

# Meeting the health care needs of street-involved youth

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## Abstract

Health care providers who see homeless or street-involved youth can help to reduce the impact of many risk factors – physical, mental, emotional and social – pertaining to street culture. The present statement describes the types and scale of homelessness in Canada, and reviews reasons why youth turn to the street, risks of the ‘street economy’ and barriers to health care. Common physical and mental health problems are considered, along with legal and ethical issues that may affect care. Principles of care, including accessibility, confidentiality and harm reduction, and strategies to target and engage this population lead to recommendations for improving services, outcomes, advocacy and increased governmental support.

**Key Words:** Health problems; Homelessness; SIY; Street; Youth

Inadequate health care, education and advocacy for homeless and street-involved youth (SIY) who present in various health care settings every day in Canada is one of this country’s great unmet needs. The intention of the present statement is to help paediatricians, family physicians and other health care providers recognize and reduce the multiple risks – physical, mental, emotional and social – of being homeless or street-involved. Recommendations are made toward diminishing the negative impact of risk factors on youth health, safety and well-being.

## Methods

A MEDLINE search was conducted for the period between 1950 and November 2012, using the terms “street youth” and “homeless youth” combined with “health care, health behaviour or health”, “health resources/health services”, “oral health”, “delivery of health care”, “adolescent health services” and “preventive health services”. The literature was limited to

English-language articles, with the majority originating in Canada and the United States.

## Definitions

The term ‘street-involved youth’ is quite broad, accounting for both varying degrees of homelessness and a wide range of at-risk behaviours. The youth who is not necessarily ‘homeless’ but who is exposed to and experiencing the physical, mental, emotional and social risks of street culture is the focus of this statement.

While elevated risk profiles are associated with street involvement, street youth studies have revealed a diverse spectrum of characteristics and lifestyles. Researchers have developed different categories for study and classification purposes.<sup>[1][5]</sup> Some terms describe how youth make their way to the street; others describe current housing status. Many SIY fit within multiple categories. Examples of common and often overlapping terms are: ‘situational runaway’, ‘runaway’, ‘throwaway’, ‘systems youth<sup>[1]</sup> crasher’, ‘curbsider’, ‘missing child’ and ‘homeless’ youth.

The two classifications used by the United Nations compare the “absolutely homeless” with the “relatively homeless”. Absolutely homeless youth live outdoors, in abandoned buildings or use emergency shelters or hostels. Relatively homeless youth live in unsafe, inadequate or insecure housing, including a hotel or motel room rented by the month, or stay temporarily with friends or relatives (called ‘couch surfing’). This group are also known as the “invisible homeless”.<sup>[6]</sup>

SIY face adverse physical, mental, emotional and social consequences of street culture. Health care providers need to identify children and youth at risk, be aware of specific health and social issues in this population, and be able to link their SIY patients with community resources that can help with support.<sup>[1][2][5][7]</sup>

## Numbers

A study from 2007<sup>[7]</sup> explained the difficulties of estimating the number of SIY in Canada and the implications this has

for policy-makers, service providers and researchers. However, the authors confirmed an urgent need for “concern with homeless youth in every large Canadian city” as well as “to reduce the numbers of youth on the street and to meet the needs of those youth who find themselves there”. A 1999 study<sup>[8]</sup> pegged the number of street youth in Canada at approximately 150,000, which is the same (although admittedly conservative) estimate cited in another 2007 study.<sup>[9]</sup>

## Etiology

Recurring themes for turning to a life on the street are: poverty, dysfunctional family life, violence, sexual and physical abuse, underlying mental illness, parental drug use and curiosity.<sup>[1][8][12]</sup> A community-based study published in 2005<sup>[10]</sup> showed that women who report a history of being sexually abused were over 2.5 times more likely to resort to runaway behaviours. Women reporting both physical and sexual abuse were almost four times more likely to run away compared with their unabused peers. Youth involved with the child welfare system become homeless when they run away from group homes or foster care.<sup>[13]</sup>

## Risks

Basic requirements for money, food, shelter and other necessities of life combine with early initiation of sexual activity<sup>[14]</sup> to place SIY at high risk of becoming involved in the sex trade or of practicing ‘survival sex’ in exchange for food, shelter, money or drugs.<sup>[2][15][16]</sup>

Dependency on aspects of the ‘street economy’ (eg, the sex trade, selling drugs or panhandling) not only puts youths at risk for psychological harm but also for behaviours with serious medical consequences such as substance use, sexually transmitted infections (STIs), violence, and physical and sexual abuse.<sup>[13]</sup> Canadian research has shown that the longer youth are living away from home, the greater the likelihood of involvement in the sex trade.<sup>[2]</sup>

## Barriers to health care

Several individual and systems-level barriers to health care exist for this population.

Individually, SIY often lack the money, transportation and knowledge to access appropriate health care. They also have issues with trusting adults or authority figures and worries about confidentiality that prevent them from seeking health care services. Often, youth with child welfare status who have run away from their last placement and individuals with legal problems avoid health care facilities for fear of ‘getting caught’. Concern about confidentiality is compounded by fear of being reported to authorities.

More formal health care barriers include: the need to present a health card or supply a permanent address; the perceived need for an adult’s consent or involvement; lack of knowl-

edge regarding mature minor protocols; and services that are poorly coordinated or difficult to access.<sup>[1][17]</sup> SIY presenting in traditional health care settings may not always reveal that they are homeless, leaving health care practitioners under-aware of risk factors. For example, a prescription to treat streptococcal pharyngitis may never be purchased by a youth who has no money. However, this problem could be avoided by administering one dose of intramuscular benzathine penicillin, which is equivalent to 10 days of oral penicillin and may be provided at no cost in certain health care settings. This treatment choice illustrates how essential it is for health care practitioners to determine the housing and economic status of each youth they see as part of history-taking. Earlier identification of youth at risk can reduce barriers to care and create opportunities for targeted support through suitable treatment options and connecting individuals with appropriate community resources.

When SIY making initial contact with health care personnel meet with criticism or any of the barriers described above, significant difficulties with follow-up usually ensue. A complete and comprehensive check-up at first visit and prompt treatment of suspected STIs without laboratory confirmation are two effective approaches with the most vulnerable youth.<sup>[18]</sup> There is an ongoing, urgent need for street-accessible medical clinics and youth agencies targeting this population, along with focused intervention programs for regular medical follow-up and on-the-spot testing for STIs and pregnancy. Health care practitioners need to provide anticipatory guidance to reduce harm, prescribe medications at no or low cost, choose simple treatment regimens, and ease follow-up by offering walk-in appointments and care during evening hours.

Removing systemic barriers to health care is crucial, but what concepts about their own health do SIY hold that influence their desire, willingness or ability to access services?<sup>[7]</sup>

## Physical and mental health concerns

SIY have both physical and mental health concerns associated with homelessness and high-risk behaviours.

### General physical health

SIY are at risk for many common, acute health problems. The street environment places homeless youths at increased risk of respiratory problems, including tuberculosis<sup>[18][20]</sup> and asthma.<sup>[21]</sup> Many youths present in acute care settings because they are unable to manage their asthma on the street. Most have had medications in the past which have been used up, lost or stolen, and do not have the resources to replace them.

Dental disease is common due to lack of oral care, poor hygiene, smoking and alcohol use.<sup>[22]</sup> Dermatological problems that are seen regularly include lice, scabies, acne, atopic dermatitis, impetigo and infections due to community-acquired methicillin-resistant *Staphylococcus aureus*.<sup>[23]</sup> Foot problems are a major concern because homeless youth endure wet, cold

and exposed extremities, with limited access to clean socks or appropriate footwear.<sup>[5]</sup> Malnutrition often occurs secondary to food insecurity (ie, poor intake and lack of resources), inadequate knowledge and drug use.<sup>[5][10]</sup> One Toronto-based study published in 2002<sup>[5]</sup> showed that the day-to-day lives of street youth were characterized by constant struggle to find safe, secure shelter, generate income and obtain sufficient food.

Injuries also occur due to intoxication, burns from crack pipes or violence (eg, sustained by being ‘jumped’, stabbed or shot).

Disruptions in healthy development can lower sense of self, while lack of schooling often leaves vulnerable youth without the basic life skills needed to navigate the adult world.

All immunizations currently recommended in the schedule for children and youth (accessible at [www.phac-aspc.gc.ca/publicat/cig-gci/p03-01-eng.php](http://www.phac-aspc.gc.ca/publicat/cig-gci/p03-01-eng.php))<sup>[24]</sup> by the Public Health Agency of Canada should be provided to street youth. Immunization programs are province- or territory-specific, and health care professionals need to be aware of programs in their own and neighbouring jurisdictions. If a vaccine is not covered, the health care provider should advocate for SIY to receive it through alternative funding sources, if available.

Regarding immunization against STI-related illnesses, the Enhanced Surveillance of Canadian Street Youth study (1999-2003)<sup>[25]</sup> suggested that up to 40% of SIY were susceptible to hepatitis B infection. This population would greatly benefit from an enhanced hepatitis B vaccine program. Be sure to ask SIY patients about their immunization status and counsel them on access and ‘catching up’ on vaccines. Street youth of both sexes are an important target group for the human papillomavirus vaccine because the majority will not have been immunized in school programs and are at high risk for cervical cancer and genital warts. Funded immunization programs should be fully supported by governmental policies.<sup>[26]</sup>

### STIs

SIY experience much higher rates of HIV infection<sup>[6][8][5][16][27][29]</sup> and other STIs.<sup>[23][30][31]</sup> Inconsistent condom use and

multiple partners increase the risk of *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* and herpes-simplex virus 2 (HSV2) infections, and injection drug use increases transmission of hepatitis B and C. Youth between 15 and 24 years of age account for more than two-thirds of reported cases of CT in Canada,<sup>[8]</sup> with risk among street youth approximately nine times higher as a result of risky sexual practices and substance use. Other correlates of CT in Canadian street youth were Aboriginal status, self-perceived risk, having no permanent home and having lived in foster care.<sup>[31]</sup>

### Mental health disorders

SIY show a wide range of mental health problems, which often coexist with addictions and related physical health problems.

Research shows that adolescents with mental health disorders are not only at a higher risk of running away but that run-aways are also at high risk of developing mental health disorders.<sup>[32][34]</sup> SIY are at greater risk of developing mood disorders, bipolar disorder, conduct disorder and post-traumatic stress disorder, and of attempted suicide. These conditions increase with history of sexual abuse and sometimes precede homelessness.<sup>[35][36]</sup> SIY show a higher rate of substance use. Alcohol and illicit drugs are sometimes used as a means of coping or as part of risk-taking behaviour but inevitably lead to morbidity and increased mortality.<sup>[3][13][37]</sup> The striking mortality rates in one prospective cohort study conducted in Montreal, Quebec, highlighted mental health and substance abuse as major issues that must be addressed by health care providers seeing this population.<sup>[16]</sup> Given the high rates of mental health diagnosis – including addictions – in SIY, at least an initial mental health screening should be integrated into various health care settings, focusing on suicide risk, self-harm and whether an individual is a risk to others. Many SIY with psychiatric diagnoses need psychotropic medications. Precarious living conditions often lead to inability to pay for a prescription, losing medications or having them stolen. This population needs extra support for managing medication issues.

Approaches to history-taking and the physical examination are provided in Table 1.<sup>[38]</sup>

**TABLE 1**  
**History-taking**

**Important questions include but are not limited to the following:**

- Do you consider yourself to be homeless or at risk of becoming homeless?
- Where do you sleep? (eg, in a shelter, couch surfing, group home)
- Where does your daily food come from? (eg, a drop-in centre, food bank, school programs, or none of these)
- Do you feel safe? (eg, experience violence or sexual coercion)
- Do you know one adult that you can depend on? (specifically, try to determine child welfare status, whether they are currently connected to a social worker, significant adults in their life, and assess sources of financial support)
- How do you get your money? (eg, a job, social assistance, illegal activity [specifically, selling drugs, the sex trade, panhandling, stealing])

**Home, Education, Eating, Activities, Drugs, Sexuality, Suicide, Safety (HEEADSSS)<sup>[38]</sup>**

Conduct a thorough HEEADSSS assessment, devoting specific attention to:

- History of homelessness, current living situation (ie, shelter or housing program)
- History of domestic violence
- History of abuse
- Learning disorders and attention-deficit hyperactivity disorder
- At-risk behaviours, notably:
  - substance use
  - survival sex
  - unprotected sexual intercourse or unprotected sex
- Involvement with the justice system:
  - arrests
  - probation
  - recently incarcerated
- Mental health history
- Dental health
- Immunizations

**Physical examination**

A complete physical examination is important because many street-involved youth have never undergone a comprehensive medical assessment. Areas not to forget:

- Vitals, height, weight and body mass index
- Vision and hearing screen
- Skin (feet in particular). Look for needle tracks and evidence of self-harm
- Respiratory examination for upper respiratory tract infection and asthma
- Genitourinary examination for signs and symptoms of sexually transmitted infections

- Sexual maturity rating

## Legal and ethical considerations

Health care providers often worry about issues of consent to treatment when dealing with youth. SIY pose a particular dilemma because they usually present in acute care facilities and clinics on their own. Decision-making should be consistent with provincial/territorial health care consent legislation, which may state (as in Ontario, for example) that consent to medical treatment depends on the mental capacity rather than the chronological age of a patient.<sup>[39][40]</sup>

Engagement in the street economy places SIY at high risk of victimization. Some governments have legislation in place to protect youth. It is important to be aware of legislation in your own and neighbouring jurisdictions. Alberta, for example, has two acts in place, one for the drug trade (The Protection of Children Abusing Drugs Act [PCHAD]: [www.albertahealthservices.ca/2547.asp](http://www.albertahealthservices.ca/2547.asp)) and comparable legislation for the sex trade (Protection of Sexually Exploited Children Act [PSECA]: [www.calgaryandareacfsa.gov.ab.ca/home/613.cfm](http://www.calgaryandareacfsa.gov.ab.ca/home/613.cfm)).<sup>[41]</sup>

## Principles of care

This population's specific health needs should be addressed by providing accessible medical services oriented to the context in which these youth live. Services should offer comprehensive, confidential health care, including but not limited to: general health care, sexual health (ie, contraception, STIs, options counselling), substance use assessment and mental health evaluation and referral. Because they will be dealing with sensitive and serious issues, staff should be specially trained in harm reduction best practices and motivational interviewing techniques. For more information, read 'Harm reduction: An approach to reducing risky behaviours in adolescents', a Canadian Paediatric Society position statement published in 2008.

Referrals could come from acute care facilities, family physicians, public health nurses, social workers and other services that work closely with at-risk youth. Any referral should have a self-referral or walk-in component. This option provides youth who have had typically limited or inconsistent medical care with unique access to medical assessment, treatment and planning for longer term medical care and follow-up. Why are clinical models for adult homeless individuals insufficient for treating SIY? Youth tend to avoid these establishments because they do not believe they are "that bad off" or feel that particular adolescent issues are not being addressed.<sup>[42]</sup> We need street-accessible medical clinics and youth agencies to target this population with focused intervention programs for regular medical follow-up. Also, evidence-based programs,

such as the Foyer Model of transitional housing for SIY,<sup>[9][12][43]</sup> need to be expanded and funded. Collaboration and coordination among youth services are essential. An example of such a clinic in Alberta is the Calgary Adolescent Treatment Services (CATS) Clinic: [www.woodshomes.ca/index.php?page=calgary-adolescent-treatment-services](http://www.woodshomes.ca/index.php?page=calgary-adolescent-treatment-services).<sup>[44]</sup>

## Recommendations for improving services and outcomes

Some of the following recommendations were developed by other organizations (acknowledged in footnotes).

### Health care providers should:

- Recognize SIY as a heterogeneous population with different degrees of street-involvement. Because these youth present in a variety of health care settings, care providers generally need to be more aware of specific issues and risk factors.
- Be aware of the mature minor protocols and inform youth of their right to confidentiality. Confidentiality issues should always be reviewed before the formal health encounter.
- Integrate an initial mental health screening should be integrated into various health care settings, focusing on suicide, self-harm and whether the individual is a risk to others.
- Determine housing and economic status during history-taking. Many youth are reluctant to reveal this information for fear of stigmatization.
- Ask whether medications can be purchased and used securely.
- Ask youth whether they can follow through with referrals. Recognize that SIY live unpredictable lives and follow-up may not occur. Try to prioritize:
  - Address the youth's most immediate concerns at first visit, then explore others at the next visit.

- Certain examinations, investigations and treatments can be recommended at first visit if follow-up is not assured (ie, with informed consent, diagnose with either a pelvic examination or a urine-based specimen collection for pregnancy, CT and *N gonorrhoeae*). Diagnose and treat CT, gonorrhea and other STIs based on Public Health Agency of Canada guidelines: [www.phac-aspc.gc.ca/std-mts/sti-its/index-eng.php](http://www.phac-aspc.gc.ca/std-mts/sti-its/index-eng.php).
- If HIV, HBV or HCV risk is identified or suspected (eg, due to sexual exposures, abuse or intravenous drug use), screen for HIV *at a minimum* at initial visit. Early diagnosis can help prevent spread. Also, be sure to discuss transmission of these pathogens at first visit
  - there may not be another chance.
- Health care workers should administer applicable vaccines at any available opportunity. Ask all youth about their immunization status. Advise how to access ‘catch-up’ or new vaccines. Better yet, be prepared to provide them ‘on-the-spot’ in any office setting.
- Advocate for SIY to receive vaccines that are not covered, through alternative funding sources if available.
- Keep treatment regimens as simple and straightforward as possible. Make follow-up procedures easier by having some walk-in appointments and evening hours.
- Learn about youth services in your community so that you can make prompt referrals and initiate collaborative care and support.
- Advocate for better postgraduate interdisciplinary health care training on issues specific to this population.<sup>[1]</sup>

#### **Governments should:**

- Provide universal coverage of vaccines such as the human papilloma virus vaccine, and fund outreach services and mobile medical vans.
- Respond to the urgent need for integrated adolescent mental health services throughout the continuum of care for SIY.
- Prioritize societal issues that place youth at risk of running away (ie, through poverty reduction, improved mental health services and family support).
- Fund specific interventions (ie, evidence-based programs such as the Foyer Model of transitional housing for SIY).
- Support networking and partnership development within communities, notably among social services, justice and educational organizations, and housing initiatives to work together locally to prevent homelessness by improving social conditions, strengthening communities, and developing age-specific, targeted interventions and care models that work.

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