# Homeless Young Adults Ages 18–24

## *Examining Service Delivery Adaptations*

National Health Care for the
Homeless Council

September 2004

This project was developed with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.



Ammerman SD, Ensign J, Kirzner R, Meininger ET, Tornabene M, Warf CW, Zerger S, Post P. Homeless Young Adults Ages 18–24: Examining Service Delivery Adaptations, 50 pages. Nashville: National Health Care for the Homeless Council, Inc., 2004.

National Health Care for the Homeless Council, Inc.
P.O. Box 60427 • Nashville, TN 37206-0427
voice: 615/226-2292 • fax: 615/226-1656
e-mail: council@nhchc • website: www.nhchc.org

## ACKNOWLEDGMENTS

*Advisory Committee*

The following individuals worked collaboratively to develop this monograph, determining priority content areas for inclusion, drafting sections of the monograph, and editing and finalizing the document for publication.

Advisory Committee Members

Seth D. Ammerman, MD
Clinical Assistant Professor
Adolescent Medicine
Stanford University Department of Pediatrics, Division of Adolescent Medicine
Packard Children's Hospital
Palo Alto, California

Josephine Ensign, FNP, DrPH
Associate Professor
Psychosocial & Community Health
University of Washington
Seattle, Washington

Rachel Kirzner, MSW, LSW
Assistant Director of Social Work
Philadelphia Health Care for the Homeless Program
Philadelphia, Pennsylvania

Eric T. Meininger, MD
Medical Director
Health and Wellness Clinic, YouthLink
Director of Outreach
Community-University Health Care Center, University of Minnesota
Minneapolis, Minnesota

Mary Tornabene, MS, CS-FNP, RN
Clinical Director of Primary Care
Chicago Health Outreach, Inc.,
Health Care for the Homeless
Chicago, Illinois

Curren W. Warf, MD
Clinical Assistant Professor of Pediatrics
Keck School of Medicine
University of Southern California
Medical Director
High Risk Youth Program
Children's Hospital of Los Angeles
Los Angeles, California

Advisory Committee Staff

Suzanne Zerger, MA
Research Specialist
National Health Care for the Homeless Council, Inc.
Toronto, Ontario
Canada

Patricia Post, MPA
Communications Manager/Policy Analyst
National Health Care for the Homeless Council, Inc.
Nashville, Tennessee

## EXECUTIVE SUMMARY

Young adults (ages 18-24) are especially vulnerable to homelessness. The estimated numbers of young adults who experience an episode of homelessness each year range from approximately 750,000 to 2 million, and are believed to be increasing; families as well as individuals are affected. To articulate and address some of the urgent issues facing these young adults, six seasoned clinicians and researchers working with displaced youth across the United States collaborated with staff from the National Health Care for the Homeless Council in developing this report. A recurring theme from these collaborative discussions is that individuals in the young adult/late adolescent phase of life present a unique and promising opportunity to prevent or arrest homelessness through early and comprehensive health and social service interventions.

This report is organized around four main topics: health care, housing, education and employment, and social support. Following a brief description of service access barriers faced within each of these topics is a list of recommended short-and long-term strategies for overcoming them. In general, the safety net of services for individuals in need is geared towards adults, so many of the strategies presented offer methods for customizing existing services for younger individuals who may lack the life experience and resources adults commonly have.

Health Care: Homeless young adults have health care needs that are similar to those of their non-homeless peers, but due to of a lack of prevention and early intervention, they often have more advanced illnesses, whether medical or psychosocial, which are consequently more difficult and expensive to treat. Compounding these health problems, especially for those aging out of the foster care system and others without parental support, is a lack of health insurance; 18-24 year-olds are more likely than any other age group to be uninsured, a pattern that has persisted and even increased over the past decade. Privacy issues, such as providing consent and accessing medical records, can be especially complicated for young adults and therefore present a barrier to accessing necessary health services. The culture of homeless adolescents can also be an access barrier; some illegal or risky behaviors in which they may engage to meet basic needs incur stigmatization, hindering social support. Many such adolescents find it difficult to trust adults, including health care providers. In addition to these general issues of health care delivery and access, special health care issues for two especially vulnerable subgroups of this population are also discussed — related to reproductive health care for young homeless women and for sexual minorities, who according to some studies comprise between 25 and 40 percent of the homeless youth population in metropolitan areas.

Housing: Within the context of a national shortage of affordable housing, young adults face special barriers obtaining and maintaining residential stability. For example, they may lack financial resources due to low-income jobs and insufficient time to amass savings. Moreover, while most young people move out of their home with the full support of their parents — who assist with signing contracts, budgeting, advising, and often financial support — for those who have lost their parents, are estranged

from their family, have grown up in foster care, or have been incarcerated, a supportive network and opportunities to access these resources and acquire life skills are not readily available.

Education and Employment: Education is the primary method whereby individuals can build the skills and credentials they need to become successful, contributing adults in the workplace. Unfortunately, the mainstream, traditional public school systems have not provided this critical resource for many homeless young adults, especially those serving low-income neighborhoods and families. Youth who lack sufficient education or employment skills at ages when most individuals have completed their schooling are disadvantaged when trying to earn a livable wage. Of those who do join the workforce, most qualify only for entry-level jobs that are more likely to be part-time- and less likely to provide benefits such as health insurance or sick leave. Finally, increasing numbers of adolescents are involved with the juvenile justice system, which gravely hinders both their educational progress and their access to employment, leaving them especially vulnerable to homelessness following discharge.

Social Support: When faced with a crisis, many adults have a well-developed network of family and friends who can offer a short-term place to stay, food, or even financial support. Such social support provides a critical safety net, and is crucial to helping individuals and families to prevent homelessness or successfully transition out of it. Young homeless adults may have a broad network of friends, but they tend to be close in age and struggling with the same issues, and their families may be unable or unwilling to provide critical social supports. This report addresses barriers young adults may face in reconnecting with their families of origin, and in creating a safe and nurturing environment for their own children.

Testimonials from homeless assistance providers and their clients and examples of recommended interventions are interspersed with program descriptions and proposed strategies throughout the document. A list of additional resources, including references that illustrate the issues described, is appended to this report. This document explains some of the most urgent issues and barriers confronting young adults at risk for or experiencing homelessness. The authors hope that it will serve as a helpful guide to resources and opportunities that will afford them a more hopeful future.

# *Table of Contents*

## INTRODUCTION

Young adults in the U.S. are uniquely vulnerable to homelessness.[1] The estimated numbers of young adults who experience an episode of homelessness each year range from approximately 750,000 to 2 million, and are believed to be increasing. This is not only a problem facing young individuals, but families as well: individuals aged 18 to 24 make up 13% of the adult homeless population and comprise 26% of homeless families (Burt et. al. 1999).

### Why Are Young Adults in the U.S. Especially Vulnerable to Homelessness?

While a crisis such as a serious illness or the loss of a job can precipitate homelessness for many people, young adults typically have fewer support resources in place to prevent such a consequence or to cope should it occur. These young individuals, many with dependent children, are more likely than other adults to have lower paying jobs with fewer benefits, and are less likely to have health insurance, large savings, or a stable network of friends who are able to provide assistance in a crunch. Also, they are less apt to have knowledge about or experience with housing matters, legal rights, and community resources. For many young adults in the United States, parents continue to be their support system, often providing some financial support well into their child's mid-twenties. But for those with parents who are unable or unwilling to provide financial support as a fallback — and there is no legal requirement for them to do so — it is more difficult to overcome even a single crisis.

Compounding the difficulty is that supportive services in this country, such as health and educational services, are unavailable to individuals once they reach 18 or 21 years of age, unless they have dependent children.[2] Young adults "aging out" of the foster care system are especially vulnerable to homelessness. One study found that nearly one quarter of emancipated youth had been homeless 2–4 years after leaving foster care (Annie E. Casey Foundation 2004).[3] A Los Angeles County study estimated "approximately 45% of the youth who 'age out' of the foster care system each year will either be emancipated to the streets, that is directly into homelessness, or will have such unstable plans that they are likely to be homeless in a very short time (Shelter Partnership 1997)." Victims of physical or sexual abuse, as well as racial and sexual minorities, are also overrepresented among the homeless adolescent population (Durham 2003).

Societal expectations of young adults are high; they are expected to achieve independence, realize their potential, and fulfill the promise of their cultural heritage. Although such expectations are

[1] Throughout this report, "young adult" is defined as an individual aged 18–24 years.
[2] See page 5 for an example of how the "cascade effect" from a single crisis can lead to homelessness.
[3] A General Accounting Office (GAO) report from 1999 similarly reported between 25 and 40 percent of foster youth became homeless after "emancipation," in large part due to lack of job and independent living skills (see Durham 2003, p.2; see also Barth 1990 and National Alliance to End Homelessness 1995).

clear, help in achieving them is often lacking, particularly for youth without financial resources or familial support and for those with special needs. Understandably, many individuals and families who find themselves homeless in their late teens or early-to-mid twenties experience a genuine sense of abandonment. Yet there is hope, in no small part because this is a developmental phase during which appropriate supports can make an especially important difference.

**THE CASCADE EFFECT: HOW ONE CRISIS CAN LEAD TO HOMELESSNESS**

Charlie, a young father, develops a relatively mild illness, such as infectious mononucleosis. As the family's breadwinner, he is working two part-time jobs, but neither provides health insurance. His family lives from paycheck to paycheck, with barely enough to make ends meet. After paying for rent, car insurance, and utilities, the rest is spent on food, clothing, and needs of his toddler daughter. Charlie has always been healthy and hasn't been to see a physician since he was a young teen. His daughter qualifies for medical assistance, and his wife brings her to a pediatrician for immunizations.

When this young man develops a severe sore throat, he is unsure how to access the health system. His wife brings him to the local emergency department where he undergoes a number of tests to identify the source of his symptoms. This results in a fairly large, unplanned expense. Even if he is able to return to work, medical payments will consume most of the family's meager reserves.

The choices this family faces are difficult: borrow money from family members; neglect to pay the bill, risking collections and a long-term negative mark on their credit rating; pay the rent late and risk an unlawful retainer from the landlord; delay utility payments; forego auto insurance; and/or restrict purchases to meet other basic needs such as food and clothing.

The family may be able to compensate for a single crisis such as this one; but if it is followed by another – if the breadwinner cannot return to work for a week and becomes unemployed, or if the child becomes ill and requires hospitalization, or there is an automobile accident and the family loses its primary source of transportation – the consequences can lead to homelessness.

## Late Adolescence: A Window of Opportunity

Adolescence is a unique biological, psychological, social, and cognitive developmental phase during which a youth transitions from childhood to adulthood. The process of adolescent development is typically divided into three stages: early, middle, and late. These stages have both theoretical and practical implications from a health care perspective. From a theoretical point of view, each of the three stages has unique characteristics, and every youth must successfully navigate early to middle to late adolescence, in order to become a healthy, functioning adult. ***From a practical point of view, the most effective prevention strategies and health care interventions are based on developmental stage rather than chronological age***.

| STAGES OF ADOLESCENCE | |
|---|---|
| **Phase of Development** | **Key Development Issues** |
| Early (Ages 10-13) | Onset of puberty; more activities with peers outside of family; cognition concrete |
| Middle (Ages 14-17) | Peer group of high importance; independence/dependence ambivalence vis-à-vis family/adults; risk-taking/exploratory behaviors; cognition starts to become abstract |
| Late (Ages 18-24) | Identify formation: comfort with and wholeness of "Who I Am" initiating work/career goals; cognition is abstract |

*Provided by Dr. Seth Ammerman, Stanford University Department of Pediatrics, Division of Adolescent Medicine, Packard Children's Hospital, Palo Alto, California*

The chronological age at which adolescence occurs depends on individual and socio-cultural factors. The World Health Organization and the Society for Adolescent Medicine define adolescence ("youth") as usually occurring from 10–24 years of age. Early adolescence usually encompasses ages 10–13; middle adolescence, ages 14–17; and late adolescence ("young adult" in the United States), ages 18–24. Although most youth cope well with the developmental process of adolescence, numerous factors can delay normal progression through these three stages, including substance use and mental health disorders and other chronic illness. Other stressors, such as a history of physical/sexual abuse or neglect, can also provoke psychological, social, and cognitive regression.

The hallmark of early adolescence is pubertal development, when youth are primarily concerned with their changing body and questions relating to "Am I normal?" Key characteristics of middle adolescence include the importance of peer influences, an increase in risk-taking or exploratory behaviors, dependence/independence issues vis-à-vis parents and authority figures, and initial development of abstract thinking. In this stage, peer counseling and outreach efforts to address health care issues may be especially helpful, and trusted authority figures other than parents may play an influential role.

Recent research demonstrates that behaviors commonly associated with young and middle adolescence have their biologic underpinnings in the continuing and demonstrable maturation of the brain through adolescence into early adulthood (see Beckman 2004; National Institute on Mental Health 2001; Giedd et.al. 1999). In particular, the frontal cortex — the region of the brain responsible for judgment, impulse control, and setting priorities — remains immature into late adolescence, and maturation of the brain continues through young adulthood. Puberty involves not only obvious sexual maturation and differentiation, but just as importantly, continued development and maturation of the brain.

We should expect young people to show occasional poor judgment and have problems with impulsivity, but we should also expect most young people to mature and become more competent as they grow. This is a strong argument for continued support of young people to assure their healthy development, and an argument against holding them to adult behavioral standards that are unrealistic for their biological and psychosocial stage.

The hallmarks of late adolescence include achieving independence from parents; comfort with one's body image; establishing sexual, ego, vocational, and moral identities ("Who Am I?"); and progression to abstract thinking. In this stage, youth are more likely to think about and plan for the future in a realistic manner, be open to questioning about behavior and goals, and be concerned about longer-term health outcomes. This final stage of adolescent development — the young adult or late adolescent stage — is crucial to a normal outcome in adult functioning. ***It is a window of opportunity during which youth can, with support, live to their potential and grow into a healthy responsibly functioning adult contributing to society, or left to their own devices face a future of dependency, marginalization and potential long-term homelessness.***

Given the many developmental tasks that take place during this stage, proper health care and psychosocial support are crucial to prevent young adults from becoming homeless and to enable those already homeless to achieve positive outcomes.

> ***Developmentally, the transition from living at home to living on one's own is difficult for any young person, and it is absurd, even negligent, to expect young people who have experienced significant trauma in their lives to handle this on their own.*** *– Durham K. for the Corporation for Supportive Housing 2003, p.3*

## This Report

An advisory team of six seasoned clinicians and researchers working with homeless young adults across the United States collaborated with staff from the National Health Care for the Homeless Council to identify key issues faced by this diverse population and to articulate effective short- and long-term strategies for addressing them. This report presents a concise overview of the advisory team's collaborative findings, focusing on issues unique to homeless individuals in the late adolescent or young adult phase of their development.

The predominant theme emerging from the advisory team's discussions is one of hope — that displaced individuals in late adolescence or early adulthood present an important opportunity for clinicians and adult role models: to guide them away from a life of homelessness on society's margins toward life as a fully functioning adult, constructively engaged with society. This fundamental hope inspires efforts to understand and overcome barriers to normal development confronting homeless youth and explains the urgency of identifying strategies to address their needs.

This report is organized around four main topics: health care, housing, education/employment, and social support. In sections devoted to each of these topics, brief descriptions of service barriers are followed by recommended short and long-term strategies for overcoming them.

## Service Access Barriers and Solutions

The most effective way to prevent homelessness is either to intervene in the initial crisis and stabilize young adults at risk for homelessness, or provide early intervention to displaced youth before they develop coping behaviors that can extend their homelessness (Auerswald and Eyre 2004).

Young adults are vulnerable in the existing adult-oriented service system primarily because of their inexperience. Some knowledge of the service system and how to access it is required. Many young adults do not become familiar with available resources until they experience a significant health or criminal justice issue. Once they are introduced to needed services, they may find they are preyed upon because of their ignorance. For instance, some young adults report having their shoes stolen in shelter because they didn't think to sleep with them on.

Homeless youth are at disproportionate risk for sexual assault; those who are estranged from their parents or have left foster care may have a history of victimization that undermines their trust of adults. In addition, it is important to remember that most of these young people have had inadequate role models and minimal help in learning how to navigate complex systems such as health care. Using soup kitchens, shelters, and treatment facilities designed for and used by older adults can be especially intimidating.

Awareness and acknowledgement of the limitations of an adult-focused safety net is an important first step in creating appropriate services for homeless youth. Ideally, resources should be targeted to adolescents, to aid in the transition from childhood to adulthood. This section of the report provides additional strategies to smooth this transition and prevent young adults from continuing to fall through gaps in services.

> ***Adolescents depend on families, neighborhoods, schools, health systems, and employment and training opportunities, and these institutions are under severe stress. As the fault lines widen, increasing numbers of youths are falling into the juvenile justice system, the child welfare system, and other even more problematic settings.*** *– National Research Council 1993, p.2*

***...IF WE DO NOT LEARN TO INTERVENE MORE EFFECTIVELY IN THE TRANSITION OF THE MOST VULNERABLE YOUNG PEOPLE, then we can expect the following outcomes:***

***Over the next decade a new generation of children will be born to parents whose ability to provide for them financially will be severely compromised. ...***

***We will spend approximately $1 billion annually to incarcerate youth in our nation's detention systems ....***

***We will spend more than $223 billion at the federal level alone to help out needy kids and families – the amount it currently costs to support federal problems that address substance abuse, violence, teen pregnancy, nutrition, school failure, and workforce preparation. ...***

***Finally, we will lose a sizeable portion of our potential labor market, along with billions of dollars in earnings and tax revenue....***

*– Annie E. Casey Foundation 2004, p.13*

## HEALTH CARE

Homeless young adults have health care needs that are similar to those of their non-homeless peers. However, because of a lack of prevention and early intervention, displaced youth often have more advanced illnesses, whether medical or psychosocial, which are consequently more difficult and expensive to treat. Additionally, homeless youth are at higher risk than other youth for health problems secondary to trauma; substance use and (frequently co-existing) mental health disorders (Drake et. al. 1991); infectious diseases such as diabetes, hepatitis, and HIV; neglected dental problems; and skin and respiratory diseases contracted while living on the streets or in shelters (Garfein et al. 1998). Homelessness poses numerous barriers to successful disease management for youth with chronic illnesses such as diabetes, including limited access to syringes, theft of glucometers, unpredictable access to nutritious food, and lack of facilities to maintain personal hygiene. Studies indicate that homeless youth have less stable sexual relationships than their housed counterparts and use variable rates of protection against pregnancy or sexually transmitted diseases (Robertson and Toro 1998; Richardson et. al. 2003).[4]

While homelessness itself presents significant barriers to health care access for young adolescents, some subpopulations are especially vulnerable. For example, adolescents leaving the foster care system are at particularly high risk. An estimated 30–40 percent have physical or emotional difficulties, and a longitudinal study of youth leaving care found that 44 percent had problems accessing health care "most of the time" (cited in Annie E. Casey 2004, p.7). Another subgroup which has an especially difficult time accessing health care is immigrant youth, who may confront barriers related to language, fear of reporting and deportation, and/or ineligibility for most forms of public benefits and health insurance. It should also be noted that despite the fact that immigrant young adults generally have a deep desire for work and frequently do find employment, they rarely are provided employment-based health insurance; too often they are entirely dependent on no-cost medical care provided by community clinics.

While a general lack of appropriate resources and services remains a barrier, some access barriers can be overcome with strategies discussed in this section of the report.

[4] For example, one recent study of young women attending a variety of health clinics found an overall prevalence of *Chlamydia trachomatis* of six percent, but the highest rate (18 percent) among those visiting homeless street health centers (Richardson et. al. 2003). It should also be noted that for young women, life on the streets also poses grave threats to their safety; sexual assault is a tragically common experience (Tyler et. al. 2004; Rosenthal and Mallett 2003).

**HEALTH CARE ACCESS: A TESTIMONIAL**

BG, an 18-year-old homeless Latina female, was referred to the Packard Children's Hospital Mobile Medical Clinic from a drop-in center. The Mobile Medical Clinic provides free, comprehensive primary care services to homeless adolescents, supported through gifts and grants. BG was sexually active and had never used contraception. She had never had a pelvic exam and had received no well care since preschool. At the clinic, she received a complete physical including an initial pelvic exam, booster immunizations, a pregnancy test (negative), HIV counseling and testing, sexually transmitted disease screening, and safe sex counseling. She was found to be positive for Chlamydia and received treatment while asymptomatic, and she was started on Depo Provera and the Hepatitis B vaccine. BG also received psycho-social support from a social worker who helped her get into a GED program from which she has since graduated. The patient is currently in a transitional living program run by the drop-in center and will soon enter a vocational training program. She has returned for regular follow up, remains on Depo Provera, and completed her Hepatitis B immunization.

## Health Insurance

The most recent census data tell us that the number of uninsured people in the United States who were without any health insurance during calendar year 2002 rose to 43.6 million; more than a quarter of these were young adults aged 19–29 years. Nearly half (45%) of young adults ages 19–23 were uninsured for at least some time during the year. Young adults are more likely than any other age group to be uninsured, a pattern that has persisted and even increased over the past decade (Collins et. al. 2004). Young adults with low incomes are most adversely affected. Family insurance plans that cover dependent young adults up to age 23 under a parent's plan, as long as they are attending school full-time, clearly advantage intact families with higher incomes. The myth that young adults do not need insurance due to general good health does not hold true for many low-income and homeless individuals, who frequently suffer from chronic conditions and are at greater risk for infections and injuries. Moreover, workers in this age category are least likely to obtain employer-sponsored health coverage, particularly those in entry-level jobs for which homeless youth are most apt to be eligible.

> ***Failing to invest in our future by leaving young adults out of the health insurance system and denying them access to the high-quality care available in the United States creates a long-term cost to personal health and, ultimately, to the health of the nation's economy.***
>
> *– Kevin Quinn, Commonwealth Fund Task Force on the Future of Heath Insurance for Working Americans*

*Strategies*

- More Health Insurance Options for Young Adults

  A recent review of health policies for young adults (ages 19 to 29) suggests three policy changes that could both extend coverage to uninsured young adults and prevent others from losing coverage. These changes include:
  - extending eligibility for Medicaid/ Children's Health Insurance Program (CHIP) public coverage to age 23;
  - extending eligibility for all dependents under private coverage through age 23; and
  - ensuring that colleges and universities offer affordable health insurance coverage to both full-time and part-time students (Collins et. al. 2004)."

  Extended eligibility for Medicaid/CHIP would help the largest group of uninsured young adults, the 2.7 million with incomes under 100 percent of poverty. Transitional insurance for youth leaving foster care is especially important.

  The federal Foster Care Independence Act of 1999 (FCIA) initiated a Medicaid expansion option for individuals aging out of foster care, as well as other options for states to help address their health care needs. A review of health care access for this subpopulation concluded, "the potential exists through Medicaid or SCHIP to ensure that nearly all former foster youth have health insurance as they leave state custody," but warned these sources cannot meet all of their health care needs. The study also noted that while many states have implemented some of their options for facilitating health care access, "most states could do much more" (English et. al. 2003). For example, a recent state-by-state analysis of transitional policies for these youth found that less than one-third of states offer former foster youth ages 18–21 access to Medicaid coverage (Annie E. Casey 2004, p. 8). Extending health insurance to individuals up to age 24 leaving child protective care systems through changes in federal policy would greatly enhance health care access for a significant proportion of homeless and near-homeless young adults.

- Universal Health Insurance

  A system providing health insurance coverage for everyone — regardless of age, employment, or other qualifying factors — would help to assure seamless access to vital health care services as young adults make critical developmental transitions, including the transition to independent living.

## Culturally Appropriate Health Care

Though homeless youth come from diverse backgrounds, and are composed of numerous subcultures, they also share many common experiences and can be said to have a unique culture with a shared way of life, common values, beliefs, dress and lingo, and ways of interacting with each other and with adults (Barry et. al. 2002). Providing culturally competent health services for homeless young people begins with knowledge and validation of their values and beliefs, with the goal of attaining mutual respect and understanding between providers and clients. Health care providers who acknowledge the experiences of homeless youth in a nonjudgmental way are most likely to be effective.

Homeless young adults involved in the street culture often survive by engaging in illegal or risky behaviors including panhandling, drug dealing, shoplifting, and survival sex or prostitution. Well aware of the negative social stigma attached to people involved in these activities, they may be hesitant to divulge their involvement to health care providers (Barry et al. 2002). Many have negative attitudes toward health care providers and other adults. Like homeless youth in general, many homeless young adults have experienced conflict-laden relationships with older adults in their lives. Their past and present circumstances can make it particularly difficult for many homeless young people to trust adults in positions of authority, including health care providers.

***Strategies***

- Nonjudgmental Care

  Health care providers should set aside negative personal judgments and address behavioral issues with their patients in a caring way. The accoutrements of homelessness such as lack of showers and laundry, poor personal hygiene and involvement in substance use can be off-putting for many health care providers. Maintain a posture of "nonjudgmental, positive regard." The initial role of health care providers is to help these young people stay as safe as possible. Over time and once a good patient-provider relationship is established, the provider can begin to suggest and encourage specific changes in habits or behaviors that may have negative consequences.

> ***Here they sort of talk to you more like — you know, just like a regular person, instead of these big words. And the guy in the front met me once, and the next time I saw him he knew my name, and he even took care of a bill that I got from a referral they gave me — he said he was sorry and it wasn't even his fault — stuff like that just hasn't happened to me other places.***
>
> *–18 year old female, cited in Barry et. al. 2002*

- Realistic Advice and Interventions

  Homeless young people respond positively to providers who can adapt health care advice and interventions to the realities of their lives. Following are some concrete examples:

  ***Clinic scheduling design:***

  - Schedule clinic hours that are convenient for homeless young people, usually in the afternoon and evenings.
  - Minimize waiting times (the most commonly cited complaint that homeless youth have with services)
  - Have walk-in appointments for acute problems.
  - Create a drop-in time in primary care clinics with no appointment required. Recognize that homeless patients' schedules are often chaotic and appointments are difficult for them to keep.
  - Encourage providers to spend adequate time with each young person during clinical visits. Expect to spend more time with homeless than domiciled patients.

  ***Clinical adaptations:***

  - Minimize paperwork burdens; reassess forms to minimize number of questions regarding medical history.
  - Provide written materials at or below a 6$^{th}$ grade reading level; do not presume literacy. Have staff available to help fill out forms.
  - Provide educational materials in Spanish and/or other languages spoken in your local community.
  - Refer to homeless youth by their street names.
  - Avoid phoniness – don't provide facile answers to questions about difficult problems.
  - Provide health care to homeless youth separately from older homeless adults. Young adults do not identify with older homeless persons and often feel exploited or threatened by them; nor do they feel comfortable being seen with pediatric patients. Create a welcoming environment designed just for adolescents.
  - Consider offering complementary health care modalities (such as naturopathic and acupuncture treatment) or other nontraditional health care approaches that are appealing to young people.
  - Provide street-based mental health services and drop-in clinics with integrated treatment of mental health and substance use disorders.

- Conduct screenings for sexually transmitted infections utilizing urine screening, remembering that the majority of chlamydial infections in both males and females are asymptomatic. Facilitate partner treatment.
- For those young people who are engaged in injection drug use, it is important to provide education about the risks of sharing needles and about sterile technique and cleanliness. In addition, if they are to avoid sharing needles, they need access to clean, new needles.
- Become familiar with confidentiality rights and reporting responsibilities.

***Community collaboration***

- School-based clinics provide an opportunity to educate adolescents about pregnancy prevention and substance abuse prevention — key elements in preventing homelessness. School-based clinics also foster early identification of mental illness, which often emerges in adolescence. Early intervention can prevent cognitive impairment and encounters with the criminal justice system that can limit employment options and treatment access.
- If possible, avoid fragmentation of social, behavioral, and medical services and provide them in a one-stop, comprehensive format. For example, offer everything from family planning to HIV counseling and testing in one place, rather than just a limited service for STD testing. Minimally, refer to local services that are readily accessible.
- Know and utilize available local resources that respond to crises of youth, in particular suicidality.
- Know and utilize available community resources for shelter, education, psychological counseling and substance abuse treatment.
- Know and utilize available community resources for pregnancy related care, including prenatal care and termination of pregnancy. Respect individual patient choices.
- Know and utilize available community resources for dental care and optometry.
- Know and utilize community resources for management of HIV infected youth.
- Develop a direct referral process to subspecialty clinics in public hospitals and other specialty care providers in the local health care system.
- Young adults with a history of gang involvement may find it difficult to access jobs and other services if they have tattoos identifying them as gang members; some communities have resources to assist with tattoo removal in these cases.

**EXAMPLES: STREET-BASED, DROP-IN, AND SCHOOL-BASED SERVICES**

The **45th Street Homeless Youth Clinic in Seattle** provides comprehensive allopathic and complimentary health care, as well as referrals and outreach to indigent, homeless youth, ages 12–23, at two drop-in centers and on the street. Most youth served are not in school. Depression, anxiety and identity issues are their primary mental health issues. (*from interview with Youth Clinic coordinator Seema Mhatre, MSW, MPH, Feb. 2000* Healing Hands*) E-mail mhatrs@psnhc.org for more information.*)

The **Mobile Health Team of the High Risk Youth Program in Los Angeles** provides primary health care to homeless adolescents and young adults at drop-in centers and shelters. The MHT is staffed by Nurse Practitioners and a Social Worker, who provide contraceptives, STI screening and management, and general health care as well as psychosocial screening in non-traditional environments. Young people who require a higher level of care are referred to the clinic of the High Risk Youth Program. (*Contact Gonaz Agai, MPH, MSW, Program Coordinator for the High Risk Youth Program in Los Angeles by e-mail at gagahi@chla.usc.edu*)

**Daly City Youth Health Center** — a subsidiary of the San Mateo County HCH Project outside San Francisco, California — is a school-based clinic that serves homeless youth or those at risk of homelessness, ages 13–21, both in and out of school. Services include mental health outreach, primary care, vocational counseling, mentoring and peer education training. Over half of their clients are immigrants; most are Latinos or Filipinos. Students from 33 countries attend one of the five high schools served. "Because our community is so ethnically diverse, cultural competency is a main concern," remarks homeless education administrator Carol Forest. (*Ms. Forest, Homeless Education Administrator for the Daly City Youth Center, can be reached by phone at 650-991-2240.*)

- Involvement in Program Design and Evaluation

  Actively involve homeless young people in the design and evaluation of programs where they receive health care. Their involvement can take various forms. For example:

  - Hire formerly homeless young adults to join the clinic's street outreach team, as well as to assist with the evaluation of services. This strategy has the added benefit of providing employment to the individual, thereby increasing his/her self-sufficiency and employment skills.
  - Involve youth in the planning of programs that are youth focused; these young people can evolve into important leaders in the field of adolescent care.
  - Place a suggestion box in the clinic to encourage youth input on an ongoing basis.
  - Frequently survey youth participants to solicit their ideas and identify potential problems.
  - Recruit homeless young adults to a health care advisory board. To maximize their involvement, it is important to provide transportation and compensate them for their time.

**TECHNICAL ASSISTANCE IN DEVELOPING PEER PROGRAMS FOR STREET YOUTH**

With support from the Centers for Disease Control and Prevention, the Division of Adolescent Medicine at the Children's Hospital in Los Angeles and the AIDS Evaluation of Street Outreach have jointly produced visually appealing training videos and workbooks that provide experience-based information on how to develop and maintain peer outreach programs with street youth. These materials can be obtained by contacting: Golnaz Agahi, Division of Adolescent Medicine M/S 2, Children's Hospital Los Angeles, Los Angeles, CA 90054-0700; Phone 213-669-4506; e-mail gagahi@chla.usc.edu.

## Privacy Issues

Like other people, homeless youth are entitled to confidentiality of personal information related to their medical care. Before their health care information may be released to a third party, the patient must consent in writing; the only exceptions to this are legally mandated reporting requirements, some of which vary by state[5]. It should also be noted that there are a variety of issues which should *not* be reported; in California these include: a disclosed history of past drug use or criminal activity, unless there is a plan to harm another person in the future; personal history of child abuse, unless there is a reasonable suspicion of a threat to the safety of a minor child; and past history of victimization or assault, unless the patient is seeking care for injuries sustained during the assault.

Though medical records are sometimes requested and copied with the patient's consent, patients are usually unaware of what exactly is in their medical chart. Physicians and others who care for homeless young adults usually make a psychosocial assessment of the patient, during which confidential and sensitive information is often written in the chart. This leaves open the potential for clinics to disclose confidential information to others without the patient's awareness, and/or gives patients access to potentially upsetting information in their medical charts.

Homeless adolescents commonly have no access to medical records, which can be problematic when documentation of vaccinations is required for school entry or employment. If the patient has been in public school, s/he almost certainly has received early childhood immunizations, so that the problem is usually one of lack of documentation, rather than lack of appropriate immunizations.

[5] For example, mandatory reporting is required if the patient is gravely disabled from a psychiatric illness, if the patient indicates that s/he has a plan to harm him/herself or another person, and if the patient discloses ongoing child abuse or indicates that minor children are in danger from an abuser.

*Strategies*

- Informing Patient of Confidentiality Rules

  It is good practice to inform patients of the limits of confidentiality during the initial interview, so they will understand the consequences of disclosing personal information.

- Discuss Health Care Responsibilities

  Because access to health care services may have been limited, it is important to demystify the health care system. Discuss with young adult patients the ways in which they can take responsibility for his/her own health care. (See table on next page for a sample handout.)

- Chart Reporting

  Providers may want to maintain a separate "psychosocial section" of their patients' chart that is not copied when there is a request for medical records. If patients ask to view their charts, have them do so in the presence of a trusted primary care provider to interpret chart information.

- Secure Medical Records

  If medical or psychosocial services are provided at a shelter or other non-conventional site, it is essential that all records remain in a locked and secure environment to prevent inappropriate access to confidential information.

## YOUTH HEALTH RIGHTS & RESPONSIBILITIES

***As a youth in the health care system, I have the right*:**

- To be treated respectfully by all staff;
- To receive comprehensive quality care and appropriate health services by staff who are comfortable and experienced with young people;
- To be presented with honest and complete health information;
- To include family members, friends, and partners in my care;
- To request a clinician with whom I feel comfortable, and to ask for a second opinion when I believe it's necessary;
- To communicate with members of the healthcare team in a language and manner that is understandable to me;
- To have the conditions and limitations of confidentiality explained to me;
- To be addressed by my name and to know the names of doctors, nurses and others who help care for me;
- To be informed about my healthcare benefits and health plan procedures; and
- To review my records.

***And I have the responsibility***:

- To give honest and complete information to my healthcare providers and let them know if my health changes;
- To ask questions about my health or healthcare including the names, purposes and side effects of medications that are prescribed for me;
- To follow the plan I decide on with my healthcare providers and let them know if I choose to change my mind; and
- To treat the clinic staff, other patients, and the clinic policies with respect.

*When you have questions, ASK! When you have complaints, SPEAK UP!*
*When you like what happens, SMILE AND SAY THANKS!*

## Reproductive Health Care

Contrary to popular stereotypes of homelessness, families make up the most rapidly growing portion of the homeless population in America. Many of these homeless families are single young adult mothers and their children. In Los Angeles, the majority of homeless people under age 30 are women (L.A. Economic Roundtable). Many of these young women are leaving relationships to escape domestic violence. Though concerns involving the care of children in homeless families need to be addressed, the young mothers clearly have a continuing need for ready access to reproductive health care, including pregnancy prevention and termination, and prenatal and postnatal care. Ensuring access to reproductive services can be difficult, as illustrated by a recent Florida study which found that more than three-quarters of the pregnant homeless women in their sample perceived barriers to prenatal care — including shelter-related factors, provider/client relationships, inconvenience, fear and cost — even though prenatal care was available for all pregnant women in the area (Bloom et. al. 2004).

***Strategies***

- Reproductive Health Insurance

  In California, as in many other states, reproductive health insurance is provided by the state public health system, independent of Medicare or Medicaid enrollment. It is important that all sexually active late adolescents and young adults be enrolled in and take advantage of these programs, and that access barriers for homeless people be eliminated.

- Accessible Contraceptives

  It is critical that young women have access to the full spectrum of effective contraceptive methods, including oral, injectable and patch contraceptives, as well as post-coital contraception. It is also critical that young men and women have ready access to condoms, for both contraception and infection prevention.

- Simple Enrollment Processes

  Among homeless young adults, who may be transient and have irregular contact with health care facilities, it is important that the enrollment process for entitlement and other health programs be simple and brief. Immigrant youth, regardless of documentation status, should not be excluded from these programs.

- Family Planning Resources

  In many states, support for reproductive health care/family planning services, including contraception and sexually transmitted infection management, is available from private sources such as Planned Parenthood, independent of Medicaid.

- Teen Pregnancy Prevention

  Teen pregnancy prevention efforts can help homeless young adults make responsible decisions about their sexual behavior. One recent report suggests that three components are essential to effective teen pregnancy prevention efforts: a high degree of community involvement, promotion and advancement of communication between youth and their parents or other adults, and "provid[ing] adolescents with information and high-quality services to make smart decisions about sexual behavior and protect themselves from unintended pregnancies and sexually transmitted diseases (STDs)" (Annie E. Casey 2004, p. 21). As with other adolescent risk behaviors, youth are more likely to protect themselves if they have attainable future aspirations – the best contraceptive is a viable future.

- Medical Outreach

  Medical outreach to young pregnant women can improve birth outcomes. Medically fragile and low birth-weight infants require even more parental time and attention than healthy babies, and may require specialized medical and behavioral interventions.

## Health Care for Sexual Minorities

Although no current national statistics exist on the number of LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning) youth among homeless/runaway youth, studies from large metropolitan areas generally estimate between 25 and 40 percent (Safe Schools Coalition 2004). As adolescents' sexual orientation emerges, it is not uncommon for homosexual youth to encounter rejection, or at least lack of understanding and support, in their home environment. Such rejection too often precipitates estrangement of sexual minorities from their families (see studies summarized in Safe Schools Coalition 2004).

It should also be recognized that for many young people, adolescence is a period of sexual experimentation, and it is not uncommon for them to encounter a great deal of internal confusion about their own sexual orientation. Young people may or may not openly declare their sexual orientation. It is not the medical provider's task to determine or expose the sexual orientation of a given patient, but it is their job to approach the individual non-judgmentally and provide appropriate health services.

Lesbian, gay, transgender and questioning (LGBTQ) youth have the same general medical health concerns as other young people, but may have increased risks for sexually transmitted infections including HIV and require special sensitivity to issues of confidentiality. Research has shown that LGBTQ youth value health care settings where clinicians understand and do not judge their lifestyles (Ginsburg et. al. 2002).

*Strategies*

- Non-Discriminatory Shelters

  It is essential that these young people have access to shelters that do not discriminate against them based on their sexual orientation.[6] Although LGBTQ youth are disproportionately represented among youth in foster care and juvenile justice systems, most of these programs do not have policies prohibiting discrimination on the basis of sexual orientation or gender identity. Nor do they train staff about the special needs of sexual minorities. (See the National Center for Lesbian Rights website for fact sheets.) Implementing such policies and training opportunities in all programs serving homeless youth, including shelters, can help to ensure a safe and welcoming environment for these vulnerable individuals.

- Adult Mentors

  It is particularly helpful if GLBTQ youth can have the benefit of mentorship and guidance from responsible adults with similar sexual orientations and gender identities.

**EXAMPLES: HEALTH SERVICES FOR SEXUAL MINORITIES**

**Health Outreach To Teens (HOTT) Program** - a comprehensive program designed specifically to meet the medical and mental health needs of lesbian, gay, bisexual, transgender, and questioning adolescents and young adults ages 13-24, and other homeless, runaway/throwaway, street-oriented, sex worker and squatter youth. These services are offered both at a dedicated youth-only medical suite on-site at Callen-Lorde, and on HOTT's medical van, which travels to areas in lower and mid-Manhattan in the afternoons and evenings where youth are known to hang out. All of HOTT's confidential services, which are offered in an accessible, non-judgmental, caring atmosphere, are provided free of charge or at low cost (insurance is accepted). HOTT will register young people 21 years old and younger for health care services, and provide ongoing care up to their 24th birthday. After their 24th birthday, they will be transitioned into adult care. HOTT now offers free HIV counseling and testing to youth ages 13-21. HOTT staff is composed of a multidisciplinary team specializing in adolescent care and other specialty disciplines. (http://www.callen-lorde.org/index.php)

[6] See O'Connor and Molloy 2001 for a review of general recommendations for better serving homeless lesbian and gay youth.

**EXAMPLES: HEALTH SERVICES FOR SEXUAL MINORITIES, continued**

The **Urban Peak homeless shelter** in Denver, Colorado, provides a safe haven for runaway and homeless youth, ages 15–20, including those who are gay, lesbian, bisexual, transgender, or in the process of questioning their gender or sexual identity. Services include outreach, case management, onsite medical care and behavioral health counseling, in addition to referrals for mental health/substance abuse treatment, and a GED program. Part of the intake process for all youth admitted to the shelter is asking about their sexual orientation and gender identity, says case manager Allison Hoffman. "This is educational even for 'straight' kids. We send a clear message that everyone is safe and welcome here, regardless of gender identity, sexual orientation or disability." …Staff and clients work together to make [the] shelter a comfortable, nondiscriminatory place to be.

*— HCH Clinicians' Network, June 2002 Healing Hands*

*Note: See additional examples of shelters and services for homeless LGBTQ young adults throughout the United States at [www.safeschoolscoalition.org/RG-homeless.html](www.safeschoolscoalition.org/RG-homeless.html)*

## HOUSING

An overarching barrier to housing for homeless young adults is the lack of affordable housing stock nationwide. According to the most recent Conference of Mayors report (2003), requests for assisted housing by low-income families and individuals increased in 83 percent of surveyed cities during the last year. Thirty-three percent of eligible low-income households are currently served by assisted housing programs; city officials estimate that low-income households spend an average of 46 percent of their income on housing. In the cities surveyed, applicants must wait an average of 24 months for public housing. This dire shortage of affordable housing provides the context within which other housing barriers are being confronted. Two common barriers presented here are a lack of sufficient financial resources and insufficient life skills. In each of these areas, it is important to provide an additional level of support to young adults who experience an episode of homelessness, to prevent long-term consequences and recidivism.

### Financial Resources

A variety of factors cause young adults to have limited financial resources, including low-income jobs with no benefits (see next section) and lack of time to amass savings. Yet to obtain rental housing frequently requires a significant outlay of cash; many landlords require a down-payment in addition to the first and last month's rent, up front.

***Strategies***

- Emergency Financial Assistance

  Emergency financial assistance has been shown to be an effective intervention to keep individuals from losing their primary housing (Burt et. al. 2002). An investment which keeps an individual in stable housing avoids time spent in more expensive alternatives (e.g., emergency shelters, the criminal justice system, inpatient facilities), prevents black marks on the tenant's housing record which may make future rental more difficult, and can prevent one crisis from leading to others.

- Rent Subsidies

  Providing rent subsidies for young adults living in poverty can create stability while they develop more mature support networks, advance in the workplace, and build financial reserves. This strategy has been shown to be less costly than are services required as a result of a single episode of homelessness.

- Move-in Money

  In a tight housing market, a steep financial investment is often required to obtain housing. Landlords may require the first month's rent, last month's rent, and a security deposit. Move-in money in the form of small grants or loans to young adults who are attempting to leave homelessness can offset this significant financial barrier.

**EXAMPLE: TRANSITIONING OUT OF FOSTER CARE**

In Los Angeles County, the Department of Children and Family Services has developed a series of "Alumni Resource Centers" for transitional (18-21 year old) youth who had been in the foster care system. The LA County DCFS has developed independent living programs for youth who have aged out of foster care to pay for move-in expenses, rent subsidies, college tuition, automobile insurance and other supports to help young people make a successful transition to adulthood. Their approach may serve as a model for programs in other parts of the country with high rates of homelessness among youth aging out of child protective services. For more information, visit their website at www.pasconline.org.

## Life Skills

Most young people move out of their home as young adults with the full support of their parents, who can be important resources for signing contracts, budgeting, advice, and often financial support. If housing is threatened, they can return home, learn from their mistakes, and start over — often before serious consequences have occurred. A support network and opportunities to gain life skills are not readily available to many young adults who have lost their parents, are estranged from their family, have grown up in foster care, or have been incarcerated. Older adults who suffer a crisis are less likely to become homeless because they have developed life skills with experience, but young adults may not have any experience managing their own home.

### *Strategies*

- Life Skills Training

  Life skills training has been shown to be effective at reducing the rates of homelessness in vulnerable young adult populations. Topics for training workshops may include: budgeting, signing a lease, maintaining an apartment, understanding renters' rights and responsibilities, preparing healthy meals on a budget, and planning for future crises. The investment in a young adult who is particularly vulnerable far outweighs the cost of a single episode of homelessness.

- Collaboration with Landlords

  Negotiate with landlords and tenants in danger of homelessness to prevent evictions when possible. HUD's Emergency Shelter Grant homeless prevention dollars can be allocated to landlords or utility companies to defray the cost of rent or utility arrearages for those who would otherwise be evicted and homeless.

- Transitional Housing Programs

  Transitional housing programs can provide an effective way to reduce failure rates for inexperienced young adults at risk of becoming homeless, as well as for those who are transitioning from homelessness to stability. There are a variety of successful models, ranging from scattered-site subsidized housing with a case management component to dormitory-style supervised housing (see Rashid 2004 for one successful model). These offer young adults a chance to establish a stable rental history and the opportunity to learn needed management skills while softening the potential negative outcomes of mistake. The current trend in adult services is to move from transitional housing to permanent housing with transitional services.[7]

- Host home programs

  Host home programs are used in a number of communities to provide individualized safe shelters and mentoring for youth or young adults in a home setting.

[7] See Durham 2003 for details about the types of programs and funding sources available, as well as thorough guidance in developing and designing supportive housing for youth and young adults.

### EXAMPLE: LOW-INTEREST LOANS, TENANT EDUCATION, MENTORING

The Launching Pad (TLP) is a program of housing assistance in Seattle, Washington, for formerly homeless young adults, ages 18-25. The basic belief of TLP is that all youth and young adults should have a home, and that the community should assist young adults who are working toward housing self-sufficiency. The primary goal of TLP is to remove the financial barriers to becoming housed that face formerly homeless youth at the end of their time in transitional housing.

This program has three key components:

- A no-interest loan that helps eligible young adults make deposits required by landlords and utility companies;
- Tenant education that teaches life and work skills such as home maintenance, financial aid application procedures, personal budgeting, and the basics of being a good tenant;
- Social supports that provide an on-going relationship with a caring adult, nurtured, in part, through monthly meetings with other participants and mentors from local faith communities.

*(www.scn.org/services/tlp/index.html; for more information, contact Rick Eberhardt: re28@u.washington.edu, 206 616-0390.)*

## EDUCATION AND EMPLOYMENT

Education is the primary method whereby individuals can build the skills and credentials they need to become successful, contributing adults in the workplace. Unfortunately, mainstream, traditional public school systems have not provided this critical resource for many homeless young adults. In particular, schools serving youth from low-income neighborhoods and families with fewer financial and material resources are less able to attract and retain the most highly skilled teachers and administrators, and generally have low achievement expectations (NRC 1993). It is not surprising, then, that many economically and socially disadvantaged youth have found education boring and irrelevant, and schools inhospitable places (Ibid., p.103).

In addition, homeless young people from varying socio-economic backgrounds who have different learning styles (or learning disabilities) may have experienced frustration and failure in previous schooling experiences. Because formal education is the primary institutional bridge to the workplace, however, those who have completed their schooling years without sufficient education or employment skills are disadvantaged when trying to achieve a livable wage in the workplace.[8] This is not to say that all homeless young adults do not have an education or are unable to work, but that even those with an education may need assistance in the transition from school to work.

Homelessness itself poses an almost insurmountable barrier to participation in education and employment. For many youth, the immediate challenges of survival, lack of physical safety, haunting memories of past trauma, and even lack of access to showers and clean clothes can all contribute to an environment not conducive to learning or work. These basic issues need to be realistically addressed while plans are developed for homeless youth to participate in education. What is surprising is the number of youth who persist in the pursuit of education despite these seemingly overwhelming challenges.

[8] "Young adults ages 17–24 with less than a high school diploma are three times as likely to be unemployed, underemployed, or working for very low wages than those with a college degree (Annie E. Casey 2004, p.12)." At-risk youth, including racial and sexual minorities, those aging out of foster care, and those involved in the criminal justice system, are most apt to experience these disadvantages.

### Testimonial: Christy

Christy left home for the big city, dropping out of the 10th grade and lived in abandoned buildings with her anarchist/punk street family for several years. She developed supporting relationships with healthcare providers and social workers and completed a GED. She worked part time in a homeless agency, frequently with pink hair and her punk regalia, while she took classes at a community college. She went on to earn a Bachelor's degree and finally a Masters Degree in Social Work from a major university.

Though Christy illustrates the hidden potential of many homeless youth and their ability to flower given support and opportunity, many other homeless youth overcome tremendous obstacles, perhaps with less dramatic accomplishments. Every step forward must be acknowledged, and realistic plans and opportunities provided based on the individual strengths and challenges of the specific young person.

## Limited Access to Education

There is a need to be creative about addressing the educational needs of young homeless adults, particularly those who have had negative experiences in middle and high schools. Helping them achieve educational goals can make it more likely that they will be able to secure gainful employment. Following are some innovative strategies for making education an achievable goal for these young people.

***Strategies***

- Increased Accessibility of Educational Services

  Examples of ways to help homeless young adults achieve educational goals:

  - Connect young adults to GED programs offered in community colleges, where they are more likely to find peers their own age.
  - Make preparatory courses available in local shelters.
  - Encourage tuition forgiveness from community colleges, recognizing that even low tuitions can be prohibitive for homeless young persons.
  - For some young adults Job Corps offers a path to stabilization, education, and job training. This is a federally funded program which offers second chances to young people. Many of these programs have residential components as well. (See http://jobcorps.doleta.gov for more information.)

- Some communities have schools specifically for homeless children and youth that are especially attuned to issues they face in trying to acquire an education. However, the rights of homeless children and youth to attend mainstream public schools are well-established in federal law, and school districts are required to accommodate their special needs, including transportation. (See U.S. Department of Education [July 2004], *Education for Homeless Children and Youth Program, Title VII-B of the McKinney-Vento Homeless Assistance Act, as amended by the No Child Left Behind Act of 2001, Non-Regulatory Guidance*: http://www.ed.gov/programs/homeless/guidance.doc. More information is available from the National Association for the Education of Homeless Children and Youth: www.naehcy.org.)

**EXAMPLES: PUBLIC SCHOOL ALTERNATIVES FOR HOMELESS YOUTH**

**YouthCare's Orion Center** in Seattle, Washington offers one-stop services to homeless youth, ages 12–21 — an alternative public school, meals provision, case management, mental health services, an onsite job project and a therapeutic recreation program including camping, sailing, dog training and volunteer opportunities. (*from interview with case manager Mavis Bonnar, HCH Clinicians' Network, Feb. 2000* Healing Hands)

The **Thomas J. Pappas Homeless Middle/High School** in Maricopa County, Arizona, was founded in 1990 to accommodate the special needs of homeless youth. The Pappas School is a public school within a district that serves children who are homeless, in need of alternative education, and those who are in the detention centers and the state hospital.

## Low-Paying Jobs

Many young adults have entry-level jobs, which are more likely to be part-time and less likely to provide benefits such as health insurance or sick leave. An accident or illness can easily lead to loss of a job. Individuals with entry-level jobs tend to live paycheck to paycheck with minimal financial reserves. To meet basic needs, they may even choose to forego expenditures for health care, a car, or auto insurance. Many of them are only one paycheck away from homelessness. Those who are homeless may be unable to obtain employment at all, due to their undocumented status or an untreated substance use disorder, or for lack of a stable address and phone number or access to showers and laundry.

***Strategies***

- Vocational Services and Training

  One of the most pressing needs of unemployed, poorly educated homeless youth is for the requisite skills to obtain and hold a job. For young people who have not adapted to the structure of school or an organized family life, the most fundamental skills — showing up at work, doing what one is told, and staying at work for the duration of responsibility — must be learned. Job training programs specifically oriented to helping these young people succeed and transition to the mainstream workforce are needed. Such programs should provide opportunities to learn achievable skills, relatively close supervision, and immediate compensation for labor. Businesses in many communities are willing to participate in vocational training programs such as this that are well supervised.

- Short-Term Employment Programs

  Programs that require low-level skills, prompt and regular working hours, and daily pay can help youth who have lived in unstructured environments achieve some basic skills. These programs may be developed in collaboration with local businesses, and provide transition to more stable employment.

- Work Cooperatives

  Youth who have immigrated to the United States for work and are unable to find legal employment frequently survive in an underground economy, and are especially vulnerable to homelessness. They may have marginal education and/or face language barriers. These youth provide casual day labor at minimum wage or less without any benefits; failing this, they sometimes fall unwillingly into desperate activities to survive. In some areas, innovative cooperatives provide work for these young people as gardeners, housekeepers, handymen and day laborers, serving as models to begin to address this difficult issue.

**EXAMPLE: INTEGRATED EDUCATIONAL AND VOCATION SERVICES**

Neon Street Programs in Chicago, Illinois, provide educational and vocational counseling, employment placement, health and mental health care to youth between 12 and 21 years of age who do not live with a parent. Most clients are wards of the state, in foster care, group care or shelter care. Clients receive health care through Neon's sister program, Heartland Health Outreach.

*— from interview with clinical coordinator Martin Jordan, MA, Feb. 2000 Healing Hands*

## Involvement with the Criminal Justice System

Increasing numbers of adolescents are involved in America's juvenile and criminal justice systems. The juvenile justice system was created to rehabilitate rather than punish young people, and to allow entry into the job market without the burden of a criminal record. Nevertheless, today's juvenile justice system increasingly resembles the adult criminal justice system, which is disproportionately populated by older teenagers and young adults, with its punitive characteristics and lack of emphasis on treatment and rehabilitation (NRC 1993). Recent federal statistics suggest that each year, more than 27,000 youth are incarcerated in secure detention facilities on any given day, an increase of almost 100 percent since 1985 (Annie E. Casey 2004, p.9).

The statistics on incarcerated youth are dire: suicide rates are four times higher than in the general population; half or more of this population suffer from mental health disorders and/or drug use problems and have limited education. Adequate and appropriate treatment and support services are rare (Annie E. Casey 2004, p.11). Failure to provide job training and education to incarcerated youth, enabling them to succeed following discharge and avoid returning to the life that led to incarceration in the first place, is a missed opportunity that often results in tragedy. Involvement in the criminal justice system significantly compounds a prior history of difficulty interacting with other institutions — such as going to school and looking for work – which can increase vulnerability to homelessness.

> ***No experience may be more predictive of future adult difficulty than having been confined in a secure juvenile facility.*** *– Annie E. Casey Foundation 2004, p. 9*

***Strategies***

- Alternatives to Incarceration for Non-Violent Offenses

  Less than one-third of youth placed in detention facilities are charged with violent offenses; more than one-third are detained there for status offenses (such as running away) or various technical violations of probation and other rules. A majority (approximately two-thirds) will enter institutions that are over-crowded, unsafe and unable to provided necessary care and support. Minority youth are most at risk: African American and Latino youth account for much of the recent increase in detention rates (see Annie E. Casey 2004, p.9). Alternatives to this national trend of incarcerating youth without providing sufficient treatment or after-care, should be seriously considered to prevent young adults from experiencing future homelessness.

- Sealed or Expunged Criminal Records

  A bill passed recently in Washington State allows juvenile records to be sealed. Formerly homeless young adults have testified that sealed criminal records of run-ins with the police while they were homeless increased their ability to get jobs and financial aid for school, enabling them to when get off the streets and achieve stability.

- Juvenile Justice System Reform

  The state of Missouri has become a national model in juvenile justice system reforms. Some of the changes which have especially contributed to their vastly improved recidivism rates include: smaller correctional programs for fewer teens; services geographically dispersed so more incarcerated youth have access to family members; college-educated "youth specialists" in lieu of traditional corrections officers; and reliance on counseling and personal development instead of punishment and isolation (paraphrased from Annie E. Casey 2004, p.19).

- Increased Employment Opportunities

  The impact of incarceration on prospective employment can be severe. Lack of employment opportunities for previously jailed individuals can increase not only the risk of homelessness, but the likelihood of repeated illegal behavior and arrests as well. Mandatory job training and education with case management during incarceration and after-care programs for young offenders can help to prevent this revolving door effect. Legal employment for ex-offenders and undocumented immigrants could prevent a lifetime of involvement with the criminal justice system for many young adults.

- Transitional Services for Ex-Inmates

  Providing assistance to young inmates returning home from detention facilities can help prevent recidivism and offer necessary resources to ensure successful transition to the community. Examples of transitional services for ex-inmates include: GED preparation classes, workplace skills, counseling and motivational programming, tattoo removal for gang-involved youth, and academic and vocational referral services in local colleges.

## SOCIAL SUPPORT

When faced with a crisis, many adults have a well-developed network of family and/or friends who can offer a short-term place to stay, food, or even financial support. Young adults may have a broad network of friends, but they tend to be close in age and struggling with the same issues. In the event of an episode of homelessness, young adults frequently "couch hop" or "couch surf" from friend to friend, staying until their welcome is worn out, potentially placing the housing stability of their friends at risk. Especially vulnerable to this situation are young adults who have aged out of foster care or the juvenile justice system, as they are most apt to have a truncated network of friends and may lack parental support as well. Social supports from family or community are crucial to help prevent homelessness or promote successful transitioning to stability.

> ***Research indicates that risk exposures among adolescents can be moderated and/or buffered by a focus on individual strengths and environmental protective factors such as community support and mentoring.*** *— Taylor-Seehafer 2004*

A 2002 study found that homeless families generally lack both social supports and social capital (social relationships or networks that allow individuals to gain access to material resources) to assist them in achieving stability (National Center on Family Homelessness/Clinicians' Network 2003). A study of Philadelphia residents found that, on the whole, young people ages 18–29 have much lower social capital than do older adults (Axler et al. 2003). Lack of social supports and social capital represents a gaping hole in the safety net for young adults who are homeless. Many homeless individuals and families move in with a series of relatives and friends before finally resorting to the homeless service system; a move into shelter often represents the end of the availability of family support (Culhane et al. 1996). This section of the report addresses barriers young adults may face in connecting with their families of origin and in creating a safe and nurturing environment for their own children.

**LIMITED SUPPORT NETWORKS: A TESTIMONIAL**

Jeff Olivet, MA, former Family Case Manager at Albuquerque Health Care for the Homeless, Inc., Albuquerque, New Mexico, …often asked his clients, "When was the last time you were housed in the same place for at least one year?" A 21-year-old recently responded, "Never." This is not unusual among the clients he saw. Many single homeless men were in and out of foster care, group homes and institutions as kids. "The majority have experienced some kind of trauma in childhood," he said. "A few with mental illness came from good homes and educated parents but may have started self-medicating with addictive substances. Most grew up in poverty, in an unstable home without good role models…. Most don't have mental illness severe enough to obtain access to case management or housing; priority is given to women and children."

*— HCH Clinicians' Network, June 2001 Healing Hands*

## Families of Origin

Young adults who are homeless frequently come from families who themselves are living in crisis. The 1996 National Survey of Homeless Assistance Providers and Clients found that 27 percent of homeless respondents of all ages had lived in out-of-home placement during their childhood (Burt et al. 1999). Twenty-five percent reported childhood physical or sexual abuse, and 21 percent reported family homelessness during childhood. Given the prevalence of family crisis and out-of-home placement in the histories of homeless young adults, it is essential to address these issues as well as provide adequate transition planning for youths aging out of child welfare systems (WRC 2003). For older teens, ages 18 and 19, placement with their families of origin may be difficult if not impossible. Many family shelters do not accept families with teens, necessitating separation of families. Shelters are often ill- equipped to handle the developmental needs and behaviors of older teens.

***Strategies***

- Family Counseling

  Even if families of origin cannot provide housing, they may be able to provide other types of concrete or emotional support. Family counseling can help to facilitate these supports, where appropriate. Other mental health services can also strengthen the utility of existing social supports, such as counseling to overcome childhood trauma.

- Education About Existing Services and How to Access Them

  Youth who lack the typical resources of family and community need assistance in connecting with existing public and private resources, such as job training, housing, and behavioral health

services. It is important to know, however, that even when youth are aware of available resources, they may lack the communication and self-advocacy skills to obtain them.

- Coordinated Services for Youth in Transition

  As noted above, youth transitioning out of institutions such as foster care, residential treatment programs, or juvenile detention facilities are especially in need of strong social support systems. Assisting during these transitional phases by coordinating support services and assisting with discharge planning can prevent homelessness or worse.

- Family Shelters: Programs and Support

  Supporting family shelters in meeting the unique needs of teens (for example, providing specialized staff training in the developmental needs of young adults) can be beneficial. Support groups in family shelters can assist teens who remain with their families of origin in coping with the perceived stigma of living in a homeless shelter.

**EXAMPLE: CENTER FOR FAMILIES WITH RUNAWAY YOUTH**

Project Safe, a component of the Cocoon House in Everett, Washington, is a resource center for parents and caretakers of youths at risk of homelessness due to problematic behaviors. Interventions are based on parental risk factors which research suggests can lead to teen homelessness, including: parent conflict, parental substance abuse, poor parent-child communication, isolation from single parenthood, and parents with low positive self-regard. This innovative program fills a gap in services available to families who do not have the resources or are too ashamed to ask for help, but desperately want to improve their teen's life and better family relationships. (www.cocoonhouse.org)

## Homeless Young Adults as Parents

Twenty-six percent of homeless families are headed by persons ages 17–24 (Burt et. al. 1999). Young homeless parents face the same challenges as all new parents; namely, the tasks of transitioning into the role of parent and of nurturing and rearing emotionally and physically healthy children. These challenges are complicated by the additional obstacles presented by homelessness. Moreover, many poor and homeless mothers have been victims of abuse, and a significant number suffer from posttraumatic stress disorder (Browne and Bassuk 1997). There is often a connection between their history of trauma and depression and developmental or behavioral problems that are evident in their children. Recent research suggests that early interventions to improve parenting skills and develop constructive responses to trauma by these mothers can foster normal emotional and cognitive development in their children (CN, May 2003 *Healing Hands*).

Parenting in shelter can be especially difficult, as the need to conform to shelter rules can undermine the autonomy of parents. Children who are corrected by shelter staff in front of their parents learn quickly that the true family authority is the shelter staff rather than the parent (Friedman 2000). Young adults in the homeless system are juggling multiple priorities such as housing, income, and physical or behavioral health needs in addition to their parenting responsibilities. Because of their current circumstances, they may have less ability to focus on the needs of their children. Because of unresolved issues from their own childhood, they may have limited coping skills and positive parenting models to follow. Nevertheless, their children are also going through the transitions and crises of homelessness and need more rather than less time, attention, and emotional availability. These children need specialized parenting strategies at the very same time that their young parents are least able to provide them.

Though homelessness, *per se*, is not itself an indication to remove children from the care of parents, homeless parents may lose custody of small children to child protective services due to instability of housing, inability to provide adequate and predictable nutrition, mental illness, and alcohol and/or drug abuse problems. It should be noted that this may be the most expensive approach to addressing this tragic situation; the financial costs of maintaining a child in foster care far exceed the costs of rent and food for the family. Considering the instability that children in foster care frequently experience, and the emotional trauma they suffer through disrupting their primary attachment, it is debatable whether the outcomes are significantly improved.

***Strategies***

- Shelter-Based Support and Services

  - Provide parenting classes that include topics especially related to homelessness from a strength-based perspective. Training should include normal child development as well as special issues involving homeless families. One model that has proven successful in various settings is Effective Black Parenting (Center for the Improvement of Child Caring). This curriculum has been adapted for use in shelters by staff from the Children's Hospital of Philadelphia with promising results.

  - Train homeless service staff to create shelter environments that support parental autonomy. Many cities have training requirements for city-contracted and private shelters. These classes should include topics relevant to child development and parenting in shelter.

  - Provide special needs screening and accessible services for the children of young parents. Children in shelter may be at higher risk for certain developmental delays; screening and service delivery can be complicated by transience and shelter living. According to the National Center on Children and Poverty, lower socioeconomic status in preschool children "accounts for more unique variation in cognitive scores than any other factor by far"

(Raver and Knitzer 2002). On-site shelter screening and accessible services can help address delays earlier and more effectively (see model program below).

- Mentoring for Young Parents

  Provide role models for positive parenting. Pairing young parents with more experienced parents who can model parenting skills and provide support and answers is invaluable.

- Legal Assistance

  Provide legal assistance for parents facing child custody and other family issues. Specialists in family and educational law should be involved in legal assistance for homeless individuals.

**EXAMPLE: CHILDHOOD SCREENING PROGRAM**

**Stenton Family Manor** is the largest family shelter in Philadelphia. At this shelter, a unique partnership between Philadelphia Health Management Corporation's HCH Program, its ChildLink program, and City and shelter staff provide screenings and follow up to every child, from birth through age five, who enters the shelter.

Each child is screened by HCH staff using either the Ages and Stages Questionnaire or the Denver Scale of Infant Development. Any children identified as needing early intervention are referred to ChildLink, funded by the Commonwealth of Pennsylvania, for monitoring and service provision. ChildLink serves all children requiring early intervention in Philadelphia and Delaware Counties. The HCH social worker provides follow-up and any needed service coordination between client, shelter and City staff, and ChildLink. Needed services, such as occupational therapy, are provided on-site at the shelter.

Early results indicate that this coordinated strategy has been effective in screening children and ensuring access to needed services even with the added obstacle of family homelessness.

*(Contact Rachel Kirzner, Assistant Director of Social Work, Philadelphia Health Care for the Homeless program at Rachel@phmc.org for more information.)*

# *Bibliography/Resources*

*(* Indicates resource is available online.)*

American Medical Association (AMA). (1989) "Council on Scientific Affairs. Health Care Needs of Homeless and Runaway Youth." *Journal of the American Medical Association,* 262:1158.

Annett JJ. (2000) "Emerging Adulthood: A Theory of Development From the Late Teens Through the Twenties." *American Psychologist,* 5:469.

*Annie E. Casey Foundation. (2004) "Moving Youth from Risk to Opportunity." www.aecf.org/kidscount/databook/essay.htm

Auerswald CL, Eyre SL. (2004) "Youth Homelessness in San Francisco: A Life Cycle Approach," *Social Science & Medicine,* 54: 1497–1512.

Axler, Kotranski, Klein, et. al. (2003) "Social Capital and Health: Does a Relationship Exist?" *American Public Health Association Annual Meeting presentation.*

Barry P, Ensign J, Lipke S. (2002) "Embracing Street Culture: Fitting Health Care into the Lives of Street Youth." *Journal of Transcultural Nursing,* 13(2):145–152.

Beckman M. (2004) "Crime, Culpability and the Adolescent Brain." *Science*, 305:596–9.

Bloom KC, Bednarzyk MS, Devitt DL, Renault RA, Teaman V, Van Loock DM. (2004) "Barriers to Prenatal Care for Homeless Pregnant Women." *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33(4):428–435.

Browne A, Bassuk SS. (1997) "Intimate Violence in the Lives of Homeless and Poor Housed Women: Prevalence and Patterns in an Ethnically Diverse Sample." *American Journal of Orthopsychiatry*, 67(2): 261–278.

*Burt M, et al. (2002) "Evaluations of Continuum of Care for Homeless People, Final Report." U.S. Department of Housing and Urban Development, Office of Policy Development and Research. www.urban.org/url.cfm?ID=310553

Burt, Laudan, Douglas, et al. (1999) "Homelessness: Programs and the People They Serve: Summary Report."

HCH Clinicians' Network (CN). *Healing Hands* (bimonthly newsletter). Issues published since 1998 available at www.nhchc.org/healinghands.htm

Cochran BN, et al. (2002) "Challenges Faced by Homeless Sexual Minorities: Comparison of Gay, Lesbian, Bisexual, & Transgender Homeless Adolescents with their Hetero-Sexual Counterparts." *American Journal of Public Health,* 92(5):773–7.

*Collins SR, Schoen C, Tenney K, Doty MM, Ho A. (2004) "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help." Report of the Commonwealth Fund Task Force on the Future of Health Insurance. http://www.cmwf.org/programs/insurance/collins_riteofpassage_ib_649.pdf

*Corporation for Supportive Housing. (2003) "Supportive Housing for Youth: A Background of the Issues in the Design and Development of Supportive Housing for Homeless Youth." http://documents.csh.org/documents/pd/youth/youthsh.pdf

Culhane, Lee, and Wachter. (1996) "Where the Homeless Come From: A Study of the Prior Address Distribution of Families Admitted to Public Shelters in New York City and Philadelphia." *Housing Policy Debate,* 7(2).

De Rosa CJ, Montgomery SB, Kipke MD, Iverson E, Ma JL, Unger JB. (1999) "Service Utilization Among Homeless and Runaway Youth in Los Angeles, California: Rates and Reasons." *Journal of Adolescent Health,* 24(3): 190–200.

Drake RE, Osher F, and Wallach MA. (1991) "Homelessness and Dual Diagnosis." *American Psychologist,* 46(11):1149–1158.

*Durham K. (2003) "Housing Youth: Key Issues in Supportive Housing." Corporation for Supportive Housing. http://documents.csh.org/documents/pd/youth/housingyouth.pdf

*Dworsky A, Courtney ME. (2000) "Self-Sufficiency of Former Foster Youth: Analysis of Unemployment Insurance Wage Data and Public Assistance Data." Institute for Research on Poverty, University of Wisconsin-Madison. http://aspe.hhs.gov/hsp.fosteryouthW100/

English A, Morreale MC, Larsen J. (2003) "Access to Health Care for Youth Leaving Foster Care: Medicaid and SCHIP." *Journal of Adolescent Health*, 32(6 Suppl): 53–69.

Ensign J. (2001) "Reproductive Health of Adolescent Women in Seattle, Washington, USA." *Women and Health,* 31(2/3):133–151.

*Families U.S.A. (2004) "One in Three: Non-Elderly Americans Without Health Insurance, 2002–2003." Families USA Foundation: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641

Friedman DH. (2000) Parenting in Public: Family Shelter and Public Assistance. New York: Columbia University Press.

Garfein RS, Doherty MC, et al. (1998) "Prevalence and Incidence of Hepatitis C Virus Infection among Young Adult Injection Drug Users." *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18(Supp 1): S11–S19.

Giedd JN, Blumenthal J, Jeffries NO, et al. (1999) "Brain Development During Childhood and Adolescence: A Longitudinal MRI Study." *Nature Neuroscience,* 2(10): 861–3.

Ginsburg, KR, Winn, RJ, Rudy, BJ, Crawford, J, Zhao, H, Schwarz, DF. (2002) "How to Reach Sexual Minority Youth in the Health Care Setting: the Teens Offer Guidance." *Journal of Adolescent Health*, 31(5): 407–416.

Klein JD, Woods AH, Wilson KM, et al. (2000) "Homeless and Runaway Youths' Access to Health Care." *Journal of Adolescent Health,* 27:331.

Lerner RM, Galambos RL. (1998) "Adolescent Development: Challenges and Opportunities for Research, Programs, and Policies." *Annual Review of Psychology,* 449:413.

*Levin-Epstein J and Greenberg MH (Ed.) (2003) "Leave No Youth Behind: Opportunities for Congress to Reach Disconnected Youth." www.clasp.org/DMS/Documents/1057083505.88/Disconnected_Youth.pdf

*National Center on Family Homelessness and Health Care for the Homeless Clinicians' Network (NCFH/CN). (2003) "Social Supports for Homeless Mothers." www.familyhomelessness.org/pubs_list.html

*National Health Care for the Homeless Council. "Some Facts about Homelessness and Health Care." www.nhchc.org/publications/basics_of_homelessness.htm.

*National Institute of Mental Health. (2001) "Teenage Brain: A Work in Progress." www.nimh.nih.gov/publicat/teenbrain.cfm

National Research Council. (1993) Losing Generations: Adolescents in High-Risk Settings: Panel on High-Risk Youth. Washington D.C.: National Academy Press.

Neinstein LS, et al. (2002) Textbook of Adolescent Medicine, 4th edition, Chapter 2, Psychosocial Development in Normal Adolescents.

O'Connor W, Molloy D. (2001) "Hidden in Plain Sight: Homelessness Amongst Lesbian and Gay Youth." London: National Centre for Social Research. (For a copy, e-mail s.johnson@natcen.ac.uk)

Rashid S. (2004) "Evaluating a Transitional Living Program for Homeless, Former Foster Care Youth." *Research on Social Work Practice Journal*, 14(4):240–248.

Raver CC, Knitzer J. (2002) "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three and Four-Year-Old Children." National Center for Children in Poverty. http://www.nccp.org/pub_pew02c.html

*Reeg B, Grisham C, Shepard A. (2002). "Families on the Edge: Homeless Young Parents and Their Welfare Experiences: A Survey of Homeless Youth and Service Providers." www.clasp.org/DMS/DMS/Documents/1037307545.54/edge_report.pdf

Rew L, Fouladi RT, Yockey RD. (2002) "Sexual Health Practices of Homeless Youth." *Journal of Nursing Scholarship*, 34(2): 139–45.

Richardson E, Sellors JW, Mackinnon S, et. al. (2003) "Prevalence of Chlamydia Trachomatis Infections and Specimen Collection Preference Among Women, Using Self-Collected Vaginal Swabs in Community Settings." *Sexually Transmitted Diseases*, 30(12):880–885.

Robertson MJ, Toro PA. (1998) "Homeless Youth: Research, Intervention, and Policy." In Practical Lessons: The 1998 National Symposium on Homelessness Research, U.S. Departments of Housing and Urban Development, and Health and Human Services.

Rosenthal D, Mallett S. (2003) "Involuntary Sex Experienced by Homeless Young People: a Public Health Problem." *Psychological Report*, 93(3 pt 2):1195–1196.

Saewyc EM. (2003) "Influential Life Contexts and Environments for Out-of-Home Pregnant Adolescents." *Journal of Holistic Nursing*, 21(4):343–367.

*Safe Schools Coalition. (9/8/04) "Homeless LGBT Youth and LGBT Youth in Foster Care." www.safeschoolscoalition.org/RG-homeless.html

*Shelter Partnership. (1997) "A Report on Transitional Housing for Emancipated Foster Youth in Los Angeles County." http://www.shelterpartnership.org/homelessness/publications.htm

Slesnick N. (2001) "Variables Associated with Therapy Attendance in Runaway Substance Abusing Youth: Preliminary Findings." *American Journal of Family Therapy*, 29(5): 411–420.

Society for Adolescent Medicine. (1995) "A Position Statement of the Society for Adolescent Medicine." *Journal of Adolescent Health*, 16:413.

Taylor-Seehafer MA. (2004) "Positive Youth Development: Reducing the Health Risks of Homeless Youth." *American Journal of Maternal Child Nursing*, 29(1):36-40.

*Texas Foster Care Transitions Project. (2001) "All Grown Up, Nowhere to Go: Texas Teens in Foster Care Transition." www.cppp.org/kidscount/foster.pdf

Tyler, K, Whitbeck, LB, Hoyt, DR, Cauce, AM. (2004) "Risk Factors for Sexual Victimization among Male and Female Homeless and Runaway Youth." *Journal of Interpersonal Violence*, 19(5): 503–520.

*U.S. Conference of Mayors. (2003) "Hunger and Homelessness Survey 2003: A Status Report on Hunger and Homelessness in America's Cities." www.usmayors.org/uscm/hungersurvey/2003/onlinereport/HungerAndHomelessnessReport2003.pdf

*U.S. Dept. of Health and Human Services/Health Resources and Services Administration/Bureau of Primary Health Care. (2001) "Understanding the Health Care Needs of Homeless Youth." Division of Programs for Special Populations, Health Care for the Homeless Branch. ftp://ftp.hrsa.gov/bphc/docs/2001pals/2001-10.pdf

U.S. Preventive Services Task Force. (1996) *Guide to Clinical Preventive Services*. 2nd edition. Williams and Wilkins.

Wilder Research Center (WRC). (2003) "Homelessness in Minnesota 2003."

*World Health Organization. (1986) "Young People's Health – A Challenge for Society." Report of a study group on young people and health for all by the year 2000, *Technical Report Series, No. 731*. Geneva: World Health Organization. http://wholibdoc.who.int/trs/WHO_731.pdf.

## ORGANIZATION WEBSITES

Center for Law and Social Policy: www.clasp.org/

CORK Bibliography: Adolescents, Homeless and Runaways: www.projectcork.org/bibliographies/data/Bibliography_Adolescent_Homeless_Runaway.html

Family and Youth Services Bureau, Administration for Children and Families, U.S. Department of Health and Human Services: www.acf.hhs.gov/programs/fysb/FYSBprog.htm

National Association for the Education of Homeless Children and Youth (NAEHCY): www.naehcy.org

National Center for Children in Poverty: www.nccp.org

National Center for Lesbian Rights: www.nclrights.org

National Center on Family Homelessness: www.familyhomelessness.org

National Clearinghouse on Families & Youth: www.acf.dhhs.gov/programs/fysb/fysb.htm

National Coalition for the Homeless: www.nationalhomeless.org/youth.html

National Health Care for the Homeless Council: www.nhchc.org

National Network for Youth: www.nn4youth.org/

National Resource Center for Youth Development, University of Oklahoma, Resources section (including Online Library and Web Resources Links): www.nrcys.ou.edu/resources.htm