

Health Care Access and Utilization by Homeless Adolescents in New York City

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ABSTRACT

To date, little data has been collected from homeless adolescents regarding their access to, and utilization of, health care. In this study, 68 adolescents aged 16-25 were interviewed after being randomly selected from among those who came to a drop-in center for homeless youth in New York City in July 1996. The interviews followed a standardized questionnaire designed to collect demographic information as well as to assess past and current use of medical services. Prior to homelessness, 68% of subjects had been utilizing medical services on a regular basis, and the principal sources of care were as follows: hospital clinics, 51%; community health centers, 33%; and private physician offices, 22% (with more than one facility utilized in some cases). By contrast, 90% of participants reported having received care during homelessness, 68% of whom obtained regular health care at shelters, 32% at drop-in centers, and 25% at hospital clinics. Despite the fact that 42.4% of the sample was covered by health insurance at the time of interview, only 10% of subjects reported having ever been denied health care at any facility visited. Taken together, these findings suggest that, in the population studied, an increase in the percentage of adolescents regularly utilizing medical services occurs upon homelessness, coincident with a shift in utilization from hospital clinics and community health centers to shelters and drop-in centers. These results clearly warrant further study on the access and utilization of health care by homeless adolescents. If substantiated, the present findings call for renewed efforts toward optimizing health care delivery to homeless adolescents at shelters, drop-in-centers, and other such facilities where these individuals utilize medical resources most frequently.

INTRODUCTION

In 1996, homelessness continues to be a major societal issue of considerable economic and medical relevance. While the stereotypical image of the homeless individual depicts the elderly and uneducated, over half of the homeless population is 35 or younger, with an average age of 29 years old. Fifty percent of all homeless individuals are high school graduates. Disturbingly, the fastest growing subset of the homeless population is comprised of families with dependent children, often including adolescents (1).

Homeless adolescents are often an overlooked group that is particularly difficult to track. Many runaway teenagers repeat the cycle of leaving home and then returning to it. Others represent migrants with no stable residence who find accommodation in a variety of locations, including homeless shelters, foster homes, and juvenile correctional facilities. In Seattle's Health Care for the Homeless project, 36% of individuals under care lived with friends or relatives, 24% on the streets, 15% in a shelter or transitional housing, and 5% in an institutional setting (2). Such unstable living circumstances constitute a barrier to continuous and regular health care, rendering follow-up for both treatment and prevention of disease nearly impossible in a population that, due to living conditions and other factors, is at greatest risk.

Among the homeless, adolescents represent a particularly vulnerable group. Common medical problems are often exacerbated by overcrowding in shelters and exposure to extremes of temperature. This increased susceptibility to illness is compounded by the fact that many homeless adolescents are uninsured.

A significant proportion of runaway adolescents take to the streets in order to escape major life stressors at home. In a sample of homeless youth in San Francisco, 30% experienced overt neglect, 53% suffered from physical abuse, and 30% reported sexual abuse (3). One study conducted in New York City revealed that 44% of homeless youth have mothers on public assistance, and over 50% have parents who are alcoholics, substance abusers, or convicted criminals (4).

Such homeless adolescents who leave a problematic environment often fall into the same pattern of problematic behaviors, or adopt new ones. Despite the abandonment of such an environment, a similar pattern is seen in adolescents when homeless. In New York City, approximately 40-50% of homeless youth does not attend school. Of those in school, 40-60% have demonstrated significant conduct problems, including conflict with the law. Furthermore, many adolescents resort to drug dealing and prostitution in order to make a living. These high-risk activities, along with the numerous aforementioned susceptibilities, may render the health care needs of homeless adolescents quite different from those of the general adolescent population.

This study evaluated health care access and utilization among a population of adolescents visiting a drop-in center for the homeless in New York City, in order to apply this knowledge toward the future improvement of health care for homeless adolescents.

METHODS

Seventy-five adolescents appearing at a drop-in center for homeless youths in New York City during July 1996 were randomly selected for interview, of whom 68 conceded. Interviews followed a standardized questionnaire designed to collect demographic information as well as assess past and current use of medical services ([Table 1](#)). Questions to define characteristics of the sample population included age, ethnicity, frequency and duration of homelessness, and present status with respect to both homelessness and health insurance. Areas of inquiry to evaluate health care access and utilization both before and during homelessness included regular use of health care, type of facility frequented, reasons for last visit, and, where applicable, reasons for not seeking care. The data from two subjects were excluded based upon no prior or present history of homelessness, yielding n=66 for the study. Due to the small sample size achieved when patients were stratified according to various characteristics being studied, data was in general analyzed qualitatively rather than quantitatively. Chi-squared statistical analyses were, however, performed on the regular use of health care in general, as well as on the specific utilization of hospital clinics and community health centers, before and during homelessness.

RESULTS

Characteristics of the sample population were collected, including data on age, ethnicity, frequency and

duration of homelessness, and present status with respect to both homelessness and health insurance. Among these data, it is of note that 70% of interviewees were either of African American or mixed heritage, that 83% were between the ages of 18 and 21, and that the sample population was comprised of a disproportionately high percentage of males (62%, versus 38% females). The data also indicate that 73% of subjects had been homeless from one to three times prior to interview, with a rather evenly distributed duration between less than one month at the lesser extreme, 5-7 years at the greater extreme. Sixty-four percent of participants were homeless at the time of interview.

[Table 2](#) presents data on utilization of regular medical services both before and during homelessness. The type of facility frequented and reasons for last visit are shown in [tables 3](#) and [4](#). The principal reasons given for not seeking care were a perceived lack of need and the lack of health insurance. Much of this data is qualitatively analyzed hereafter. Statistical analysis of the results for regular use of health care in general revealed, during periods of homelessness as compared to the period prior to homelessness, a significant increase in the percentage reporting regular use of medical services ($p < 0.05$). In addition, statistical analysis of the specific utilization of hospital clinics and community health centers showed significant decreases in each during homelessness as compared to before homelessness ($p < 0.05$ in both cases).

DISCUSSION

This study evaluated the access to, and utilization of, health care by homeless adolescents. Like many other urban drop-in centers, the drop-in center from which the participants were recruited offered a multitude of services, including health care. The principal services provided were general physical examinations and pregnancy testing. Medical-related services included the distribution of antibiotics and asthma medications and the collection of urine for culture. HIV testing and ob/gyn services were not available. Visitors to the drop-in center included adolescents and young adults who had been and/or currently homeless. Personal counseling, clothing, and laundry, and shower facilities were also provided.

The results of this study did not support the widely-held belief that homelessness is associated with a loss or reduction in medical care. Prior to homelessness, 68% of the sample utilized care, as opposed to 90% while homeless; the rate of utilization of health care was significantly increased following the onset of homelessness ($p < 0.05$). The degree of health care utilization among homeless youth found in this study, however, is presumably higher than that which might be obtained from a random sample of homeless adolescents interviewed on the street, due to the fact that many of the adolescents at the drop-in center had stayed at a nearby homeless youth shelter where the guests were required to have a physical examination. Nevertheless, the results reported here are extremely useful in their illustration of the high degree of access and utilization attainable in the drop-in center as a model of health care delivery for homeless adolescents.

Although access to health care was not found to be more limited among homeless adolescents, a marked distinction in the facilities from which adolescents sought medical care was evident as compared to prior to homelessness. During homelessness adolescents utilized hospitals and community health centers much less frequently than prior to homelessness ([Table 3](#)). This decrease in the rates of hospital and community health center utilization as adolescents became homeless was significant ($p < 0.05$ for each). The use of these facilities was replaced by utilization of shelters (68%) and drop-in centers (32%) during homelessness. Importantly, a large fraction of individuals continued to frequent the drop-in center after finding a home, as shown by the fact that slightly more than one third of those interviewed were no longer homeless at the time of interview. Based on this finding, one may surmise that a drop-in center represents a convenient place to seek health care since numerous services can be obtained at once at a single facility. Another convenience may be offered by greater ease of access to drop-in centers than to hospital clinics. Finally, this continuity of drop-in center utilization may be attributable to greater patient comfort in the less clinical atmosphere of the drop-in center, and to the trusting relationship that may have been achieved with drop-in center personnel.

Results from the population studied here contradict suggestions from previous studies with regard to the use of emergency departments as primary care facilities by the homeless. Only 14% of those surveyed in the present study reported prior visits to the ER, most of which were for trauma rather than general care. In a study involving rural adolescents, however, use of emergency care was greatest among those without regular access to primary care (5). Yet, emergency room utilization has been much better explored among homeless adults than homeless adolescents. In Minnesota, 34% of those residing in homeless shelters were reported to have used hospital emergency rooms in the past(6). A study on homeless men and women in Columbia, South Carolina found a similar rate of ER use at 38% (7). It is likely that the considerably reduced rate of ER utilization demonstrated in the present study reflect greater utilization of primary general care among homeless individuals in the drop-in center than among homeless populations studied previously

The reasons cited for the last health care visits ([Table 4](#)) were found to be comparable to those of a chart review performed previously on 609 youth at a drop-in center in Portland, Oregon (8). In the latter study, homeless adolescents were reported to have sought care for common medical problems; respiratory (28%), dermatologic (17%), gynecologic (11%), head/neck (10%), and traumatic (9%) in nature. Interestingly, problems related to substance abuse and sexually transmitted diseases were seen much less frequently than had been anticipated.

The reasons for not receiving or utilizing care both prior to and during homelessness were also investigated. In most cases, the responses indicated a perceived lack of need or the lack of health insurance, and were independent of whether subjects received care either before or during homelessness. It has been reported previously that only 25% of street youth in New York City were interested in having medical care (6). The results of both the present and prior studies thus concur that a clear discrepancy exists between the actual health care needs of homeless adolescents and their perceived needs, perhaps to a greater degree than that typical of the adolescent age group in general. Various reasons accounting for perceived lack of health care needs in both adolescents and the homeless have been explored in previous studies. These include relatively insufficient knowledge of health maintenance and health promotion activities, low motivation for health maintenance, and inadequate coping and life management skills (9). Clearly, in order to optimize health care utilization by homeless adolescents, these individuals must be sensitized to their health care needs. It may be the case that personal counselors and medical personnel at drop-in centers are ideally suited towards fulfilling this dual medical-educational role.

The level of insurance coverage among homeless adolescents studied here (42.4%) is similar to that reported in other studies. In a recent health profile comparison between delinquent and homeless youth in California, 42.9% of the homeless were found to have some form of medical coverage (10). Clearly, such an apparent lack of health insurance poses a barrier to health care access. However, since all homeless adolescents are eligible for Medicaid, it is unexpected that less than half of the sample were enrolled at the time of interview.

Despite the encouraging results reported here for health care access and utilization among adolescents visiting a drop-in center, it should be emphasized that the continuity of care of individual patients among such centers must be improved. The treatment of the same HIV-positive adolescents by five agencies in New York City, without knowledge of medical and legal status, family history, living situation, and sexual orientation of the patient, has been previously reported (4). Future efforts must be made to achieve continuity of care without restricting ease of access among different drop-in centers. On a broader scale, continuity of care of the patient among differing facilities, from hospital to drop-in center, must be achieved, from both the patient care perspective and that of health care cost containment. Above all, health care professionals, and physicians in particular, must strive to use their stature and expertise toward the advocacy of improved quality medical care for homeless adolescents.

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REFERENCES

1. Gorder C. Homeless! Without Addresses in America. Tempe, AZ: Blue Bird Publishing; 1988.
2. Smart DH. Homeless youth in Seattle. *Journal of Adolescent Health* 12(7): 519-27; 1991.
3. Kennedy MR. Homeless and runaway youth mental health issues: No access to the system. *Journal of Adolescent Health* 12(7): 576-9; 1991.
4. Rotheram-Borus MJ. Serving runaway and homeless youths. *Family and Community Health* 14(3): 25-8; 1991.
5. Lehmann CU, Barr J, Kelly PJ. Emergency department utilization by adolescents. *Journal of Adolescent Health* 15(6):485-90; 1994.
6. Kroll J, Carey K, Hagedorn D, et al. A survey of homeless adults in urban emergency shelters. *Hospital and Community Psychiatry* 37(3): 283-6; 1986.
7. Clarke PN, Williams CA, Percy MA, et al. Health and life problems of homeless men and women in the southeast. *Journal of Community Health Nursing* 12(2): 101-10; 1995.
8. Reuler JB. Outreach health services for street youth. *Journal of Adolescent Health* 12(7): 561-6; 1991.
9. Adkins CB, Fields J. Health care values of homeless women and their children. *Family and Community Health* 15(3): 21; 1992.
10. Forst ML, Harry J, Goddard PA. A health-profile comparison of delinquent and homeless youths. *Journal of Health Care for the Poor and Undeserved* 4(4): 386-400; 1993.

BIOGRAPHY

Michael S. Irwig graduated *summa cum laude* from Vanderbilt University (Nashville, TN, USA) in 1995 with a bachelor's degree in Spanish and Spanish-American Literature. He is presently a second year medical student at Cornell University Medical College (New York, NY, USA). His research on homeless adolescent health care was conducted during the summer of 1996 at the New York Children's Health Project of the Division of Community Pediatrics at Montefiore Medical Center/The Albert Einstein College of Medicine. Portions of this study were presented to the National Association of Community Health Centers at its annual meeting on 26 August 1996 in San Francisco.