

Illness Experiences of Homeless Youth

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The purpose of this study was to document the illness experiences of homeless youth. The research was a focused ethnography with 45 clinic- and street-based homeless youth aged 15 to 23 years. The authors noted gender differences for health-seeking behaviors, with most male youth reporting embarrassment about needing to seek care, and female youth reporting fears over safety issues while ill and homeless. Most youth under age 18 stated that they were often denied health care at hospitals because of their underage status, and youth over age 18 stated that health care bills contributed to their inability to obtain stable housing. Street-based youth reported more illnesses related to substance use and greater reliance on emergency departments for health care than clinic-based youth did. Policies and programs focused on improving the health of homeless youth need to address the differences in illness experiences by age, gender, and sampling site.

Keywords: *homeless youth; qualitative research; primary care; health issues*

In the United States, it is estimated that there are 1.6 million homeless youth each year (Ringwalt, Greene, Robertson, & McPheeters, 1998), and that young people aged 12 to 17 years are more at risk of homelessness than are adults (Link, Susser, Stueve, Phelan, & Struening, 1994; Robertson & Toro, 1998). The most common reasons for youth homelessness include family conflict, and physical and sexual abuse in their families of origins, as well as multiple foster care and other out-of-home placements (Robertson & Toro, 1998). Homeless youth are widely acknowledged as being a particularly medically vulnerable population (Greene, 1995). The realities of street life, including substance use; survival sex; lack of reliable, safe shelter; and basic hygiene needs place homeless youth at high risk for many negative health consequences (Ensign & Gittelsohn, 1998). Studies have found that homeless youth have high rates of human immunodeficiency syndrome (HIV) infection, sexually transmitted diseases (STDs), depression and suicide attempts, and unintended pregnancies (Ensign & Santelli, 1998; Greene, 1995; Greene & Ringwalt, 1998). Injuries, dermatologic problems (including lice and scabies), and malnutrition also are reported to be common health problems for these youth (Rew, 1996).

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Homeless youth are characterized as having inadequate access to primary health care and as seeking care at emergency departments only after they are no longer able to ignore their condition (DeRosa, 1999; Geber, 1997; Greene, 1995). Homeless youth have greater problems with access to care than do their nonhomeless peers, including a more profound lack of insurance/payment source, greater anxiety over confidentiality, and more confusion over their ability to consent for care (DeRosa, 1999; Ensign & Gittelsohn, 1998; Ensign & Santelli, 1998; Geber, 1997). Homeless youth do not usually seek care at clinics for homeless adults, and very few localities in the United States have special health care services for homeless youth (Bureau of Primary Health Care, 2001; Ensign & Gittelsohn, 1998).

Research on homeless youth suffers from the lack of consistent definitions of the terms *homelessness* and *youth*, making comparisons between studies difficult. Research is also complicated by homeless youths' distrust of adults and institutions, lack of standardized instruments appropriate for use with homeless youth, research ethics issues such as ability of youth to consent for participation, and lack of use of appropriate comparison groups and sampling methods (Ensign, 2003; Robertson & Toro, 1998). In addition, the bulk of existing research on the health of homeless youth has been quantitative in nature. Qualitative research is particularly useful for understanding the sociocultural context of complex phenomena such as health-seeking behavior, especially for marginalized populations (Hurley, 1999; Sofaer, 1999).

Homeless youth have their own unique culture, including lingo, and ways of interacting with each other, with service providers, and with others in their lives (Barry, Ensign, & Lipke, 2002). A greater understanding of how they view illness and health care, and of how these might vary by age, gender, and sampling site are essential for planning and evaluating the impact of appropriate health care interventions. In this study, we describe the illness experiences of homeless youth and how these experiences differed by age, gender, and sampling site.

METHOD

Population and Setting

The study was conducted in a homeless youth clinic and in two street locations known to be popular "hang-out" areas for homeless youth in Seattle, Washington. We recruited homeless youth from both clinic- and street-based sites, because these sites represent different subgroups of the homeless youth population, and youth are likely to report different experiences with illness. There are an estimated 500 to 1,000 street- and shelter-based youth (aged 12 to 24 years) in Seattle on any given night, and when including "other" homeless youth, such as couch-surfers (doubling up with friends or lovers) and systems youth (between foster care or other out-of-home placements), the number is close to 2,000 (Henning & Goldsmith, 1995; Kombula et al., 2000). Based on recent survey results, the vast majority (94%) of shelter-based youth in Seattle/King County are residents of the city/county (Shaw, 2000).

The homeless youth clinic where we collected clinic-based data is a community health clinic and a Health Care for the Homeless site that targets homeless and at-risk youth aged 12 to 23 years. It currently provides health care for the largest

number of homeless youth in Seattle. The clinic is open two evenings a week and offers allopathic and naturopathic health care, as well as mental health, dental, acupuncture, massage, HIV services, and substance abuse counseling on site. All services are free of charge to homeless youth. During 2002, the year of the present study, the Youth Clinic served 2,006 youth, with 64% of the total being female, 76% being White (11% African American, 4% American/Alaskan Indian, 4% mixed race, 2% Hispanic, 1% Asian), and the average age being 19 years.

The two street-based areas of Seattle included as study sites were the University District in North Seattle, near the University of Washington campus, and the Broadway/Capitol Hill area in Central Seattle, near the downtown area. These two areas have long been popular areas for homeless and other youth to hang out. Data collection in these two areas was facilitated by our working with the staff of a medical van that serves homeless youth in these areas. The medical van is operated by a local children's service agency in conjunction with a private hospital and an interdisciplinary health sciences training program at the University of Washington. The van is a medically equipped mobile home that provides street-based medical care free of charge for homeless youth aged 12 to 23 years in the evening and early morning hours in the University and Capitol Hill districts of Seattle two evenings a week. For calendar year 2002, the medical van provided care for 417 homeless youth, with 60% being male, average age 20 years, and 59% White (27% unknown, 4% American/Alaskan Indian, 4% mixed race, 3% Hispanic, 2.5% African American, 0.5% Asian). The medical van operates in tandem with a smaller outreach van and staff, who provide basic services seven nights a week, providing items such as food, clothing, blankets, and referrals to shelters for homeless youth.

Data Collection and Sampling

The study design was descriptive, using a focused ethnographic qualitative method that included participant observations, key informant interviews, semistructured interviews, and focus groups. Because the aim of the research was to explore information on the shared experience of illness among the subcultural group of homeless youth, we deemed focused ethnography to be the most appropriate method (Morse & Richards, 2002; Roper & Shapira, 2000). The study design did not have a predetermined conceptual framework but was intended to provide rich, descriptive information from which concepts and theories could later be developed. The study took place from January 2002 to December 2002 in Seattle, Washington. The sampling strategies were convenience for the participant observations and purposive for the interviews and focus groups. In the purposive sampling, we sought equal numbers of clinic- and street-based youth, as well as equal numbers of male and female youth, and under and over age 18. We chose the age groups based on the results of previous surveys, which suggested that youth in these age groups had different issues with regard to accessing services.

All data were collected by the principal investigator (PI), a White female nurse-researcher in her 40s who has more than 15 years' experience in providing health care and in conducting qualitative and mixed-method research with the homeless youth population; for 8 of these years, she has worked directly with the homeless youth and service providers in Seattle. Four data collection methods were used in this study.

Participant Observations

Participant observations involved time spent by the PI “hanging out” in the Youth Clinic with youth and staff, as well as with the youth and outreach staff on street areas around the vans. The PI’s hanging-out sessions continued throughout the study period, lasted for 3 hours per session, and took place at least once a week. Semistructured observations were conducted, in that the PI paid particular attention to the health-related conversations between young people and between the young people and staff or other adults. The PI completed in-depth, handwritten, expanded field notes after each participant observation session.

Key Informant Interviews

We chose two key informants for participation in the research; they were available throughout the entire research period. One was male, and one was female, and both were in their mid 20s, had experience being homeless, and were now stabilized in their living situations. The PI interviewed the key informants at least once a month throughout the research period for a total of 30 interviews. The key informants helped to clarify unfamiliar terms used and situations described by the homeless youth.

Semistructured Interviews

We selected clinic- and street-based youth ages 12 to 23 years using purposive sampling, with equal numbers selected from the two settings. We chose individuals for inclusion based on their experience with illness while homeless and on their willingness to talk about these experiences (Morse, 1998). None of the youth from the street-based site were seeking care on the medical van but, rather, were using the smaller van’s services of food and clothing. The purposive sampling included equal numbers of males and females. We recruited and interviewed youth until saturation of responses occurred. The final sample for the interviews was 30 young people with a mean age of 20 years (range 15 to 23 years). The racial/ethnic mix of the young people in the present study was close to that of the clinic and medical van population overall (80% White, 13% African American, 7% Hispanic/mixed race).

The interviews covered the topics of most recent illness experience while being homeless, health-seeking behaviors, and access to care issues both for the youth being interviewed and for homeless youth they knew (shadow data). We asked them to compare and contrast their illness experience with those of others they knew. This shadow data is important for providing information on the range of illness experiences as well as possible explanations for differences in experiences (Morse, 2000). The interviews also covered the topic of youth pattern of homelessness and their perspectives on the reasons for their homelessness.

The data were collected at the Youth Clinic during regular Youth Clinic evening hours (6 to 9 p.m.), as well as on the streets during van outreach hours (9:30 p.m. to 2 a.m.). Only youth who identified themselves as currently being homeless, within the age range of 12 to 23 years, and English speaking were included in the study. There are very few non-English-speaking homeless youth seen at either site; none were present on the nights of the research. For the purpose of this research, *homeless*

was defined as staying in a temporary shelter, in a public place such as a park, under a bridge, in a car, or in another similar place. Thus, the youth included in this research were experiencing literal homelessness. A male outreach worker from each site who knew the youth well assisted with initial recruitment on the evenings of the data collection. There were no youth refusals among those approached for the study who met inclusion criteria.

The PI conducted the interviews in a private consulting room in the clinic, or street-side in the front seats of the medical van (as nearby coffee shops or eateries were closed at that time of the night). All individual interviews were tape-recorded with care taken not to record personal identifiers. Youth who completed the interview received a U.S.\$10 prepaid phone card as compensation for their time.

Focus Groups

After the interviews were complete and had been analyzed preliminarily, we conducted focus groups for more in-depth exploration of identified themes and topics. We conducted two mixed-gender focus groups, one each at the clinic and on the medical van, for a total of 15 youth. For focus groups, a White male anthropologist in his 20s served as recorder for the group process. The sampling for the focus groups was purposive, with an attempt made to include an equal number of both genders, as well as under and over age 18 years. The clinic focus group was held in a private meeting room upstairs from the main clinic. The focus group on the van was conducted during regular van outreach hours, but on a night when regular medical care was not being provided. Both groups included different youth from those interviewed or in the other focus groups (no duplicate youth). The groups had an average age of 20 years (range 16 to 23 years). They were led by the PI assisted by the male recorder, followed standard focus group format, and were tape-recorded. Youth who completed a focus group received a \$10 prepaid phone card along with snacks and milk as compensation for their time.

Ethical Issues

We obtained verbal consent from all youth, with information statements signed by the researcher. We used verbal rather than written signed consents, because the research was deemed to pose a minimal risk, and the young peoples' signatures would otherwise be the only possible identifiers of their participation in research. In Washington State, where this research was conducted, minors 14 years and older can consent for their own medical care involving reproductive health, substance abuse, and mental health issues. In addition, emancipated minors living on their own and who are 14 years of age and older can consent for all of their own medical care. All of the homeless youth included in this research could be considered emancipated minors and were deemed capable of giving consent for participation in the research. To help minimize possible coercion in the research recruitment process, we used intermediary persons to approach and initially recruit the youth for participation in the research. These intermediaries were familiar with the young people and helped to screen out youth who were under the influence of drugs or alcohol on the nights of the research. The intermediaries also screened out young people who had an ongoing primary care relationship with the PI. In addition, although the PI

had also been a health care provider at the research sites, she was strictly a participant observer and interviewer on the nights that the research was conducted. Many other health care providers were available to provide health care for the youth at these sites. With homeless youth and outreach workers' guidance, the research compensation was kept small enough and in the form of a prepaid phone card that it was not considered to influence unduly a young person's decision whether to participate in the research (English & Morreale, 2003). The research was reviewed and approved by the human subjects committee at the University of Washington.

Data Management and Analyses

Initial analysis of the data began simultaneously with data collection, as we searched for emerging patterns and themes in the data, followed up on negative cases, and explored additional questions. In preparation for more formal data analysis, an experienced transcriptionist transcribed tape recordings of all interviews and focus groups. The PI typed up handwritten field notes. Transcribed files and typed field notes were entered into the Atlas-ti qualitative data analysis software, coded, and checked for inconsistencies by the PI. After initial coding by the PI, the male research assistant independently coded the material and then, together with the PI, refined the coding. We validated and refined summaries of the research by cross-checking the results with the original individuals from whom the information was obtained. Qualitative data management and analysis followed standard ethnographic techniques and included latent and manifest content analyses, and frequency tabulations (Morse & Field, 1995). For latent content analyses, we reviewed passages within individual interviews or focus group discussions within the context of the entire interview to determine the major theme or significant meaning. Manifest content analyses followed latent content analyses and consisted of searching all transcripts for certain words or terms, tabulating them, and then conducting frequency tabulations.

RESULTS

We have reported the results of the research by the following categories: (a) experience of homelessness, (b) most recent illness experience, and (c) access to care issues.

Experience of Homelessness

There were differences in reported length of homelessness between the street- and clinic-based youth who were interviewed or who participated in the focus groups. Although the average length of homelessness for clinic-based youth was 4 months (range 1 to 9 months), the average length of homelessness for the street-based youth was 3 years (range 1 month to 8 years). In addition, the majority of clinic-based youth reported that they were currently staying in emergency shelters, whereas most of street-based youth were living in various places on the streets, in squats (abandoned buildings), or in their cars. From the participant observations, these dif-

ferences between sites were also noted; in addition, many youth from both sites were currently couch-surfing.

The majority of homeless youth from both sites reported having grown up either in the Seattle area or in other areas in Washington State; however, more street-based youth than clinic-based youth reported being from areas outside of Seattle or Washington State and of having traveled to different states while homeless. The homeless youth who had traveled while homeless were mostly over age 18 and reported traveling south to cities including San Francisco, Los Angeles, Phoenix, Albuquerque, Dallas, and New Orleans. Homeless youth most often reported having grown up in California, Oregon, Alaska, and Minnesota.

Reported length of homelessness did not differ by gender, but more male than female respondents from both sites reported living on the streets. More of the over-18-year-old youth were currently living on the streets or in squats. All of the youth who had been homeless for more than a year reported episodes of being in and out of homelessness. Many of the street-based youth talked about histories of poverty in their families of origin as well as multiple foster care and other institutional placements. One male street-based youth reported that he had had eight different foster care placements within 4 years as a teenager and then decided that living on the streets was better than being in foster care. Several of the street-based youth reported that their parents were currently living on the streets in Seattle and could not take care of them. None of the clinic-based youth interviewed reported homelessness or extreme poverty in their families of origin.

Youth from both sampling sites most often reported that the primary reason for their homelessness was family conflict. The reasons for homelessness did not appear to differ by age or gender.

There's a lot of issues and me and my Mom don't get along. We don't talk at all right now, because whenever we try to talk it ends up being a fight and she kicks me out, so that's why I'm out here now. (23-year-old White female participant, interview on the streets)

I had an argument with my uncle where I'd been living for years and he kicked me out. Then I stayed with some friends in their apartment for awhile, but that didn't work out so now I'm homeless. (19-year-old Hispanic male participant, interview in clinic)

At the same time, many of the youth from both sites reported maintaining some level of contact with their families, even if they did not always get along with them.

Everybody has their own experience of what homelessness is. For me, it just happened so quick, and it's like "Whoa! I'm out here, I'm doing it, I'm on my own!" Even my Mom is surprised, but hopefully I can get back in the home. She told me that I have to get a job, go to school, keep myself going in a good direction, and then I can move back inside. (18-year-old White male participant, interview in clinic)

Several homeless youth reported that they had first become homeless in rural areas and had found it more difficult to get help while homeless in these areas, so they had traveled to Seattle. One young woman, who had a serious chronic medical condition, described it this way:

I grew up south of here in a tiny little place, so when I was homeless there it was kinda like camping. The school people knew I had health issues and everything, but just nobody would help me. It was like homelessness there was kind of unheard of, you know, I was probably the only one. It was like they wanted to sweep me under the carpet and pretend I wasn't there. (19-year-old White female participant, interview on the streets)

Most Recent Illness Experience

The majority of the street-based homeless youth described a most recent illness experience related to drug use, most often abscesses from intravenous drug use, but also being "dope-sick" and ill from trying to get off of heroin. In addition, several of the street-based youth reported a most recent illness episode of "abscesses from mersa," meaning infections from Methicillian-resistant *Staphylococcus aureus* (MRSA). Several clinic-based youth also described a last illness episode related to drug use, but the majority described illnesses such as "stomach flu" and respiratory illnesses such as bronchitis. Types of illness did not appear to differ by gender.

Homeless youth contrasted what it was like to be ill and homeless to what it had been like to be ill when they were not homeless. The main differences noted by youth were not having a place to rest and recuperate, and not having as much social support when they were ill and homeless.

The worst thing was not being able to rest, basically being homeless in itself kept me from getting better faster. I kind of caught myself laughing a few times, reminiscing to the times when I had a cold and was at home in bed, and I had my mom and even my mean ole' step-dad bringing me fluids and a humidifier, and just the comfort of being able to rest. (19-year-old White male participant, interview in clinic)

Many of the clinic-based youth and several of the street-based youth reported that they sometimes were able to go home to their parents or other relatives when they were ill. Both key informants stated that this did occur, especially for younger homeless youth who had relatives in the area. They stated that once the youth had recovered from their illness at home, family conflicts would reemerge, and the young people would become homeless once again.

The last time I was sick I had strep throat, had a bad fever and was practically dead. I went back to my dad's house because I didn't have any other choice. I barely remember getting there. I told the bus driver I was homeless and sick and needed to go home. He made sure I got off at the right place. I stayed at my dad's for a couple of days and then I had to go. We got into a fight; he dropped me off at the clinic to get some medicine and that was that. (17-year-old White female participant, interview on the streets)

More of the clinic-based homeless youth reported having help during their most recent illness from shelter workers and other youth advocates, as well as from their homeless youth friends. Several of the older clinic-based youth reported riding a city bus all night when last ill to stay warm and dry. An additional theme that emerged from the illness narratives of the older youth was that of the interaction of illness and homelessness.

I'm paranoid about getting walking pneumonia again. I'm always out in the cold and the rain in the winter, and if I get sick I can't work. And if I can't work I lose my job. Then I lose my chance for getting my own place and getting off the streets. And because I'm so stressed, I know I'm vulnerable to getting sick. It's like I can't win. (20-year-old White male participant, interview in the clinic)

Male and female youth reported feeling more vulnerable when they were ill and homeless; however, this vulnerability was expressed in different, gender-specific ways. Many of the homeless male youth reported being embarrassed at being sick and of needing to ask for help. This appeared to be a stronger theme for the older respondents than for the younger ones.

I was raised in a family where my stepdad said I was supposed to be tough and take care of myself—like I was supposed to be a grown man when I was 14. And it was really embarrassing and hard to bring myself to the clinic, because I felt like I had to give up my pride to ask for help. I felt like I was a whining little 11-year-old boy. (18-year-old White male participant, interview in clinic)

When asked if men had a harder time asking for help with health issues, youth in both focus groups agreed.

Yeah, I'd say in general it's harder for guys to ask for help or to come to the doctor. It's like we're supposed to tough it out on our own. And being homeless can do that to you, too. You have to be tough to survive out here. (22-year-old White male participant, focus group on the streets)

In contrast, most of the female homeless youth described increased vulnerability while ill and homeless in terms of physical safety issues, especially for female youth living on the streets or in squats. One 16-year-old White female respondent living on the streets said, "I don't know the meaning of safety, not when I'm high or sick." A 19-year-old White female youth living in squats reported that the last time she was ill with the "flu," she had been raped by an older man who visited the squat: "I was so out of it I didn't know what had happened until it was over."

Access-to-Care Issues

Homeless youth from both sites talked about health care as being more difficult to access while homeless. Many youth talked about the problem of getting to a clinic when they were feeling sick, especially if the clinic was in an unfamiliar part of town. Most of the street-based youth said that they did not have a regular source of primary care and relied on local emergency departments (EDs) for care when the medical van was not around. They said they had heard of the "free clinics" for homeless youth but were not sure where they were located. The street-based youth liked the convenience of the medical van, with one 23-year-old male respondent laughing and saying, "I'm lazy. It comes to me." The clinic-based youth reported less frequent ED visits, and most knew of the "food van" but not the medical van. The clinic-based youth who were staying at shelters said that the shelter providers would often drive them to the clinic for health care. The youth who were new to homelessness or to the Seattle area said that it took them a while to find out where

they could receive free health care specific to homeless youth. They said that they avoided areas downtown where the “old drunks hang out” and where there are health and social services for older homeless adults.

There were age differences for access to care issues. The majority of youth under age 18 reported that their main barrier to health care was being hassled about their ability to consent for care. They said that issues of consent were more of a problem at hospital EDs than in hospital clinics or community clinics. Several youth said that they had been denied care at a local ED, because they were told by staff that they were unable to consent for their own care even though they were 17 years old at the time. A male youth described an experience of trying to help a homeless female friend who “went into seizures from detoxing” and was refusing medical care for fear that hospital personnel would contact her parents because she was underage. Another youth described her experience:

I was 15, but I told them [hospital ED staff] I was 16 in hopes that they wouldn't harass me too much. I had strep throat and it was my first time out on the streets and I didn't know what I was doing. My friends dragged me to the hospital. The hospital people said, “You're under age and we're going to call CPS [Child Protective Services].” I said, “Thank you very much,” and ran. (16-year-old White female participant, interview on the streets)

The youth said that they had never had problems with ability to consent for care in clinics specific to homeless youth, either in Seattle or elsewhere if they had traveled. Youth who had traveled while homeless said that different areas of the country seemed to have different age designations for when they could consent for their own care. Older homeless youth who had homeless friends who were younger reported that they were worried about whether they were legally liable for their friends if they accompanied them to get health care. Both key informants reported that issues of consent were a common barrier to health care for homeless youth. The youth who participated in the focus groups agreed that “the whole age of consent thing is confusing.” In addition, youth in the street-based focus group stated that the hardest health care to access while homeless and under age 18 was drug and alcohol detox centers.

Youth who were over 18 years often stated that they had increased difficulty obtaining and keeping health insurance as they got older and were homeless. A 19-year-old African American woman said that she was “too old” for insurance, and had gone through classes and lengthy paperwork for insurance only to be told later that she was ineligible.

I was pretty mad. I'd wasted my time on something that made no sense. Some of the medical conditions I have they said they couldn't pay for, so they said it wasn't worth trying. Now I get 3-4 bills a day from these other medical freaking people, and then it messes up my credit. It's like if you get off the streets, then you just got bad credit from all the health care stuff from when you were on the streets. (19-year-old African American female participant, interview on the streets)

Similarly, another youth said,

Once you turn 18 there's no insurance and you gotta start paying for health care. And that will keep a lot of us from going to the hospital or whatever even if we need

to, just because we don't want to rack up any bills. (21-year-old White male participant, focus group in the clinic)

A related issue that most youth over age 18 discussed was not having adequate preparation for navigating the health care system. Many of the older youth said that when they were younger, they had never had an adult teach them how to get health care when they needed it. This was especially true for the older male youth who had been homeless for at least 2 years, or for male youth who reported histories of multiple foster care or other out-of-home placements.

They kind of tell you after you turn 18 that you've got to take care of yourself. "I ain't going to take you to the clinic, not like when you were young." But there's not much preparation for that; just one day you're on your own. (19-year-old African American male participant, focus group in the clinic)

Youth who had been ill while homeless in other cities said that only a few places had good health services specific to homeless youth. They rated health care services for homeless youth in Seattle as "among the best," along with Portland, San Francisco, and Albuquerque, and said that many cities they had been to did not have health care services for homeless youth. Youth from both sampling sites who reported going to the homeless youth clinics in Seattle said that the availability of naturopathy and acupuncture and other complementary health care was an attraction for them and their friends to access care. In the focus group in the clinic, a 19-year-old male respondent said, "Regular doctors freak me out, that's why I came here to see the acupuncturist." The youth who had traveled described their experiences in EDs across the country as well as in Seattle as poor:

I've been to a lot of places while I've been homeless, and it's pretty much the same everywhere in the emergency room. If you can't pay they're going to put you on the back burner, because they know that nine times out of ten if they make you wait long enough, you're just going to leave. And they don't want to deal with the paperwork and the hassles of trying to find out if you're who you say you are and if you're old enough to be there on your own, and what your address is so they can bill you. You've got to be really desperate or almost dead. (23-year-old White male participant, interview on streets)

Youth from both sites and age groups said that health care was not usually a priority until they became ill or injured. A 19-year-old male youth summed it up this way: "Basically, we don't go for health care unless we absolutely have to." He explained that "absolutely have to" meant being either so ill or in so much pain that he could not go about his usual activities. At the same time, the youth said that access to free youth-centric health care was essential to their lives, and for helping transition out of homelessness. The youth at both sites wanted to have more health education on how to stay healthy. In a focus group, when asked what health care providers could do better to help homeless youth be healthy, one young man summed up the ensuing discussion this way:

Teach us how to take care of ourselves, We didn't get that growing up. (22-year-old White male participant, focus group on streets)

DISCUSSION

The results of this study provide insights into the illness experiences and access-to-care issues of homeless youth, and how these differ by age, gender, and sampling site. Not surprisingly, we found differences between the street- and clinic-based youth, with the street-based youth reporting longer and more entrenched homelessness, more illnesses related to drug use, increased reliance on EDs for health care, and less use of emergency shelters. The clinic-based youth in this study were more likely to report staying in emergency shelters and accessing services for homeless youth, and had been homeless for less time than their street-based counterparts. Similar results were found in a study of homeless youths' access to health care from a U.S. multicity sample, in which street youth were much more likely to report ED visits than sheltered youth, and the street youths' visits were often related to drug or alcohol use (Klein et al., 2000). Research in Baltimore found higher rates of ED visits, especially for injuries and substance abuse, among street- versus shelter-based homeless youth (Ensign & Santelli, 1997). Information from the youth in the present study indicates that street youth might come from childhoods of more poverty and disruption, as well as have traveled farther from their hometowns. Therefore, many street youth have fewer resources overall than do other subgroups of homeless youth, which contributes to their prolonged homelessness and higher rates of most health and social problems.

The results of this study show that different health care service models within the same geographic region are serving different subgroups of the homeless youth population. There have been debates in Seattle and elsewhere among service providers about the relative merits of mobile health vans for homeless youth versus regular clinic services geared toward homeless youth. Some providers have voiced concerns that the medical van could divert homeless youth from being seen at the regular youth clinics, which provide a broader range of primary care services, and does not "train" homeless youth in how to access traditional primary care. Observations and interviews with street youth indicate that if the medical van were not available, most street youth would ignore their health concerns until illness forced them to go to a local ED. In many cases, they do not appear ready to access other primary health care due to their substance use and chaotic lifestyles. However, other street youth do want to access health services not offered by the mobile clinic. Better integration and coordination between the medical van and the free homeless youth clinics has begun in Seattle, partially as a result of the feedback from the youth. The three agencies providing health care services for homeless youth, with guidance from the local health department, meet on a regular basis to coordinate activities and health advocacy work. This coalition recently developed a homeless youth "health care passport" brochure with information on the three agencies, as well as maps and bus route information, to give out to youth. Based on information provided by the youth in this study in terms of community support persons, these brochures are also being given to emergency shelter and drop-in center staff, as well as to the Metro bus drivers on routes frequented by the youth.

Homeless youth in this study reported that during their most recent illness, they mainly wanted a place to rest and recuperate. This finding, along with the fact that many homeless youth reported missing their families of origin while ill or even going back to stay with family members on a short-term basis, have important

policy and program implications. As pointed out in their qualitative study and proposed conceptual model of the life cycle of youth homelessness, Auerswald and Eyre (2002) found that illness and injury often lead to a disequilibrium in a homeless youths' lives that can sometimes motivate them to extricate themselves from homelessness. Programs could be developed to shelter and care for homeless youth who are ill and to provide links with other services, such as substance abuse treatment, life skills training, and transitional housing, to help them move out of homelessness. These programs could also be used to support family members of homeless youth who go back home temporarily while they are sick. One such program, the MedRest program, was piloted in Seattle for homeless youth under age 18. The program is currently not in operation, but the advisory committee is looking at ways to reopen it to include services for homeless youth over age 18, as well as to serve youth who have coexisting substance use/abuse issues.

The older male youth in this study reported having had messages growing up from male role models equating being ill with being weak. Many male youth said they had to overcome feelings of not being "tough" enough when asking for help, and that this feeling was compounded by being homeless and needing to be tough to survive. Many of the male youth said that although traditional doctors "freaked them out," they were willing to come to the youth clinics for acupuncture and other complementary medicine. Male and female homeless youth in Seattle have been found to have high rates of use and acceptance of complementary medicine (Breuner, Barry, & Kemper, 1998). A recent study found that male youth ages 16 to 20 years use clinical health care services significantly less often than do their female counterparts, whereas male youth ages 11 to 15 years sought health care at similar rates to female members of that age group (Marcell, Klein, Fischer, Allan, & Kokotailo, 2002). Possible reasons for this disparity in health care use include the fact that teenage women have a higher need for reproductive health care, and societal gender roles allow women to express symptom concerns and seek care more easily than men do (Marcell et al., 2002). These issues seem to be present for the homeless males in this study, with the additional overlay of the meaning of homelessness. Based on information from the male youth in this study, the presence of complementary medicine at homeless youth clinics can help draw them in to care and then help to make them more comfortable with getting health care in general. In addition, male youth wanted to have more education on self-care and how to navigate the health care system. Based on previous research results, having male outreach workers as well as male clinic staff and medical providers can help increase access to care for male youth (Marcell et al., 2002).

Female homeless youth, especially those living on the streets or in squats, were more likely to report increased concerns for their safety when they were ill. Many of the female youth also talked about the need for a friend to accompany them to get health care. This is a similar finding to the narratives of homeless female youth in previous research studies, who said that lack of social support for seeking health care was a barrier to care (Ensign & Panke, 2002) and that safety issues were a major concern when they were homeless (Ensign, 2001). It is important for health care providers to be aware of these issues, to encourage a young woman to bring a friend with her, even into the examination room if deemed appropriate and desirable by the young woman. Providers can also help a homeless young woman develop a safety contingency plan for the next time she is ill, including emergency telephone numbers for youth-centric programs that could help her stay safe and get to care.

The main barrier to health care voiced by the youth in this study under age 18 was not always being able to consent for their care. This is more understandable for the younger youth in this age group, but youth as old as 17 years reported being hassled about consent and even denied health care. It is reassuring that youth in this study reported that this had never been an issue for them at clinics designed for homeless youth, both in Seattle and elsewhere in the country. However, providers' questioning of their age status and ability to consent for needed care often compromised their care at local EDs and other EDs around the United States. Current Washington State laws on a minors' right to consent for his or her own care are among the most liberal in the nation, whereas Utah and Texas have the most conservative minor consent laws (Boonstra & Nash, 2000). Therefore, if homeless youth in Washington State report having difficulty with access to care due to questions of their ability to consent for it, it is likely they experience even more greater barriers due to this issue in other areas of the United States. It is important for health care providers working with homeless adolescents to advocate for saner adolescent consent laws. The results of this study also highlight the need to educate providers, as well as the young people and people who work with them, about a young person's right to consent for needed health care while homeless. Locally, the Seattle homeless youth health care coalition is working with adolescent legal experts to develop educational materials on this issue for homeless youth and providers, especially for local ED personnel. Similar efforts could be beneficial in other localities in the United States and elsewhere where homeless youth live.

The barriers to care for over-age-18 homeless youth in terms of problems getting health insurance and navigating the health care system are equally troublesome. Young adults in general are currently the most underinsured and uninsured age group of any in the United States (English, 1998; English & Morreale, 2003). It is probable that homeless young adults have even more profound difficulties obtaining insurance. It is important to note that obtaining public health insurance such as Medicaid is difficult for all homeless youth in the United States because of lengthy forms, the necessity of providing a stable address, proof of documentation of parents' income, and many homeless youths' fears of being tracked down by their parents. In addition, in most of the United States, young people over age 18 are not eligible for state health insurance (Morreale & English, 2003).

In addition, an important and often overlooked factor in access to care for homeless youth is that the youth do not have an adult to help them navigate the increasingly complex health care system. The results of the current research indicate that male youth who have histories of foster care or other out-of-home placements, or who have lived on the streets for longer than 2 years have the most difficulty in knowing how to access care. As the youth in this study recommended, health care personnel can help by providing education for homeless youth in self-care and in how to access health care.

The research was with homeless people from a clinic and two street settings in Seattle, Washington. Although none of the street-based youth were seeking medical care from the medical van the night of their interviews, they all were accessing basic services from the smaller van nearby. Therefore, differences might exist for Seattle homeless youth who were not seeking any services, as well for homeless youth from other cities in the United States or internationally. In addition, this was an urban study, and illness experiences of rural homeless youth were not captured adequately. The few youth in this study who had first been homeless in rural areas

stated that services were even more difficult to access there. The young people in this study represent the average age of the clinic and medical van population (age 19 years), but important differences might exist for homeless youth in younger age groups. Evidence exists that fewer homeless youth under age 15 are being seen in Seattle and other major North American West Coast cities known for their large homeless youth populations. The fact that the PI has been involved in the provision of health care and advocacy for homeless youth introduces potential bias into the study. However, this bias was minimized by our use of triangulating methods, data sources, and researchers, and by cross-checking results with the original informants. In addition, the current study was not meant to be an in-depth ethnographic study addressing the entire culture of homeless youth, but instead addressed aspects of their health issues and illness experiences within the larger sociocultural context in which these young people live. As such, it provides important insights into how homeless youth experience illness and what health care providers can do to help them lead healthier lives.

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