Health and Health Needs of Homeless and Runaway Youth

A Position Paper of the Society for Adolescent Medicine

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The Society for Adolescent Medicine (S.A.M.), a national organization, is involved in worldwide health issues affecting youth. Runaway and homeless adolescents are youth who live without the support of traditional societal structures, such as family, school, church, and community institutions. This White Paper, although not an exhaustive review of all of the issues, highlights the most important problems of this population from an international and national perspective. It classifies them, discusses their health and social needs including barriers to health care, describes some models for their care, and presents recommendations for improving services and outcomes. The goal of S.A.M. is promotion of health-care services for this population as part of its mission of advocacy for all youth with special health needs.

Important questions remain unanswered in our effort to understand the problems of runaway and homeless youth. Have we adequately characterized the magnitude and causes of the problem of homelessness? Do we really know the costs, economic and human? What is the natural history of being young and homeless? How does the problem look in smaller, more rural communities? Last, why is adolescent medicine so little involved with these youth in this country where the health-care system is so much better developed? The answers to these and other questions are addressed to the extent possible in this White Paper and in the Society's recommendations.

International Perspective on the Health Needs of Homeless Youth

Data are being generated regarding homeless and street youth in various countries of the world. The term “street children” is commonly used to refer to children and youth under 18 years of age who live and survive by a variety of means on city streets. The estimated number of street children and youth in the world ranges from 30 million to 170 million (1).

United Nations International Children Emergency Fund (UNICEF) divides the population of street children into two categories. The larger category includes “on” the street, who work these during the day and often return to their families at night. These children and youth may use social resources such as school, church, and other community groups. The second category is that of youth “of” the streets. These youth work and live on the streets, having some ties with their families (UNICEF, Executive Board, 1986). Childhope estimates that 75% of street children and youth are “on” the streets;
20% are "of" the streets. Only 5% are truly abandoned street children with no family ties (2).

Demographic studies of the population of homeless and street youth, in many countries, are lacking or rudimentary. Brazil, for instance, estimates 17 million working children and youth and 7 million living on the streets (UNICEF, 1987). India estimates 44 million homeless children, which includes those who are working, yet homeless and on the streets (Voluntary Association for Health, India, 1989).

In most countries the foundation for homelessness is recalcitrant poverty which prevents the family from meeting the fundamental developmental and nurturant needs of the youth. There is a tremendous spectrum of conditions under which these youth survive outside of the home: from youth who live at home but work on the streets during the day, bringing food and money home to support the family primarily; to those who return home at regular intervals; to those who are forced to leave their families because of abuse and/or lack of any support; and finally, to youth who are totally abandoned and have no knowledge or relationship with family.

There are an estimated 40 million abandoned children and youth in Latin America (3). Without any social support, abandoned street youth form groups or gangs that offer a social structure for both individual and collective survival on the streets. Health problems are rampant for these youth, as documented later in this report (4).

The work in which these youth engage includes "casual work," "marginal occupations," and the "informal sector." The informal sector is characterized by small, competitive individual- or family-owned firms and petty retail trade and service activities that circumvent child labor legislation and other constraints (5). Activities may include selling candy and cigarettes, hauling garbage, washing windshields, guarding cars, and carrying luggage. With poverty and lack of opportunity in the formal sector, youth seek out the informal sector for survival and employment. Lack of access into the formal sector puts youth at risk of not gaining benefits of the formal sector and places them at risk of being exploited and put into dangerous, violent, and/or illegal activities and circumstances (6).

Street youth are invariably involved in the acquired immunodeficiency syndrome (AIDS) pandemic on an international scale. Data are accumulating indicating the high risk for human immunodeficiency virus (HIV) infection in street youth. Youth are vulnerable to sexual exploitation, prostitution, and intravenous substance use. Many S.A.M. members are collaborating with several international organizations, including CHILDOHOPE, World Health Organization, Street Kids International, and the Pan American Health Organization in order to mount a coordinated approach to this problem (7-9).

A Typology of Runaway and Homeless Youth in the United States

In the United States, running away from home is not a new phenomenon. During the 19th and 20th centuries, many young men left home seeking adventure or in rebellion from a restrictive environment. Then it was relatively easy to integrate into the community and secure jobs. During the 1960s, many youth left home for excitement and to become involved in the counterculture movement of that time. Few data are available concerning this group, so that the part played by abuse, dysfunctional families, or neglect is unknown. A 1968 study of male juvenile prostitutes indicated that most had come from dysfunctional families, with a high incidence of neglect and abuse (10).

From the mid-1970s to the present time, life on the streets has become more dangerous owing to increasing sexual exploitation and drug use. An understanding of runaway youth is made more complex because of a lack of standard definitions. The Runaway and Homeless Youth Act (Title III of the Juvenile Justice and Delinquency Prevention Act) defines runaways as "juveniles who leave and remain away from home without parental permission." Among this group of runaways there are several different categories, which may be overlapping and indistinct:

Situational Runaways. This, the largest group, is comprised of young people who leave home for a day or two after a disagreement with parents. Although they may be seen in runaway shelters or spend a brief time on the street, they usually return home within a few days. A small percentage may repeat this behavior and remain away for longer periods. If so, they become a part of the chronic runaway group.

Runaways. These, youth leave home because of problems with parents, such as neglect, abuse, or serious conflicts. They leave for long periods of time, often progressing from repeat runaway to chronic runaway to street youth. The latter do not return home at all, but live in transitory housing, such as
friends' apartments, shelters, cheap hotels, or abandoned buildings ("squats"). These youth are usually totally on their own for their survival and are frequent victims of the violence and numerous dangers of the streets.

Many runaways leave home because of conflicts with parents over their sexual orientation. It is difficult to know the actual number of homeless gay adolescents, particularly because many heterosexual males will engage in same-sex relations for money. In a study by Stricof et al. (11) in 1988, 20% of New York male runaways identified themselves as gay. A study by Yates et al. (12) in 1988 found a gay or bisexual identification in 16.5% of males in the Hollywood area.

"Throwaways." These are defined as youth who have left home because their parents have abandoned them, asked them to leave, or subjected them to extreme levels of abuse or neglect. Many in this group may have spent time previously with relatives or had periods of residence in foster care.

Systems Youth. These children, though similar in most respects to runaways, frequently have had no recent family contact but have been living in private or public institutions or foster homes and have been unable to tolerate their living situations. They are generally not part of the growing number of families using shelter services. They have left to become part of the runaway subculture. Many have spent a large portion of their lives in institutional care and they have frequently run from these institutions or foster care. The younger ones are usually returned, but by the time they are age 11 to 12 years, most are unwilling to return and remain on the streets.

Magnitude and Characteristics
It is very difficult to count the number of runaways (13). National studies of the prevalence of missing children state there are half a million runaways and 127 thousand "throwaways" in the country (14). Other estimates are as high as 2 million (15). There are many confounding factors in accurately counting these youth: They are frequently recidivists and are then unlikely to reside in adult shelters, where such data are collected. Federally funded shelters are estimated to serve only 1 in 12 runaway youths. A count of the "visible" youth living independently in streets, parks, subways, and abandoned buildings ("squats") would be required to be complete.

There seems to be a fairly even gender distribution among runaways, although the number of girls is frequently higher in shelters, while boys are more likely to travel further from home (16,17).

The median age of runaway youth is between 14 and 16 years (17,18). Younger runaways are more often reported by parents to police or come to the attention of shelters. Since many federally funded programs will not accept youth over 18 years, runaways who do not have contact with shelters are particularly difficult to track.

The racial and ethnic makeup of youth on the street is similar to that of the nearby community. Most runaways come from within a 50-mile radius (19), although in certain larger urban areas, such as San Francisco, Los Angeles, and New York, many come from further away (16).

Causes
There are a number of reasons why children run away. Information obtained from the Administration for Children, Youth and Families (ACYF) found that 65% of runaways interviewed said relations with parents were the main reason for running (17). A number of studies have shown that less than one-third come from homes with both parents present (20,21).

Physical and sexual abuse also are major factors; 60%–75% of runaways report serious physical abuse, and the prevalence of sexual abuse, especially among young women, is even higher (22,23).

Survival Techniques
Once these youth are on the streets, there are few legitimate means of survival. Although some try various kinds of delinquent activity such as selling drugs, stealing, and panhandling, one of the most common means of obtaining funds is through "survival" sex. Few young women who are on the streets for any period of time fail to become involved and, although young males have more options available for survival, they too are likely to become involved in hustling or other forms of "survival" sex. Street youth often exchange sexual activity for food, shelter, drugs, or protection, from someone who is older and more streetwise (24). Many youth have little or no knowledge of prostitution when they first reach the street, but after talking with involved peers who seem to be making easy money, it becomes less frightening. The number of street youth involved in
prostitution varies greatly, and it is usually higher in the largest urban areas, especially New York and Los Angeles (12,24). Gay or bisexual youth are even more likely to be involved in prostitution (25,26).

**Health and Social Consequences of Being Young and Homeless**

The following section provides a brief review of the health and social consequences of homelessness among youth.

**Physical Health Problems**

Limited data collected from primary health clinics in the United States suggest that the health of youth worsens after they become homeless, and homeless youth are at particularly high risk for developing serious health problems, including sexually-transmitted diseases, malnutrition, pregnancy, and premature death resulting from suicide and homicide (27-32). Many of these problems are a consequence of living in health-compromising settings such as abandoned buildings or vehicles, or living on the streets, and from involvement in unprotected sexual intercourse in prostitution or other forms of survival sex.

In Bogota, Colombia, for example, knife and gunshot wounds are commonplace. Common ailments include infected lacerations, burns, contusions, head lice, fleas, and “sores of all descriptions” (4). As victims of repression and negative social sanctions, they do not use organized health care. Substance use and abuse is a common problem, both because of the effects of drugs and the dangerous lifestyle associated with drug activities. Though the specifics vary from country to country, substance abuse and drug activity are parts of survival for many street youth (4). Violence against street youth has escalated in some cities so that they have become homicide victims of “death squads.”

Preliminary data collected at an outpatient medical clinic in Los Angeles suggest that homeless youth are significantly more likely than non-homeless youth to be diagnosed with a sexually-transmitted disease (particularly Chlamydia), allergies, ear, nose and throat problems, dermatologic problems, gastrointestinal problems, infectious diseases, drug abuse, trauma, and psychosocial problems (33). An Illinois Governor’s Task Force estimated that over 21,000 youth under the age of 20 years in Illinois were homeless; of these, 7,000 were thought to be teen mothers or pregnant (32).

In an outpatient health clinic, 13% of homeless females were found to be pregnant during their clinic visits (12). Homeless pregnant teenagers are at risk for low-birth-weight babies and high infant-mortality rates because they are unlikely to receive prenatal care and may not have adequate health and dietary habits (34).

AIDS seroprevalence studies suggest that homeless youth are at significantly greater risk for infection with HIV compared with non-homeless youth. Military recruit data collected from New York State from October 1985 through December 1988 revealed an HIV seroprevalence rate of 0.06% for persons aged 17-19 years old. In contrast, a New York City shelter for homeless runaway youth reported 5.3% of the 15- to 20-year-old youths and 8.6% of those 20 years old anonymously screened between October 1987 and December 1989 were HIV seropositive; the prevalence rate was 4.2% among females and 6.0% among males (11,23,32). A community-based medical clinic for the homeless in San Francisco reported that 12% of 14- to 20-year-old youths seen from May 1989 to March 1990 were HIV seropositive; in the males, 19.5% were seropositive (35). The predominant risk factors for HIV transmission among homeless youth are homosexual and bisexual activity, intravenous drug use, crack use, history of sexually-transmitted diseases, and prostitution (11,36).

**Alcohol and Other Drug Abuse**

Alcohol and other drug abuse also appears to be a pervasive problem among homeless youth. Although these agents may play a functional survival role by deadening emotional pain and helping youths cope with the uncertainty and instability in their lives, it may also serve to further destabilize their lives, making it more difficult for them to utilize services and be reunited with their families or transition to more stable living circumstances. Homeless youth become more involved in substance abuse the longer they remain homeless (37).

Alcohol and other drug abuse may also increase homeless adolescents’ risk for health problems, particularly trauma from accidents and injuries, acute infections, and sexually-transmitted diseases (33).

**Alcohol Abuse.** Alcohol is the substance most commonly used and abused by homeless youth. Among youth residing in 16 shelters located throughout the country, 79% reported use of alcohol, and 60% reported regular use (38). In a study of youth residing at a New York City shelter, one-fifth reported using...
alcohol to intoxication at least once per week, and those that were most “disturbed” were significantly more likely to report getting drunk weekly (39). The majority (69%) of runaway youth seen at an outpatient medical clinic in Los Angeles reported recent use of alcohol (40).

In a study conducted in Hollywood, homeless adolescents began using alcohol at an earlier age, experienced greater social impairment owing to alcohol use, and practiced exaggerated consumption patterns compared with nonhomeless youth (29). Current prevalence of alcohol abuse was six- to eight-times higher than for nonhomeless adolescents (according to DSM-III criteria), and virtually identical to the rate for homeless adults from the skid row area of Los Angeles (29). In addition, homeless alcoholic adolescents demonstrated a behavior profile reflecting pathological alcohol use and impaired social function similar to that of homeless alcoholic adults.

Other Substance Abuse. Although limited information is available about the prevalence of substance abuse among homeless youth, it appears that it may be as prevalent as alcohol use in this population. In the Hollywood sample, more than one-third (38.7%) met diagnostic DSM-III criteria for substance abuse, a rate five-times higher than for nonhomeless age peers (29). Among homeless youth seen at an outpatient medical clinical elsewhere in Los Angeles, 53% reported marijuana use, 32% reported stimulant use (cocaine and amphetamine derivatives), and 9% reported use of narcotics within the previous 6 months; 8% reported lifetime intravenous drug use (IVDU) (40). In a recent study of 168 Covenant House adolescents in New York City, alcohol was used by 80%, marijuana, by 68%, cocaine by 48%, crack by 38%, and IVDU was reported by 6% (41).

Other Mental Health Problems

Homeless youth also suffer from a wide range of mental health problems, which often coexist with physical and substance abuse problems. Recent studies report high rates of depression (variably defined), suicide attempts, conduct-disordered behaviors, physical and sexual abuse, and other mental health problems (31,42–44). Rates of psychiatric hospitalizations are also significantly higher for homeless youth as compared to their nonhomeless peers (45). Homeless adolescents in Hollywood were found to have a higher prevalence of all mental health indicators compared with nonhomeless adolescents (29). Rates of formally defined disorders including major depression, conduct disorder, and posttraumatic stress disorder were at least three-times higher than those of a nonhomeless comparison group. Comorbidity of alcohol abuse and mental health problems was also high, and a “dual diagnosis” of major depression and alcohol abuse was applied to 11% of the sample. In the New York City sample, runaway youth were described as having a psychiatric profile indistinguishable from adolescents attending a children’s psychiatric clinic (39). Among substance-abusing homeless youth seen at a mental health clinic, 85% were diagnosed as depressed, 9% were actively suicidal, 20% had previously attempted suicide, and 18% suffered from a severe mental health problem (12). Lifetime suicide attempts were reported by 24% of runaways in New York City shelters and by 18% of runaways using an outpatient health clinic in Los Angeles (12,39). About half (48.4%) of another Hollywood “street” sample had attempted suicide sometime in their lives (29). Of those who had made an attempt, more than half had attempted more than once (28% of the sample), and more than half (27% of the sample) had attempted suicide during the previous 12 months. In both the Hollywood and New York City studies, females reported higher suicide attempt rates than males. In Hollywood, almost one-quarter of the street sample had ever been hospitalized overnight for mental health or emotional problems. About two-thirds of these (17.2%) had been hospitalized for suicide attempts. In the New York City study, 9% of the shelter clients had been hospitalized; the authors attributed the high rate of psychiatric hospitalization to excess suicide attempts (39).

Involvement in Illegal Activities

Homeless youth frequently report involvement in antisocial and criminal activities such as street prostitution, drug-dealing, theft, and assault in order to survive. Drug-abusing homeless adolescents are even more likely to engage in criminal offenses in order to obtain the money to purchase drugs. Some youth even report committing criminal offenses that result in arrest in order to secure shelter (29,46). It is estimated that 75% of the “hard-core” street youth engage in some type of criminal activity, and that half engage in prostitution to provide themselves with a means of support.

Data collected in an outpatient medical clinic in Los Angeles revealed that 16% of homeless adolescents and 4% of the nonhomeless adolescents re-
ported having been arrested during the previous 12 months; the number of arrests among homeless youth ranged from 1 to 15 (33). An additional 19% of the homeless adolescents reported being currently involved in prostitution or “survival sex,” and 8.5% reported being a member of a gang (as compared to 4% of the nonhomeless youth). Thus, a total of 41% of the homeless adolescents and 8% of the nonhomeless youth were reportedly involved in illegal activities; homeless adolescents were 17 times more likely to have been arrested in the previous year and twice as likely to be involved in a gang. These figures, do not however, include involvement in illicit drug use or dealing.

Barriers to Health Care
The formidable barriers to comprehensive health care for all adolescents are amplified for independent homeless youth. Although approximately 75% of runaway and homeless youth originate from the area in which they seek services, most lack familiarity with local health-care resources. When presenting at a traditional site such as a hospital emergency room, they are likely to be asked for a permanent address, health insurance information, and parental permission for treatment. Although some states consider these adolescents to be emancipated minors, confidentiality remains a key concern. Many such youth have been exploited and victimized by adults and are reluctant to trust health professionals and the traditional health-care system. Legal concerns regarding status or criminal offenses may lead to fear of police or social service agency notification. Affordability, denial of need, delay in seeking care, and lack of adequate follow-up, owing to the transient nature of the populat ion, all complicate the management of health problems. Finally, health services are neither linked nor coordinated with the social, educational, vocational, and legal service needs of these youth.

Model Services
Health and social service organizations worldwide are attempting to meet the needs of homeless youth. For example, effective educational material and social intervention programs for HIV prevention in “hard-to-reach” youth are being developed. Street workers serve youth at risk for HIV infection in many inner cities throughout the world. For example, an Ashoka fellowship provider in Bangkok works in bars with young male prostitutes. This work is demanding, dangerous, and requires a profound commitment. These outreach services are beginning in other developing countries of Latin America and Africa.

In the industrialized European countries, such as the Netherlands and Denmark, social and health services for runaway and homeless youth are advanced and innovative, partly because of the unacceptability of true homelessness in these societies. In Amsterdam, for example, a coalition of providers provides services to youth: Poortgebouw (shelter/housing), De Vuurtoren (day shelter/education/counseling), Kruispost (medical, substance abuse care), and Stichting “street cornerwork” (outreach/food/case management) (46). In Denmark, many governmental and private initiatives exist. The Bornehotellet (Copenhagen) provides short-term housing for adolescents 14–18 years of age. Youth leisure centers flourish in nearly every community. Single occupancy apartments for homeless youth are provided by the Projekt Bosted, and a portion of the project’s government funding is specifically set aside for outreach to previously unidentified street youth. Approximately 4,000 single apartments throughout Denmark have been set aside for this purpose. Another innovative project has been developed in Denmark in which small ships are being used as isolated environments for close supervision and “resocialization.” While on board for extended sea journeys, each ship typically consists of 3–4 adult seamen, 3–4 adolescents, and social workers. Each “tour” takes from 1 to 1½ years. The parent social service agency has contact with each vessel every 6 weeks (an evaluator is flown to ports of call on each vessel’s route). The cost of this arrangement is roughly the same as that of community placement in a group home. There are currently 19 such ships, a few of which are fishing vessels that provide paid work opportunities to the adolescents on board. The youth social service infrastructure in these countries is remarkable for its variety, ingenuity and broad mission (46).

In the United States, services are not generally as comprehensive, but model outreach and service delivery programs do exist. In Seattle, the Division of Adolescent Medicine at the University of Washington has provided free street-side health services to youth for many years. The partnership between an academic program (with medical trainees) and a youth outreach program in the provision of high quality care to street youth represents a low-cost approach which sensitizes future physicians to the needs of the population and lowers access barriers.
Similar health-care delivery programs and partnerships exist in San Francisco, Los Angeles, Boston, New York, and several other major urban centers. Some programs offer mobile health services such as the Bridge, Inc., in Boston, and Youthcare in Seattle, as well as the High Risk Youth Program in Los Angeles. A handful of cities have multifaceted service programs such as Bridge over Troubled Waters (Boston), Iowa Homeless Youth Center (Des Moines), Neon Street Center for Youth (Chicago), San Diego Youth and Community Services, Youth Development, Inc. (Albuquerque), Youth Care (Seattle), and The Door in New York City. Collaboration and coordination among agencies that provide services to this population have become essential. For example, the Los Angeles System of Care for runaway and homeless youth consists of over 40 public and private agencies working together under one unifying body with ties to the Division of Adolescent Medicine at the Children's Hospital of Los Angeles (47).

Model programs base their exemplary services (48) on the following principles:

1. Adolescent-Centered: Adapts services to the adolescent, rather than expecting the adolescent to adapt to the services.
2. Community-Based: Provides local, integrated, and coordinated services.
3. Comprehensive: Recognizes the multiple needs of these youth and ensures comprehensive services and holistic care.
4. Collaborative: Draws on the resources of a community or works in coordination with other programs to provide a range of services, in-house or through inter-agency agreements.
5. Egalitarian: Provides services in an environment and a manner that enhances the self-worth and dignity of adolescents; respects their wishes and individual goals.
6. Empowering: Maximizes opportunities for youth involvement and self-determination in the planning and delivery of services, and fosters a sense of personal efficacy that encourages youth to effect changes in their lives.
7. Inclusive: Serves all runaway and homeless youth or provides and tracks referrals for those youth whom the program is unable to serve.
8. Visible, Accessible, and Engaging: Provides services that attract youth.
9. Flexible: Incorporates flexibility in service provision and funding to support individualized services.
10. Culturally Sensitive: Works to provide culturally competent services.
11. Family-Focused: Recognizes the pivotal role that families play in the lives of high-risk adolescents and involving family members where appropriate.

Summary
The experience of runaway and homeless youth in the United States is not entirely unique and should be viewed in an international context. The youth in this country do have some unique characteristics and needs. Homeless youth in affluent societies such as ours are often on the streets for different reasons than those of their counterparts in developing countries. Nonetheless, life on the streets brings with it hazards for all homeless young people. Homeless youth are at risk for a number of serious physical and mental health problems, some resulting in pain and discomfort, others in disability and death.

Less dramatic, but just as critical, is the role that homelessness plays in disrupting an adolescent’s healthy development. Many of the youth who become homeless come from dysfunctional families where physical and sexual abuse, neglect, and substance abuse are common.

Homelessness and the experiences associated with homelessness further negatively impact youths’ physical, emotional, psychologic, and social development. As a result, most do not develop a healthy sense of self, nor do they establish healthy, supportive peer relationships. The majority of homeless youth drop out of school during their early teens. Thus, they miss the opportunity to develop the kinds of problem-solving and intellectual skills required for securing and maintaining employment as adults.

Homeless youth involved in alcohol and other drug abuse are even more likely to have significant deficits and may be more irresponsible and emotionally immature. Thus, a vicious cycle is established. Rather than acquiring the types of enriching experiences and skills that would enable them to develop into healthy adults, homeless youth become over time more alienated from society. As a result, many will become chemically dependent and chronically homeless adults.
Recommendations

The Society for Adolescent Medicine in its leadership and advocacy role supports improved outcomes for homeless and runaway youth with the following initiatives. The recommendations are prioritized into three areas: 1) support for data collection and research, 2) prevention efforts, and 3) improvement in quality of access to appropriate health services. Some of the recommendations have been developed by other organizations (in parentheses) and are supported by the Society for Adolescent Medicine.

1. Support Data Collection and Research
   - Support worldwide scientific conferences on health care and health needs of runaway and homeless youth.
   - Encourage systematic collection of data on the physical health, mental health, and other needs of homeless and runaway adolescents (Office of Technology Assessment, 1991).
   - Support rigorous research on the causes of runaway behaviors (including white, middle-class and gay adolescents) (Office of Technology Assessment, 1991).
   - Encourage its membership to further define the type of the problems facing this population, i.e. meeting service needs, professional training needs, and creating a research agenda.
   - Support research to identify the etiologic factors in runaway behavior, followed by demonstration studies which attempt early recognition and intervention with the family, in the schools, and on the streets.

2. Prevention
   - Support programs of health education for street youth (including HIV infection and other Sexual Transmitted Diseases), including development and dissemination of related educational materials for these youth.
   - Given that sexual identity concerns and family rejection constitute a major causative factor, support programs of education and training on homosexuality and related issues for professionals working with children, youth, and families. Such education and training should be preventive in nature to the extent that it prepares professionals from a variety of disciplines to better assist youth and families and to support such youth in remaining at home whenever possible. (MCHB Adhoc Advisory Committee Report, 1985).
   - Support for training should be provided through service delivery agencies to begin addressing the multiple needs of street youth. Efforts should be made to target such groups as state health officers, maternal and child health, and other professionals working in adolescent programs. Public school educators and juvenile corrections personnel should be included.
   - Support interdisciplinary graduate level training, which includes the development of curricula and the development of stipended fellowships in adolescent medicine, that have these youth as a key training focus. (MCHB Report, 1985).

3. Services
   - Given that the “strict medical model” does not work with this population, creative multidisciplinary service strategies should be encouraged along with entrepreneurial efforts to develop and fund services for this youthful population.
   - Support continuity of care, including case management and follow-up services that provide multidisciplinary approaches to care, support collaborative efforts to provide for tracking of youth, and provide specialized care for street youth with chronic illnesses.
   - Given that outreach services are an important component of the service delivery system for these youth, support outreach education about the network of services, including available legal services. (MCHB Report, 1985).
   - Programs should be supported which have strong outreach components to all youth on the streets as a vehicle that brings information and care to them via: outreach workers, mobile units, and the media.
   - Support for transitional housing on a long-term basis. Shelter services should include supervision, training in independent living skills, in-depth medical screening, evaluation and treatment, and psychological evaluation and treatment. (MCHB Report, 1985).
   - Given the increased number of pregnant adolescents and young mothers with babies and toddlers who frequent the “street scene,” support for specialized health services and outreach services for this population, which incorporates family planning counseling and comprehensive primary health care. (MCHB Report, 1985).
   - Given that youth involved in the juvenile justice system are at high risk for returning to street life, special efforts should be made to reach
those in correctional facilities in terms of utilizing outside social and medical services and help these youth find an alternative to "life on the streets."

- Given the high rates of alcohol and other drug abuse and homeless youth, substance abuse assessment, referral, and treatment should be integrated into outreach, shelter, and primary health-care settings.
- The health care of street youth should be given a priority by the National Health Service Corps with assignment of corps professionals to locations where there are large numbers of street youth and a provider scarcity.

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