensign, 2004) and that social policy for this group should be implemented at the grassroots community level (Rew et al., 2001). One way to achieve high-quality programs designed to improve health care for homeless adults is to solicit these adults' input in program development. The purpose of this article was to gain a further understanding of the perceptions of homeless youth regarding their health-care-seeking behaviors and included the following research questions:

1. What are homeless young adults' perspectives on facilitators and barriers to receiving health care?
2. How can existing homeless youth and young-adult-centered health care programs be improved?

This study is based on the comprehensive health seeking and coping paradigm (Nyamathi, 1989). Variables such as demographic factors, situational factors, or personal resources situate and characterize one's environment and how they affect an individual's health-seeking and coping responses. The framework guiding this research concerns a situational factor (homelessness among young adults) and available resources (social support, financial security, and physical and emotional health) and provides some understanding on how homeless young adults might view facilitators and barriers to receiving health care.

Methods

Design

A qualitative study was conducted with 24 homeless young adults frequenting services of a drop-in site in Santa Monica. Using focus groups guided by a semistructured interview guide (SSIG; Table 1), the focus of the study was to engage homeless young adults in providing perspectives about the health problems they experienced, the struggles they encountered in seeking health care, and how they managed to seek care despite these challenges. The study was part of a larger study exploring the effect of an arts program on risky behaviors among homeless young adults. An early version of a SSIG was designed with previous focus groups with youth, funded as a small pilot study. However, there was no discussion on artistic messaging at that time. With the current focus groups, one of the tasks was refining the previous SSIG to fit the current circumstances.

Community Advisory Board

On the basis of the community-based participatory research approach (Horowitz, Robinson, & Seifer, 2009; Lindamer

TABLE 1. Semistructured Interview Guide

1. Please tell us what health services you have sought in the last few years?
2. If you ever had a time when you had a health problem but did not seek care for it, what got in the way?
3. What has helped you get health care when you needed it?
4. What kind of substances do your friends or youth like you use?
5. For youth who use, what do you think are the reasons they would not get treatment?
6. What do you think has helped your friends or youth like you in accessing drug treatment or what do you think would help?
7. For those of you who might want more information about your health and where to go for help, what might be the best way to communicate these messages to you or to your friends?
8. How would you or your friends be willing to help health care providers develop health messages related to the dangers of drug and alcohol use and of HIV/AIDS?
9. What are the creative ways you might be able to create messages?
10. How can these creative ways better enable you to develop such messages?

et al., 2009), a community advisory board (CAB) was formed, which included homeless young adults in guiding the design, implementation, and assessment of the Phase I qualitative segment in preparation for a Phase II intervention.

Grounding in cultural sensitivity for the qualitative phase of the study and in the formation of the SSIG questions to be utilized in the focus group sessions was achieved using a CAB. Board membership included three University of California, Los Angeles (UCLA), researchers and staff; three faculty and graduates of the California Institute of the Arts; three homeless young adults; and one staff member affiliated with Common Ground, a homeless youth and young adult drop-in site located in Santa Monica, California. Common Ground offers a hangout place for youth and young adults. This includes computer terminals, television, and music and the ability to take a shower, have a snack, or talk to a counselor. In addition, on specified nights, dental or medical students provide basic care and referrals. Common Ground is known widely, and all youth and young adults receive these types of services to the extent that they need.

The CAB actively engaged in a number of meetings prior to the conduct of the focus group sessions. These discussions were centered on the importance of modifying the SSIG to ascertain that questions were being asked in a culturally sensitive manner and to understand from the homeless young adult participants within the CAB that the questions would adequately capture an understanding of the life experiences of homeless young adults, particularly those who are drug users, as it relates to interest in accessing health care and how their lifestyle impacted their health-seeking activities. With an overarching goal to utilize art messages for promoting a healthy lifestyle for homeless young adults, the CAB members designed art posters that were used to attract homeless young persons to the focus group sessions.

Participants and Setting

Twenty-four young adults who participated in the focus group sessions resided or congregated in Santa Monica and frequented the services of the Common Ground drop-in site. Individuals were eligible if they were 18 to 25 years old, self-reported as street youth, and reported use of drugs over the last 30 days.

Procedures

Recruitment was encouraged by posting the colorful art flyers at the Common Ground site. These flyers featured the human-subjects-approved information about the study and referred young adults to the research staff. Interested persons were presented information about the study by the research staff and were read and discussed the consent form detailing the nature of the study. For all young persons still interested in participating, the consent form was signed. Subsequent to the signing of the consent, a brief sociodemographic questionnaire was completed. All participants who signed informed consent completed the focus group session to which they were assigned.

A total of five focus group sessions were conducted, with 4 to 6 participants in each group. Smaller groups were recommended so everyone had a chance to speak, along with at least two facilitators (Speziale & Carpenter, 2007). The 24 participants selected which focus group they wanted to attend based on the flyer announcement; each attended only one session. The focus groups, each lasting 1 hour, were conducted by one UCLA researcher or one California Institute of the Arts faculty, along with one homeless young adult CAB member. Each focus group had two facilitators. Common Ground staff were not involved in the focus groups. Input was solicited from participants about facilitators and barriers to seeking health care. The project director and two California Institute of the Arts or UCLA research staff members facilitated focus groups. Focus groups were audio recorded, and participants were able to create pseudonyms for confidentiality purposes. During the focus groups, one facilitator raised the questions detailed on the SSIG while a second facilitator was the scribe, taking down any non-verbal dynamics or observation. The facilitators contributed to the discussion by posing additional questions. Cash payments of \$15 were provided as compensation for their time.

Content Analysis

Upon completion of the sessions, the investigator oversaw transcription and content analysis of the focus group recordings as performed by trained research assistants. Initial line-by-line coding resulted in focused codes, followed by theoretical coding, to explain social interactions and meanings

according to homeless young adults (Charmaz, 2006; Miles & Huberman, 1994). Trustworthiness and dependability of data were achieved by presenting categories with narrative examples to members of the CAB (which included homeless young adults). In addition, categories and accompanying data were reviewed between two research staff and an experienced qualitative researcher for agreement (Miles & Huberman, 1994). Once coding was completed, categories emerged from the data from which illustrative examples were selected.

Results

Most participants were men (75%) and identified themselves as White (63%). Fewer were African American (21%) or Hispanic (13%). A quarter of the participants had attended or completed college, and nearly half had completed high school. The remainder did not finish high school. Few participants ($n = 5$) had children, none of whom lived with the homeless young adults.

Participants were quite verbal in expressing their perspectives and experiences in order that positive changes could be made. The major themes expressed related to the issues they experienced in accessing health care, followed by barriers that homeless persons frequently face. A number of unmet needs were experienced, as well as a pervasive sense of stigma and discrimination, which was quite telling.

Failing Access to Health Care

Homeless young adults revealed that accessing health care was challenging due to scarcity of service sites and generally long waiting times for services, yet homeless young adults experienced a number of health problems ranging from chronic conditions such as migraine headaches to more serious conditions of asthma and meningitis. Mental health issues were reported most commonly, and for one young man (20 years old, White), illegal drugs were used to help alleviate the symptoms, "I have bipolar, manic depression...and it [drugs] helps me to literally stay calm and see clearly." The need for mental health services was pervasive, as one man (24 years old, African American) revealed:

...if you want to look at the whole, I mean everybody is mentally ill, you know what I mean. Who doesn't have mood swings? Who's not depressed?...So it's like everybody needs some help...

For general health care, participants reported a few drop-in sites that provided free medical services. Although these young persons knew where medical care was provided and the times services were offered, receiving care was problematic. One man (20 years old, White) commented,

This place is open for the youth and young adults on Tuesdays from 5:45 to 10:30, Fridays from 5:45 to 8:30, and then Saturdays from 11:45 to 5. There needs to be more places like this. That's the only thing. [For the second site]...they have young adult day on Tuesdays; that's the only thing.

The same participant continued,

You can't really get the services you need cuz everybody's pushing you out of the way. Um, not to be disrespectful,

but people smell, and you don't have enough services. You go out to Hollywood, you got three places.... There's needs to be more places for youth cuz there's not enough. There needs to be a place youth can go everyday. That they don't have to worry bout getting pushed around, having to wait in line for bus tokens, having to wait in line only for the first 10 people to get bus tokens, first 30 people in line to use the phone, to do all that stuff.

In addition, two homeless young adults (23 years old, White man, 20 years old, African American woman) were concerned about the long hours spent in emergency rooms. As both agreed, "good luck...they make you wait for hours and they send you home right away with bunch of Tylenol." Another young woman (23 years old, Hispanic) recounted her experience in an emergency room vividly as well, "they help you, and once they give you the right resources they tell you, you can't come here no more." For another man (19 years old, White), the only solution for homeless young adults was "...you have to have 911...there [is] no medical help..."

Overall, some participants were able to receive government assistance, whereas others found it difficult to get. One woman (23 years old, Hispanic) learned early on that "you can't get Medicaid or Medicare, unless you are bipolar...that's the only way you can get SSI." For several of the young persons, lack of insurance was a barrier to receiving health care. A stumbling block for one participant in getting government assistance was not having an original birth certificate.

Many homeless young adults revealed that another serious barrier to health care was discrimination expressed by health care providers toward young adults who were homeless or used illegal drugs. As one woman (20 years old, African American) revealed,

...like when I was using, I had a few emergency situations that I had to go to ER, and they wouldn't do anything...when they asked me about my drug history, I told them, and right after, they just send me away with just a Tylenol...I was in massive amount of pain...I couldn't...get help...they would kick me out because of that.

Perceived rules and hidden agenda of support institutions often were perplexing for participants and served as barriers to seeking health care and other services. For example, length of time participants were homeless was a policy that one community agency had to enforce prior to the release of services. This was frustrating for participants because other states did not have such policies. As one young man (19 years old, Native American) explained,

You have to be homeless for a year in order to get a shelter...that is why people are heading out to San Francisco and northern California because they have services available...the youth out there, within a month of being homeless, they find you a job and give you a place...the law there is that youth cannot be on the street.

Even when treatment was provided, one woman (23 years old, Hispanic) was upset about the length of time treatment could be given. "You can't get to treatment unless you are on drugs...and when the person is clean for 2 months, they say, 'oh, that is too long.' You got to lie...honesty will take me

nowhere.” Young persons recount that it is very challenging to find a shelter in Santa Monica “because all of them are full...the only ones that are available are on skid row, and those are very nasty.”

Needing More Help

Homeless young persons experienced a number of unmet needs. For one woman (23 years old, Hispanic), “how to take the damn shower...that’s the biggest thing...clothing to change into and somewhere to keep the clothing...” For two men, dental care was an unmet need. For the same woman (23 years old, Hispanic) who had mental health problems, receiving mental health treatment was a critical unmet need not only because of lack of services but also because young adults often do not realize that they were mentally ill. As the homeless woman revealed,

...but also for who are mentally disabled, you have to reach to their level...because they don’t know...they don’t know they are sick...like me...I didn’t know...I was sick for several years until my man helped me...I knew I was sick, but didn’t know how sick I was until this year...

As a result, young adults called out for more outreach, particularly for mental health treatment, as one man (24 years old, African American) indicated, “there needs to be more outreach on...mental status...because I know my depression makes me not want to get up. Sometimes, I don’t get out of bed until like 5. I’m just like you gotta get up...”

Despite their hardships, young adults craved for support from family, friends, and homeless peers. One man (24 years old, White) commented, “they [homeless youth peers] are so depressed because they don’t think anybody would believe in them...all they need is the boost...most probably they would change their action.”

Perceiving Stigma

The youth were most frustrated by the discrimination they experienced from passersby and law enforcement. Rather than provide resources for homeless youth, youth frequently were confronted with unforgettable comments that were full of judgment. As one young man (24 years old, White) recounted, “if you remove judgment, then people can say, how I can help find a job for this person, or let’s help him and find him resources instead of walking by and say that is a dirty bum.” A young adult woman (22 years old, African American) admonished another person for making such a comment,

Don’t judge anybody until you walk in their shoes...he [ex boyfriend] used to talk bad about gangbangers and stuff, and I was like, you have no idea about the crap they had while they were growing up...It wasn’t too long ago that we ended up at skid row, and there were no rooms available, and a gangbanger found us a shelter.

Moreover, in Los Angeles, young adults perceived that police were discouraging homeless young adults to be on the street, regardless of whether resources were not being

The youth were most frustrated by the discrimination they experienced from passersby and law enforcement.

provided. “They want the people off the streets, but they don’t realize there is a waiting list and some people don’t know how to get help.” Another young man (23 years old, Native American) remarked, “being homeless is illegal...you get a ticket for just standing on the street...you have cops chasing you...and are very mean...you sit down, they think you are camping out, and they give you a ticket...they find every way to aggravate you to send you to jail.”

In general, the young adults perceived the police as not understanding the challenges homeless young adults had to endure and that their job was to keep the area free of homeless people. As one woman (23 years old,

Hispanic) reported, “the judges they want to get us off the streets...we can’t sleep on the alleys...we have no family...where the hell do we sleep?”

A more indignant revelation was that police were putting homeless young persons in jail or citing them with steep fines for minimal offenses. As a young man (24 years old, African American) reported,

They [the cops] take you to jail just for being homeless...They lockin all the homeless people up, that’s crazy, you know what I’m sayin. They’re not trying to help at all, they’re just lockin ’em up. When I was in county jail, there was a dude who been in there 4 years.

Another man (20 years old, White) reported, “homeless friend of mine, flicked out a cigarette, they gave him a ticket for littering. That’s \$500.”

Discouragingly, one male young adult (24 years old, African American) commented,

...you know, this conversation is nice and lovely, but what I see happening and what I see coming is they gonna...shut all this down. They don’t want no homeless people out here. And they doing whatever they wanna do to push ’em out, you know. They gonna try to stop what you try to put out there. They’re gonna be adversaries against any other help you try to place out there.

A young woman (20 years old, African American) stated it clearly:

...I think one of the main issues that homeless youth have is the lack of love they feel...I think what would grab them is like something that comes from the family...somebody that cares for them...some[one] that says, I love you...something that gives them hope.

Making it Work

Regardless of the challenges experienced, homeless young adults were able to deal with life in the only ways they knew how and were grateful for the help and support of others. For several homeless young adults, they were grateful for the information they received from the more experienced homeless young persons in terms of when services were available and where to go. Support also came in other forms. For one

woman (20 years old, African American), love from her family was always present, as she indicated, "my family never stopped loving me, but they just had to push me away until I got better..." For another woman (23 years old, Hispanic), it was her boyfriend that helped her get mental health treatment. Homeless young adults were helpful to each other by providing information on where to go for services.

What was also impressive for the young adults was when drop-in sites, such as Common Ground, conducted outreach to inform youth and young adults about the services they provided. "They came out to the streets, they walked out there themselves, [they] did the footwork...—cuz you know, we do [get] hungry—so they passed out, you know, chips and juices."

Discussion

The purpose of this study was to obtain perspectives from homeless young adults on accessing existing health care services and to solicit their input on how services can best fit their needs. To improve the system, young adults initially felt it necessary to identify barriers to the system, which can be classified as structural or social. Structural barriers are composed of scarce clinic sites and hours specific to homeless young adults. Although they appreciate sites that cater to homeless persons, participants expressed displeasure that clinics limit their hours of service and have long wait times. Other structural barriers are health-related disorders or living conditions that receive priority care, such as bipolar disorder, drug addiction, or time spent homeless.

In failing access to care and needing more help, a number of our homeless young participants reported experiencing chronic conditions, such as asthma and migraine headaches, as receiving short shrift based on health system protocols. Migraine headache pain and symptoms of asthma are debilitating symptoms, which can create disequilibrium among persons. As previously written, homeless young persons seek health care in crises situations, contrary to when they are in stasis. In our comprehensive health seeking and coping model, homelessness is a situational factor. Situational factors, such as homelessness, duration of homelessness, past experiences with illness, and timing the illness, serve as environmental constraints to one's ability to participate in appropriate health-seeking and coping behavior. Health-seeking and coping behavior, however, can be "actualized" through social support and "guided learning" (Nyamathi, 1989, p. 284). Perhaps more outreach is needed to homeless young adults in stasis about target services to enhance prevention behaviors.

Social barriers to seeking health care are unmet needs for hygiene, such that homeless young adults cringe sitting hours next to another homeless person who "smells" in a clinic waiting area. Professionals are perceived to be dismissive and discriminatory, even when resources are scarce or wait lists are long. Ultimately, homeless young persons report feeling judged and unwanted by society and perceive that all municipal efforts are spent making them invisible. In making it work, these youth can serve as peer supporters for other homeless young persons. More research is needed, however, on ethnic differences in service utilization among homeless young adults.

The homeless young adult participants did report several factors that facilitate their health-seeking experiences. First, they appreciate youth-specific agencies, such as Common Ground. Second, they are grateful for support from others, such as family and significant others. Finally, they expressed gratitude for information given to them by more experienced homeless young adults regarding available accessible resources. These are structural and social linkages that keep homeless persons from destitution.

Limitations

This research is limited by the one geographic location and narrative data. Therefore, generalizations to all homeless young adults cannot be made. Given the current economic situation, it is necessary to explore health-seeking challenges among homeless young adults across the United States. In addition, our participants might be apt to make socially desirable statements since they receive services from Common Ground. The number of two facilitators per focus group might incur a power differential, whereby participants' responses to interview questions could serve as a threat to internal validity.

Implications for Practice and Further Research

Street living or being unstably housed pose health risks to homeless young adults. Symptomatic health conditions have clinical implications. If unmanaged, they disrupt work potential or educational potential. Perhaps it is best for homeless young persons to receive care based on priority conditions, such as drug use or bipolar disorder, but accompanied by symptom management education. Moreover, health care providers can be more aware of community resources and make necessary referrals during the clinic visit so that homeless young adults are not wandering the streets looking for services and shooed away by law enforcement.

Formal institutions, such as clinics and emergency departments, are not equipped to provide the kinds of opportunities and positive social experiences that homeless young adults need at their stage of development. Therefore, our findings show that more street outreach and drop-in centers are needed for homeless young adults to take a shower, participate in life skills training, learn about preventive health strategies, and symptom self-management. ▣

Accepted for publication November 3, 2009.

Support for this research was provided by Grant DA023521 from the National Institute on Drug Abuse.

Corresponding author: Adeline Nyamathi, PhD, ANP, FAAN, School of Nursing, University of California, Los Angeles, Room 2-250, Factor Building, Los Angeles, CA 90095-1702 (e-mail: anyamath@sonnet.ucla.edu).

References

- Alexander, B., & Schrauben, S. (2006). Outside the margins: Youth who are different and their special health care needs. *Primary Care, 33*(2), 285–303.
- Barkin, S. L., Balkrishnan, R., Manuel, J., Andersen, R. M., & Gelberg, L. (2003). Health care utilization among homeless adolescents and young adults. *Journal of Adolescent Health, 32*(4), 253–256.
- Bucher, C. E. (2008). Toward a needs-based typology of homeless youth. *Journal of Adolescent Health, 42*(6), 549–554.
- Carlson, J. L., Sugano, E., Millstein, S. G., & Auerwald, C. L.

- (2006). Service utilization and the life cycle of youth homelessness. *Journal of Adolescent Health, 38*(5), 624–627.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Los Angeles: Sage.
- Christiani, A., Hudson, A. L., Nyamathi, A., Mutere, M., & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally sensitive health care. *Journal of Child and Adolescent Psychiatric Nursing, 21*(3), 154–163.
- De Rosa, C. J., Montgomery, S. B., Kipke, M. D., Iverson, E., Ma, J. L., & Unger, J. B. (1999). Service utilization among homeless and runaway youth in Los Angeles, California: Rates and reasons. *Journal of Adolescent Health, 24*(6), 449–458.
- English, A., Morreale, M. C., & Larsen, J. (2003). Access to health care for youth leaving foster care: Medicaid and SCHIP. *Journal of Adolescent Health, 32*(6 Suppl.), S53–S69.
- Ensign, J. (2004). Quality of health care: The views of homeless youth. *Health Services Research, 39*(4), 695–707.
- Ensign, J., & Bell, M. (2004). Illness experiences of homeless youth. *Qualitative Health Research, 14*(9), 1239–1254.
- Ensign, J., & Panke, E. (2002). Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing, 37*(2), 166–172.
- Flick, U., & Rohnsch, G. (2007). Idealization and neglect: Health concepts of homeless adolescents. *Journal of Health Psychology, 12*(5), 737–749.
- Haldenby, A. M., Berman, H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research, 17*(9), 1232–1244.
- Hickler, B., & Auerswald, C. L. (2009). The worlds of homeless White and African American youth in San Francisco, California: A cultural epidemiological comparison. *Social Science & Medicine, 68*(5), 824–831.
- Horowitz, C. R., Robinson, M., & Seifer, S. (2009). Community-based participatory research from the margin to the mainstream: Are researchers prepared? *Circulation, 119*(19), 2633–2642.
- Hudson, A. L., Nyamathi, A., & Sweat, J. (2008). Homeless youths' interpersonal perspectives of health care providers. *Issues in Mental Health Nursing, 29*(12), 1277–1289.
- Johnson, R. J., Rew, L., & Sternglanz, R. W. (2006). The relationship between childhood sexual abuse and sexual health practices of homeless adolescents. *Adolescence, 41*(162), 221–234.
- Kelly, K., & Caputo, T. (2007). Health and street/homeless youth. *Journal of Health Psychology, 12*(5), 726–736.
- Klein, J. D., Woods, A. H., Wilson, K. M., Prospero, M., Greene, J., & Ringwalt, C. (2000). Homeless and runaway youths' access to health care. *Journal of Adolescent Health, 27*(5), 331–339.
- Kushel, M. B., Vittinghoff, E., & Haas, J. S. (2001). Factors associated with the health care utilization of homeless persons. *JAMA, 285*(2), 200–206.
- Kushel, M. B., Yen, I. H., Gee, L., & Courtney, M. E. (2007). Homelessness and health care access after emancipation: Results from the Midwest Evaluation of Adult Functioning of Former Foster Youth. *Archives of Pediatrics & Adolescent Medicine, 161*(10), 986–993.
- Lim, Y. W., Andersen, R. M., Leake, B., Cunningham, W., & Gelberg, L. (2002). How accessible is medical care for homeless women? *Medical Care, 40*(6), 510–520.
- Lindamer, L. A., Lebowitz, B., Hough, R. L., Garcia, P., Aguirre, A., Halpain, M. C., et al. (2009). Establishing an implementation network: Lessons learned from community-based participatory research. *Implementation Science, 4*, 17.
- Martins, D. C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing, 25*(5), 420–430.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Nyamathi, A. (1989). Comprehensive health seeking and coping paradigm. *Journal of Advanced Nursing, 14*(4), 281–290.
- Rew, L., Taylor-Seehafer, M., & Fitzgerald, M. L. (2001). Sexual abuse, alcohol and other drug use, and suicidal behaviors in homeless adolescents. *Issues in Comprehensive Pediatric Nursing, 24*(4), 225–240.
- Rosenthal, D., Mallett, S., & Myers, P. (2006). Why do homeless young people leave home? *Australian and New Zealand Journal of Public Health, 30*(3), 281–285.
- Sneller, V. P., Fischbein, D. B., Weinbaum, C. M., Lombard, A., Murray, P., McLaurin, J. A., et al. (2008). Vaccinating adolescents in high-risk settings: Lessons learned from experiences with hepatitis B vaccine. *Pediatrics, 121*(Suppl. 1), S55–S62.
- Speziale, H. J., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott, Williams, & Wilkins.
- Wen, C. K., Hudak, P. L., & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in health-care encounters. *Journal of General Internal Medicine, 22*(7), 1011–1017.
- Wenzel, S. L., Hambarsoomian, K., D'Amico, E. J., Ellison, M., & Tucker, J. S. (2006). Victimization and health among indigent young women in the transition to adulthood: A portrait of need. *Journal of Adolescent Health, 38*(5), 536–543.
- Wright, N. M., & Tompkins, C. N. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice, 56*(525), 286–293.