

Special Populations

Adolescents in the Juvenile Justice System

Introduction

The number of adolescents in the juvenile justice system continues to grow. These youth experience significant medical and mental health problems, yet tend to be underserved when it comes to receiving health care services in detention and correctional facilities.

National

Healthy People 2010 objectives (U.S. Department of Health and Human Services, 2000) related to adolescents in the juvenile justice system are to:

- ❖ Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems. The prevalence of mental disorders for youth in juvenile justice facilities is higher than in the general population and includes behaviors such as suicide and self-injury. This is a developmental objective.
- ❖ Increase the proportion of youth detention facilities and adult city or county jails that screen for common bacterial sexually transmitted diseases within 24 hours of admission and treat STDs (when necessary) before persons are released. This is also a developmental objective.

Findings from a study interviewing 800 young offenders in Chicago's Cook County Temporary Detention Center show that the majority (95 percent) of offenders have engaged in a minimum of three behaviors and about two-thirds engaged in 10 or more behaviors which place them at risk of HIV (Centers for Disease Control and Prevention, 2003). The most commonly reported behaviors, especially among older teens, were having unprotected sex and getting tattoos with a dirty needle. Over half of girls ages 10-13 reported being sexually active and using marijuana and alcohol. Many also reported having sex while high or drunk, but most used protection. Another study of 2000 juveniles in 39 correctional facilities across the U.S. found that incarcerated youth are more likely to smoke cigarettes and marijuana, more likely to have had sex, and twice as likely to have been forced to have sex (Joseph-Di Caprio, 2002). Findings from other studies also show that adolescents in correctional facilities have higher rates of STIs, have engaged in sexual intercourse from a young age (median, 13 years old), have had several sexual partners (median, eight partners), and have inconsistently used condoms (American Academy of Pediatrics, 2001a).

Other preexisting conditions incarcerated youth have include asthma, orthopedic problems, and otolaryngologic conditions. In a position paper of the Society for Adolescent Medicine, authors cite a high prevalence of seizure disorders, respiratory disease, nutritional deficiencies, skin problems, and dental problems among juvenile detainees (2000). Among the most common preexisting mental health conditions are attention-deficit/hyperactivity disorder, conduct disorder, oppositional-defiant disorder, and depression. In a study of 8,000 incarcerated youth in California, almost half of all youth entering detention facilities had a

learning disability (California Adolescent Health Collaborative, 2000). Not surprisingly, between 25 percent and 31 percent of incarcerated juveniles have a history of family abuse and neglect. During incarceration these adolescents have a high rate of suicide and suicide attempts, especially those detained in adult jails or lockups. They also may become victims of physical and sexual abuse and are susceptible to other accidental or self-inflicted injuries while incarcerated.

Only a third of teens in detention facilities report having a regular source of health care, and medical care while incarcerated is limited due to lack of funding for these services in most states. Federal regulations prevent those incarcerated from receiving Medicaid benefits. Experts recommend educating these high-risk adolescents about health risks while they are in jail, which may be the only way to reach this population. The Society for Adolescent Medicine believes that government agencies should provide medical and dental care for emergent, acute, and chronic conditions in incarcerated youth, and mental health services for acute and chronic psychiatric and emotional conditions. States should also screen those exiting the juvenile justice system for Medicaid and SCHIP (State Children's Health Insurance Program) eligibility (Brindis, Morreale, & English, 2003).

Arizona

Data from the Arizona Department of Juvenile Corrections for the first quarter of 2003 on juveniles in five correctional institutions throughout Arizona indicate that the greatest needs of newly committed adolescents were for treatment related to substance abuse, violent behavior, theft behavior, intellectual/education deficits, peer relationships, and school behavior/adjustment. Also of significance was the need for treatment of sexual behavior and emotional stability for females. Over a third of juvenile males and over half of females had health and hygiene needs, with a slightly greater number needing services to address abuse and neglect.

Arizona Supreme Court (2003) data from two detention centers within Maricopa County show that of the juveniles who are on medication, the majority are on psychotropic medications. A small number are also on tuberculosis and HIV medication. Pima County data from March/April 2003 show that the most common reason for a nurse sick call visit was for headache and migraines (28 out of 167 visits), followed by nasal congestion (12 out of 167 visits), and stomach pains and acne (11 out of 167 visits). The majority of doctor/nurse practitioner visits were for routine physicals (41 out of 72 visits).

Homeless and Runaway Adolescents

Introduction

The Federal government defines (U. S. Code Title 42, Section 11302) a homeless person as someone who "lacks a fixed, regular, and adequate night-time residence; and...has a primary night-time residence that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations...; (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

Many homeless youth have left their homes due to family problems such as physical and sexual abuse, drug abuse, and severe family conflict (Children's Action Alliance, 2003). Once on the street, they are prone to engage in risky behaviors in order to survive. Given the few legal means to earn money for basic needs, homeless teens often exchange sex for food, clothing, and shelter. This puts them at a high risk for contracting STIs. Furthermore, access to health care is limited.

National

A study of 30 youth ages 13-24 on the streets of Seattle (Yale New Haven Health, 2003) finds that the biggest problem for homeless adolescents is that they do not understand how the health care system works. When they do attempt to receive medical treatment, many are hassled by hospitals because they do not have a guardian's consent. Many homeless teens are afraid to seek medical care since laws on confidential care for adolescents vary from state to state and teens are not aware of their rights. Those over 18 years of age report that there are more free services for those younger and that they are suddenly expected to have health insurance or to pay for medical treatment. Young adults said they could not afford to pay medical bills and pay rent.

As for gender differences, boys felt embarrassed and that it was a sign of weakness for them to seek medical services, but that if they had more male outreach workers it might encourage them to seek medical attention. The major barrier to seeking medical care for girls was safety-related, since many feared traveling to clinics at night. Suggestions for improving health care for homeless teens include providing better access to drug treatment programs and helping those over 18 apply for government-funded health insurance.

Homeless children are more likely to have stomach problems, ear infections, and asthma. Many homeless children also experience anxiety, depression, withdrawal, behavior problems (including aggression and delinquent behavior), and are diagnosed with learning disabilities such as dyslexia or speech and language impediments (National Resource Center on Homelessness and Mental Illness, 2003). Homeless youth also have low self-esteem and are prone to suicide attempts.

Arizona

Each day an estimated 1,900 youth under 18 are homeless in Arizona (Children's Action Alliance, 2003). In 2001, 70 percent of the 3,204 homeless youth received community-based services (in seven of the 15 counties). Over a quarter of these youth reported that their parents abandoned them, while 11 percent ran away from home.

Among the youth served by the Homeless Youth Intervention Program in 2002 in Maricopa, Pima and Yavapai Counties, 62 percent reported being abused (e.g., physical, sexual, and/or emotional abuse), 65 percent reported being raised in drug or alcohol dependent families, and over a third reported having mental health problems. Recommendations for improving the program included first meeting the basic needs of food, shelter, and safety, so that youth can feel confident about influencing the directions of their lives. After this is achieved, services should focus on substance abuse and mental health issues.

According to an annual report on homelessness from the Arizona Department of Economic Security (2002), homeless youth constitute one of the largest groups of homeless persons in Arizona. Many programs serving homeless youth throughout the state offer a continuum of services that begins with outreach and recruitment of youth into the program. This is critical since many youth are afraid to search for services and do not trust agencies or programs with their care. 2001 survey findings of eight homeless youth providers found that over half of homeless youth served were 14-17 years of age, and were more likely to be female than male (52 percent versus 48 percent).

Adolescents with Special Health Care Needs

Introduction

According to the Maternal and Child Health Bureau, children with special health care needs are defined as “those children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally” (Family Voices, 2003). This definition goes beyond identifying children based on their diagnosis, by emphasizing the impact of their special health need and their need for health services. Various conditions and chronic illnesses may be included in this definition, such as cerebral palsy, developmental delay, attention deficit hyperactivity disorder, depression, asthma, sickle cell anemia, or cystic fibrosis.

National

Approximately 18 percent of children and adolescents in the United States have a chronic condition or disability. Disabilities are most prevalent among boys, older children, and children from families with low incomes and from single-parent families. Disability in children and adolescents results in approximately 66 million days of restricted activity annually, 26 million physician contacts, 24 million days lost from school, and five million days in the hospital. (Patrick, Spear, Holt, & Sofka, 2001).

According to the Agency for Healthcare Research and Quality (AHRQ), asthma is the most common chronic childhood disease (Agency for Healthcare Research and Quality, 2002). Other common conditions are attention deficit hyperactivity disorder, otitis media with effusion, and diabetes.

The Family Partners Project, a collaboration of Family Voices and Brandeis University, surveyed over 2,000 families with children with special health care needs in 20 states to find out about their experiences (Wells, Krauss, Anderson, Gulley, Leiter, O’Neil, et al., 2000). Children ranged in age from infants to 18 years of age and had more than one health condition or disability. Those reported most often were allergies, cerebral palsy, behavioral problems, orthopedic problems, vision problems, mental retardation, seizure disorders, and asthma. Most children currently had health insurance from a mixture of sources (e.g., Medicaid, parent’s employer) and also received health care services from other government programs and/or school systems. Only three percent did not have insurance. Public sources such as Medicaid provided care from specialists, home health services, therapies, and other services. Families had the most difficulty obtaining home health care and mental health services, because of the difficulty of finding skilled and experienced providers and, for home care, the

difficulty of getting the number of needed hours of service approved. Problems were also reported in getting prescription medications, receiving therapy services, and getting appointments with specialty doctors. Care for these children is aided in some cases by case managers, but mostly remains uncoordinated.

In an online survey of 2,000 adolescents ages 13-17, three groups of at-risk adolescents were identified, one of them being teens with special health care needs (Foundation for Accountability & The Robert Wood Johnson Foundation, 2001). Adolescents from this group were more likely to engage in risky behaviors such as smoking, alcohol and other drug use, or carrying a weapon, compared to adolescents without a special health care need. These adolescents are less healthy, less confident about life, and less connected with their community and schools. Smaller studies have found that youth who have disabilities, chronic illnesses, learning disorders, or emotional disorders have higher rates of suicide (Ozer, Park, Paul, Brindis, & Irwin, 2003). These teens also visited the doctor 2.5 times more frequently than teens without chronic health problems and were five times more likely to be hospitalized in the last year. In accordance with other findings, these teens felt that providers of specialized services such as mental health and counseling did not spend sufficient time with them.

Sexuality and physical education are two areas that tend to be minimized or totally ignored for youth with special health care needs. As stated elsewhere in this report, sexual awareness blossoms during adolescence and adolescence helps to transition a person from childhood to a healthy sexual adulthood. This is true for any adolescent with or without physical or developmental disabilities. "Unfortunately, there are many misconceptions about the sexuality of children with disabilities. The most common myth is that children and youth with disabilities are asexual and consequently do not need education about their sexuality... Many people also think that individuals with disabilities will not marry or have children, so they have no need to learn about sexuality. This is not true either" (National Information Center for Children and Youth with Disabilities, 1992). According to a 2001 American Academy of Pediatrics (2001b) Policy Statement pertaining to the need for accurate and comprehensive education about sexuality: "Rates for sexual activity for adolescents with disabilities are the same for those adolescents without disabilities. However, children in special education may not receive sexuality education in school. Children and youth with disabilities should be provided developmentally appropriate sexuality education."

According to *Bright Futures* (Green & Palfrey, 2001), childhood and adolescent mortality resulting from chronic conditions and disabilities is declining; therefore, the population of adults with a chronic condition or disability will continue to increase. Cardiovascular disease risk factors are appearing much earlier in children and adolescents, physical fitness in children and adolescents is steadily decreasing, and the prevalence of childhood and adolescent obesity is increasing. In children and adolescents with special health care needs, a sedentary lifestyle is associated with an increased risk of morbidity. Children and adolescents with special health care needs benefit from regular physical activity. It can make the tasks of daily living easier for them, improve their health status, and ultimately reduce morbidity from secondary conditions during adulthood. Physical activity for children and adolescents with special health care needs can help control or slow the progression of the chronic condition or disability, minimize its side effects, and reduce associated disabilities. It can improve overall health and function; minimize the psychological and social impact of the condition or disability on children and adolescents and their families; and help normalize their daily living experiences. (Patrick, Spear, Holt, & Sofka, 2001).

For adolescents with special health care needs, transition to the adult world is a significant issue. The transition from high school to the adult world will vary from adolescent to adolescent, whether the adolescent has a physical or developmental disability and/or special health care need or not. This milestone involves the youth looking ahead and planning for the future as he/she becomes increasingly more independent. Planning for post secondary education, vocational training, and/or employment starts while the adolescent is still in high school. For youths with a disability or special health care need, planning for and achieving this milestone can be more challenging. Transitional planning is important for all students whether they have an individual education plan or not. Under the 1990 Individuals with Disabilities Education Act (IDEA) for those students who have an Individual Education Plan (IEP), it is required by federal law that transitional planning begin when the student is 16 years or older, or younger if deemed appropriate by the IEP Team. The 1997 revisions to IDEA require a statement of transition service at the age of 14. For those students that do not have an IEP, but qualify for and receive special education accommodation services under Section 504 of The Rehabilitation Act of 1973, there is no required plan.

Arizona

According to the State and Local Area Integrated Telephone Survey (SLAITS), a national survey of children with special health care needs, approximately 10.8 percent of Arizona children have a special health care need. The survey was conducted from October 2000 through April 2002 (Centers for Disease Control and Prevention, 2002). Data from a statewide needs assessment of children (over 3,000 children under age 21 sampled) estimates that 21 percent of children in Arizona have special health care needs (Arizona Department of Health Services, 2002b).

The statewide needs assessment also showed that over half had a “medical home,” defined as health services that are family-centered, comprehensive, coordinated, accessible, continuous, compassionate, and culturally competent. The areas of greatest unmet service needs were: dental care (including checkups), routine medical checkups, and prescription drugs. The most common conditions were asthma and allergies, followed by psychological/behavioral disorders and attention deficit hyperactivity disorder. Children with special health care needs were more likely to miss school compared to other children (Arizona Department of Health Services, 2002b).

In Arizona, fewer (84 percent) children with special health care needs have a source of insurance for primary and specialty care compared to national numbers (Arizona Department of Health Services, 2002a). In the statewide needs assessment, children who were non-White were less likely to have health insurance, and if they did have insurance, it often did not cover therapy, mental or behavioral health, and preventive services, as well as prescription drugs and medical equipment and supplies. Seventy percent of children in the needs assessment had dental insurance (Arizona Department of Health Services, 2000a).

Adolescents from Immigrant Families

Introduction

Adolescents who are immigrants include those who are legal and those who are not (undocumented immigrants). These adolescents face more complexities in their normal development and socialization than other teens due to the process of assimilating into a new culture. They may experience stress within their families as they associate more with peers and pull away from family during this stage, which may conflict with their families' cultural practices. Adolescents may experience the effects of several psychosocial factors such as separation from support systems, adjusting to a new social and economic status, and dealing with depression, grief, or anxiety resulting from the efforts to stabilize themselves in a new community and culture.

National

Immigrant adolescents tend to have difficulties accessing health care due in part to changes in public policy. The Personal Responsibility and Work Opportunity Act of 1996 (96 Public Law 104-193) bans most forms of public assistance for legal immigrants who are not citizens. They are not eligible for Medicaid until after five years in residence. Illegal immigrants receive very little public assistance, which usually comes in the form of emergency services (American Academy of Pediatrics, 1997). For example, a mother will be covered for labor and delivery, but not for prenatal or well-child care.

Case study site visits were conducted with clinic and hospital administrators, doctors and nurses, local Medicaid and health officials, community-based organizations, and immigration and health experts and advocates in Los Angeles, New York, Miami, and Houston during late 1999 and early 2000 to determine immigrants' access to health insurance and health care services and changes in the health care system due to policy changes (Ku & Freilich, 2001). It was found that, as a result of the 1996 welfare reform, the number of immigrant families utilizing Medicaid declined (by more than 50 percent in Los Angeles County). Many immigrants had to rely on safety net health care providers, such as public and nonprofit hospitals and clinics offering free or reduced-price services.

Other barriers to health care for immigrant families include the cost of health care services, language and cultural barriers, and fear of being discovered by immigration authorities (for undocumented immigrants). With respect to language barriers, it was found that many providers had Spanish-speaking staff, but patients could not communicate with their nurses or doctors. Providers at the various sites, however, claimed that these numbers have been rising since 1998 and 1999 (Ku & Freilich, 2001). Because of these factors, immigrants may delay seeking help for minor conditions until they become more serious. Legal and policy barriers to care and coverage must be addressed since they are key to serving immigrant adolescents (Brindis, Morreale, & English, 2003). Furthermore, U. S. health care providers may not correctly diagnose and treat infectious diseases such as malaria, amebiasis, schistosomiasis and other helminthic infections, congenital syphilis, hepatitis A, hepatitis B, and tuberculosis.

In a nationally representative study of over 20,000 adolescents in American schools (grades 7-12) in 1995, researchers compared the physical health, emotional health, and health risk

behaviors of immigrant youth (and native-born youth of immigrant parents) to native-born adolescents (National Research Council and Institute of Medicine, 1999). For all of these outcomes, native-born youth with immigrant parents had poorer physical health and were more likely to engage in risky behaviors than foreign-born youth. The native-born youth from immigrant families were more likely to have poor health, miss school due to health or emotional problems, have learning difficulties, be obese, and have asthma. They were also more likely to have ever had sex and at a younger age, to engage in four or more delinquent acts, to be involved in three or more violent acts, and to use three or more controlled substances. Foreign-born immigrant adolescents had better physical health and engaged in less risky behaviors than native-born youth, with the exception that foreign-born youth were less likely to use birth control at first intercourse. Native-born adolescents from ethnic minority groups had poorer emotional health compared to foreign-born immigrant youth. Findings show that the longer the time since the immigrant youth arrived in the U. S., the more likely he or she would engage in risky behaviors. Factors such as poverty, single-parent homes, and unsafe neighborhoods lead to poor health outcomes and health behaviors for more assimilated youth of immigrant parents.

A study of two national surveys (1994 and 1996) of over 60,000 children birth to age 17 found that non-citizen and citizen children in immigrant families lacked health insurance compared to youth whose parents were born in the U.S. (National Research Council and Institute of Medicine, 1999). Hispanic youth fared the worst of this group. More immigrant children did not have a doctor's visit in the past year compared to children of immigrants and children with U.S.-born parents.

What would help?

- ❖ Communities can ensure that incarcerated youth receive needed services, with particular attention to mental health and substance abuse treatment and reproductive health.
- ❖ Communities can provide health care coverage and improve access to adolescent-friendly health care for runaway and homeless youth.
- ❖ Communities can forge linkages between health and mental health systems on behalf of special adolescent populations.
- ❖ Communities can work to make the transition to the adult health care system smooth and successful for all special adolescent populations. All eligible adolescents should be enrolled in health insurance programs before they leave the State system. Both providers and the youth themselves need to be prepared for the transition.
- ❖ Communities can promote programs for adolescents with special health care needs that address the issue of sexuality. Developmentally appropriate sexuality education should be provided.
- ❖ Schools and communities can make available physical activity program appropriate to the needs and preferences of adolescents with special health care needs.

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