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# Drug use and barriers to and facilitators of drug treatment for homeless youth

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**Abstract:** In the United States, homeless youth are becoming increasingly entrenched in problem substance use, including high prevalence of alcohol abuse and injection use. A total of 54 substance-using homeless youth (18–25 years) participated in focus groups in order to provide their perspectives on barriers to and facilitators of seeking treatment. Participants were recruited from shelters in Hollywood, CA, and from a street-based, drop-in site in Santa Monica, CA. Participants identified personal barriers to treatment, but reported that facilitators of treatment tended to be more systematic. Homeless youth used and abused substances to dim the psychological effects of living on the streets. They appreciated programs that facilitated treatment and rehabilitation such as mentoring, support groups, and alternative choices to substance use. Implications point to the need for further development and research on culturally-appropriate, age-sensitive programs for homeless youth. The experiences of these youth underscore the need for strategic interventions.

**Keywords:** homeless, substance use, Los Angeles

Nationally, homeless youth are becoming increasingly entrenched in a street culture that engages in substance use and abuse. An extensive body of literature documents the high prevalence of substance abuse among homeless youth, including higher prevalence of injection drug use compared with their nonhomeless youth counterparts (Rew et al 2001; Martin et al 2005, 2006; Techakasem and Kolkijkovin 2006). According to the Institute for the Study of Homelessness and Poverty (2004), the most recent studies of homeless youth living in shelters and on the streets in Los Angeles reveal that nearly three-quarters meet the clinical criteria for drug or alcohol abuse disorder or both: 60% use methamphetamine, 41% use heroin, and nearly one-third use other drugs.

Homeless youth are known to mitigate the many challenges they face with street-based living and other life experiences by using drugs (National Coalition for the Homeless 2006). Moreover, homeless youth are significantly more likely to abuse substances compared with nonhomeless youth (Woods et al 2003). As a result, barriers to and facilitators of accessing social and health services are important considerations for health care providers that interact with this vulnerable population (Carlson et al 2006).

## Barriers to and facilitators of drug treatment

Several challenges exist among homeless youth in accessing substance abuse treatment. For many homeless youth, substance abuse is not perceived as a problem; therefore, their motivation for seeking treatment is low (Slesnick et al 2000; Clatts et al 2005; Lennings et al 2006). Generally, homeless youth cringe at authority figures who challenge their independence and autonomy; they often choose to engage in survival skills, such as looking for food, shelter, and safety regardless of risk entailed

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(National Coalition for the Homeless 2006; Peterson et al 2006). Unresolved problems that led to using substances may also create barriers for youth to become clean, sober, and ultimately return home. Often, as family conflict, familial drug abuse, physical and sexual abuse precede homelessness and eventual substance use, there are strong objections by homeless youth to return to a previous dysfunctional environment (Adlaf and Zdanowicz 1999; Mallett et al 2005). Moreover, as these youth use drugs to cope with a disordered and chaotic life, the advice of healthcare providers to stop drug use without offering an acceptable coping alternative is a barrier to effective treatment. The length of time using drugs, the number of substances used, and peer pressure also create challenges for healthcare providers for successfully treating homeless youth (Rew et al 2001; Roy et al 2003; Slesnick and Prestopnik 2005).

Facilitators of drug treatment for homeless youth also exist and have been successful in eliminating or reducing drug use or abuse. Street-based youth who completed a drug treatment program, attended school, or were employed were more likely to stop injecting drugs (Steensma et al 2005). The “first contact phase of engagement” by a drug treatment counselor is key to facilitating trust and commitment among homeless youth in order to begin a treatment program (Slesnick et al 2000). As youth can become suspicious and threatened by treatment counselors who are confrontational about their using drugs, the best approach is for the counselor to be empathetic and serve as the youth’s ally in helping them deal with issues related to parents, guardians, school, or their mental health status (Slesnick et al 2000).

Length of homelessness, group status, and family support also relate to homeless youths’ acceptance of drug treatment. Youth who are new to living on the streets and in the “initiation phase” of homelessness (Adlaf and Zdanowicz 1999) or less entrenched in street culture (Carlson et al 2006) are more likely to accept interventions by drug treatment counselors. Moreover, counselors who provide interventions that both address drug abuse and mental health disorders early in the youth’s experience of homelessness are generally most effective (Rosenthal et al 2007). Brief motivational interviewing was one successful strategy found to reduce illicit drug use among homeless youth (Peterson et al 2006).

In general, youth are amenable and accepting of drug treatment services that facilitate their reduction or elimination of drug abuse; however, barriers continue to exist. Few studies document barriers to and facilitators of treatment from the personal perspectives of homeless youth themselves. Therefore, the purpose of this qualitative study was to assess,

from the perspective of homeless youth frequenting two types of youth-based sites in the Los Angeles area, barriers to and facilitators of receiving preventive health services. The specific aims are to explore: 1) factors that might motivate or prevent homeless youth in seeking or obtaining brief, drug-related preventive services; and 2) strategies that healthcare providers could use to encourage them to seek these services.

## Methods

### Design

Using a qualitative focus group design, this community-based participatory pilot study assessed the factors that motivate or prevent 54 drug-using homeless youth from project research sites in Los Angeles in seeking or obtaining drug-related preventive health services. This study additionally assessed from the youth themselves, culturally-appropriate strategies that could be incorporated into healthcare settings, to encourage homeless youth to seek services. Our community partners—including a director and youth from each of two youth shelters and two faculty from the CalArts (California Institute of the Arts) Community Arts Partnership (CAP) program—assisted in the design of the study, the construction of the semi-structured interview guide, and an understanding of the analysis of the findings. This study was approved by the institutional human subject protection committee.

### Subjects and setting

Two sites were selected by the community partners as they represented both a typical drop-in shelter and a residential shelter for youth in Los Angeles. The drop-in homeless shelter was located in Santa Monica while the residential homeless shelter was located in Hollywood. A total of six focus groups were conducted on four separate days in December 2005; with 5–10 eligible participants per session, resulting in a sample size of 54. Eligibility for participation in the focus group sessions was determined through socio-demographic data (15–25 years of age) and being a current or recent drug user (used drugs in the last six months).

### Procedure

Flyers were posted at the sites and assistance was provided by shelter staff to recruit eligible homeless youth. A \$15 incentive was provided for youth as disclosed in the flyer (\$3 for participating in the drug-dependency screen, and \$12 for participating in the focus group discussion). Informed consents were obtained for participating in both activities. After the signed informed consents were obtained, the drug screener

information was obtained, followed by a focus group session conducted by research facilitators in private areas within each site. Two to three facilitators were present for each focus group; these facilitators were experienced in conducting qualitative focus group sessions by virtue of extensive training and experience in conducting previous focus groups. One facilitator, using a semi-structured interview guide (SSIG) (Table 1), raised issues with participants while a second facilitator contributed to the discussion and documented the themes that were disclosed as well as dynamics in the room. Each focus group session lasted one hour.

Each of six focus groups was captured on cassette tape, with notes on nonverbal communication and other observations captured by the co-facilitator. A socio-demographic questionnaire was filled out by participants after each focus group. Cash payments were made to each participant on-site upon completion of these procedures.

### Socio-demographic information

Socio-demographic assessment included the items of age, gender, ethnicity, and emancipation status. The youth ranged in age from 18–25 years. The mean age was 20.5 years. The majority of youth were African American ( $n = 24$ ), followed by Anglo Americans ( $n = 13$ ), and Hispanic Americans ( $n = 12$ ). Two were Native Americans; 1 was Asian/Pacific Islander; and 2 considered themselves “Other”. The majority were male ( $n = 37$ ), and all were emancipated; defined as living apart from family or friends and financially independent of family.

### Semi-structured interview guide

A SSIG was developed and modified in a culturally-sensitive and linguistically-appropriate manner by our community partners, which included members of the homeless youth population, the research site staff, and CalArts CAP program. Table 1 displays sample SSIG questions.

### Data analysis

Data was captured by audiotape and transcribed using the aliases participants chose to protect their identities during the focus group sessions. Upon completion of the focus group sessions, the investigators oversaw transcription and content analysis of the taped recordings. The analysis was done directly from the transcripts using the constant comparative method (Glaser 1978). This method involves a line-by-line analysis of the transcribed interviews, with data coded into relevant sentences and phrases using Atlas.ti (Sage Publications Software, London, UK), a qualitative software program. Concurrent coding and analysis continued until saturation

**Table 1** Sample questions from the semi-structured interview guide

#### What you know

- Please tell us what health services you have sought in the last few years?
- If you ever had a time when you had a health problem but did not seek care for it, what got in the way?
- What has helped you get care when you needed it?

#### Types of healthcare needed

- What kinds of care do you or your friends like to use or feel you need?
- Where do you typically go to seek this care and why?
- What kind of substances do your friends or youth like to use?
- For youth who use, what do you think are the reasons they would not get treatment?
- What do you think has helped your friends or youth like you in accessing drug treatment, or what do you think *would* help?
- How many of you have been vaccinated? How many of you do not know?
- For those of you who have been vaccinated, where did you receive the vaccinations? How many did you get?
- For those of you who have not received one or both of the vaccines (or are not sure if you got them): have you ever been interested in receiving vaccinations for Hepatitis A virus and Hepatitis B virus?

#### Future access to care

- Do you think you or your friends would be willing to receive care at the shelter for drug problems?
- [If “no”] What are the disincentives to receiving this care at the shelter?
- How can the doctors and nurses at the shelter better enable you to access these services onsite or offsite?
- For those of you that might want more information about your health and where to go for help, what might be the best way to communicate these messages to you or to your friends?
- How can the doctors or nurses at the shelter better enable you to access vaccinations for Hepatitis A and B onsite or offsite?

#### Future health messages for friends

- Do you think you or your friends would be willing to help health care providers develop health messages related to the dangers of drug and alcohol use and of HIV/AIDS?
- [If “yes”] What are the creative ways you might be able to create messages (such as poetry, music, drawing, etc.).
- How can artists and musicians better enable you to develop such messages?

was reached and unique categories were no longer identified. Inter-coder reliability was assessed by independent coders who had experience in content analysis.

## Results

### Types of substance use

All focus group participants were current or recent users of some type of substance; marijuana (pot/weed) and crystal

methamphetamine (meth/crystal) were the most common, followed in varying degrees of use by alcohol, cocaine, mushrooms, heroin, crack, PCP, ketamine, ghb, and others. Multiple use of drugs, eg, marijuana and crystal, was common. Among participants at the drop-in site in Santa Monica, the consensus voiced in all focus groups was that marijuana was used more than methamphetamine, although one participant suggested that methamphetamine was the “biggest thing in Hollywood right now.” Residential site participants differed amongst themselves about whether methamphetamine or marijuana had higher usage. One participant quoted a research statistic placing 35% of youth on marijuana versus 65% on methamphetamine, while others estimated that users “graduate” from marijuana to the methamphetamine at an 80%–85% level. One male participant summed it as follows, “I’ve been doin’ drugs up and down the state and it’s meth and pot, man. That’s it. This state’s a tweaker state, man.”

Other participants attempted to explain youth drug use among ethnic/racial subgroups. As one male explained, “I think, on the Latino side, number one (at least for me and most of the people I know) ... in first place was coke; then it was marijuana; and then it came to the different types of marijuana ... and then it would be crack; and then crystal meth; and then it was heroin injected; opium; and acid; and ecstasy ... There’s a lot of drugs out there.” Another male added, “In, like the circle of people that I used to hang out with ... there was a lot of crystal meth use ... like, just everyone I knew was using crystal meth.”

A male who had used injection drugs in the past estimated that 60% of methamphetamine users (“tweakers”) inject while the other 40% smoke and/or snort the drug. Heroin, on the other hand, was not heavily used; and those who used heroin were generally older (people in their 30s and 40s). One male added, “If it’s not clean and being rolled, I don’t want no part of it.” Moreover, heroin users were depicted as not being very sociable, “They’re like the trolls lying under the bridge. You don’t see them unless you’re looking for them ... They’re in the park passed out.” Alcohol, because of its legality, was also used a lot by youth. One participant from Santa Monica reported, “There’s a lot of alcoholics in Santa Monica that keep the crack heads in balance.”

## Reasons for using substances

Substance use by homeless youth was regarded by many participants in all the focus groups as a choice, with personal triggers to both use or not use drugs. Examples given for choosing to use included enjoyment and recreational use, depression-therapy, avoidance of hurtful relationships

or memories, an aid in socializing, chemical-fix or self-medication, harm-reduction, and other perceived “benefits.” One male youth explained that because of its relaxing effects, marijuana was good for depression (if you’re homeless, you’re depressed); whereas the stimulant effects of methamphetamine kept youth awake if they were having problem finding a safe place to sleep. Another male youth from the homeless shelter explained that people end up using drugs because someone they looked up to used drugs. In his case, his mother used crack which served as an outlet for her depressive symptoms. However, this participant recounted that because crack “messed up” his mother, he chose instead to use marijuana for his depressive symptoms.

## Reasons for not seeking substance use treatment

From the perspective of most participants in several of the focus groups, treatment from outside drug treatment programs was not warranted except in cases where there was substance “abuse”. As one male participant expressed, “don’t let the drug use you.” Another homeless youth concluded that the 12-step formula assumes that substance use is a “problem” that needs to be stopped or a “disease” that needs to be treated. This was an issue for him because he did not regard his marijuana use as problematic. Instead, he preferred a harm-reduction approach, which, he stated, doesn’t exist for drug treatment.

Participants in this group agreed that some youth did not need any kind of healthcare service to stop using drugs if it was their decision to get on drugs in the first place. However, another participant who maintained that he was “born addicted” through his mother’s drug-use, believed an addict cannot just quit on their own,

“I still feign for it every f..... day of my life and I will always feign for it until the day that I die. Why? Because it’s in your brain. It’s been programmed in your brain. Did it for so long that your brain naturally produces it now and it needs it to survive now. Until you completely dry out from it, you’re not going to be able to say no.”

Other participants repeated the assertion that the responsibility resides with the user, but seeking help could be a sign of weakness. In other instances, participants using drugs were “afraid to ask for help ‘coz they don’t know who to ask.”

As one participant stated,

“I never got treatment because ... it depends if you want to, not if somebody else wants you to ... So if you want to stop, you’re gonna stop, and you’re not gonna need nobody

else's help. If you need somebody else's help, that's because you're not sure that you want to stop ..."

Another participant advised that youth who needed treatment would often not seek it because of the image they wanted to maintain with their peers who were unaware of what was going on behind closed doors. As one youth revealed: They may want to get off of that trip, but they don't want to come out and have to go to a group and maybe see one of their friends there ..."

One male participant also conceded that a youth seeking drug treatment would be looked down on by older drug treatment therapists because of the youth's age and their school-dropout/homeless/jobless status.

## Facilitators of seeking treatment or quitting substance use (Table 2)

### Pursuing other activities

Several participants expressed distaste for needing some authority figure to tell them to stop using. They advocated that when youth experienced anxiety or needed some kind of emotional crutch, instead of turning to drugs, they should engage in creative or physical activities such as a sport. For them, these were moments to do some empowering activity rather than giving in to drug use, and eventually letting it deteriorate to the point of abuse because of the negative trigger or addiction pressure.

### True listeners

True listeners were an aid for those seeking substance use treatment. For one female participant, a nonjudgmental listener, preferably a close friend who empathizes, and doesn't absolve her from her responsibility was perceived as helpful. "An ear ... somebody to listen. Don't solve my problem. Just listen. That's all I need.... I need someone who is gonna be like, 'Okay, what do you want to do? Are you gonna continue this shit?'"

**Table 2** Facilitators of seeking treatment and/or ending drug use

1. Personal decision to stop using drugs
2. Engage in creative or physical activity to empower them
3. Nonjudgmental listener to assist in problem-solving
4. Getting away from the drugs
5. Personal shame or pain to family/friends as a result of using
6. Narcotics Anonymous
7. Epiphany R/T why they are using or why they should stop
8. Legally required treatment
9. Negative impact of drug use
10. Mentorship
11. Support Groups

Other participants agreed that listening was key to solving problems, but for one participant, she felt counselors were being paid to listen and provide recovery formulas. They were not perceived as "true listeners" that would care if they weren't getting paid for it. Another female felt that "therapists manipulate you to say things they want to hear through their knowledge of the human mind." She would rather have a listener be someone she feels close to.

### Getting away from the environment

Leaving the drug scene worked for one female participant at the residential site. A male participant in the same group shared his experiences and explained that the only way he was able to get off drugs was to travel by bus to a city he had never before traveled, where he would be away from his established drug-circle and be too shy to approach anyone in the next city for a hit. Another male from the drop-in site similarly expressed that the unavailability of drugs becomes frustrating, and is an incentive to quit "... just go somewhere where people don't do it anymore ... where they don't do that."

### Personal shame/pain for family

Personal shame and pain resulting to family members triggered another female to quit methamphetamine cold turkey after seeing the look on her little sister's face when she broke into her piggy bank for money to get drugs. "Just my hurt ... That look on her face and her saying I needed it to get better." Another male agreed that when drug use hurts a person around them, it is an incentive to quit. For other females, a baby was inspiration to quitting or growing up watching her heroin-addicted parents use and go through detox, made another female youth decide never to use any drugs.

### Narcotics Anonymous

Narcotics Anonymous (NA) meetings were approved as a facilitator by some participants because all persons (perceived as "peers") who attend NA meetings generally were once or still are addicts; and are coming from a genuine place of concern and share the same goal of quitting the addiction. "I don't want to talk to just any old addict. I want to talk to someone who is either looking for the same thing as me or has already achieved that." Another male who was currently in a 12-step program shared,

"The positive experiences I had were ... I've been able to talk to other people who've had similar experiences that I have, and I've been able to get support for some big things that were happening in my life ... you know, things I needed support with.... I mean just the fact that I was in an

environment where ... like, people weren't using drugs and ... you know, that they were happy to be not using drugs"

### Epiphany

For other participants, the experience of "an epiphany" occurred. "... One day you sit there and you just realize damn! Is the way you want to live your life?! ... cuz I mean five dollars, ten dollars, twenty dollars here and there is just coming out your pay check. And really this place is supposed to help you save so I mean where's the money going to? It's gone ... (You know what I'm saying?) because you've wanted to smoke up!"

### Pros and cons of legally required treatment

Legally required treatment was an incentive for several males in one focus group, "I go to treatment because the courts asked me to and I don't want to go to jail ... But I've been clean for a long time anyways so it's good." However, another male youth argued that he had a problem with having to commit 6 months to be in rehabilitation, "It's not the time, it's people wasting their time on you because you know what, I'm not going to stop unless I want to stop. Nobody can force me to stop. Nobody can stick a needle in my arm and detox me and tell me, 'hey! they tell you you shouldn't smoke no more'. I'm gonna go do it because you tell me I can't do it anymore?"

### Negative impact of drug use

Negative effects were also considered an aid to quitting. A male at the drop-in site thought methamphetamine was the fastest rising narcotic amongst youth users. After having tried it once, he found it "disgusting" and never used again. Another male stopped doing methamphetamine cold turkey, mainly when he experienced the physical effects of it "seeping through the skin" (creating abscesses/boils). In addition, he reported that using methamphetamine "messed up a good relationship" as he was getting paranoid and experiencing delusions. "... I knew that there was some bad stuff in the dope, so I ... didn't need to do it anymore." The discomfort he experienced over time helped another participant quit methamphetamine, although he stated it was like he was still "addicted to the misery" of the uncomfortable feelings the drug created, eg, paranoia, hallucinations ... which were difficult to overcome. He explained his decision and process of getting off methamphetamine:

"It was the discomfort. Because, as far as meth is concerned.... I mean, I don't know what a heroin addict goes through. I hear that heroin addicts, they go through a sickness ... a physical sickness where they're actually,

health-wise, dependent on the substance otherwise they become very ill. But after using for ... like, a short period of time ... even just seven days, you get to a point where you need sleep ... and you lose attachment to the drug.

### Mentoring program

Referring to methamphetamine treatment, one male participant raised a concern that some youth might not be strong enough to kick the habit. He felt that youth would need a lot more than "sponsors" used in the 12-step programs. He suggested "mentors" or a "mentoring program where they do things to keep them occupied so they don't have to deal with that stuff ... I know people that smoke crystal meth on a daily basis, and are some of the most talented people." Keeping them occupied through mentoring will help provide incentive to "better their lives," will help change their thinking patterns which in turn will stop them from using over the long haul. Another male participant suggested that people who want to get off narcotics would benefit from a mentor who can relate to the client's troubles; smokes marijuana with them during mentoring sessions as a way to get their mind off narcotics-use; and exposed them to other activities. "I truly feel marijuana would be a good drug treatment."

### Support groups

Support groups were available at the residential site, but not actual detox or drug-rehabilitation. One group of participants felt that the nurses and doctors at the treatment site had been helpful in facilitating their access to care, providing referrals etc. as warranted by the situation. At the drop-in site, it was suggested that probably having a mix of different programs would be great: "like, have some support groups on evenings at places youth normally hung out at, and then also have it available for people that are more private ... if youth felt like they don't want to be exposed to their buddies".

### Discussion

The purpose of this study was to explore facilitators and barriers to drug treatment in a sample of 54 homeless youth living in shelter sites using community-based participatory research. Focus group sessions were an ideal methodology as it allowed youth to provide perspectives which were based upon their life experiences. The narratives are consistent with findings from previous research on drug use among homeless youth, in that use of illicit substances is a prevalent and customary aspect of street life for these young persons (Rew et al 2001; Roy et al 2003; Bousman et al 2005). It is apparent that there were certain harm-reduction "benefits" to their use of drugs. For

example, street living can be dangerous. The stimulant effects of methamphetamine are helpful to youth who must assimilate to living a transitory lifestyle or have difficulty finding a place to sleep at night and need to stay awake to maintain their safety. To manage depression, marijuana often is the “drug of choice,” due to its relaxing effects; and for other youth, crystal methamphetamine mimics medication to manage conduct disorder (National Coalition for the Homeless 2006). Consequently, illicit drugs appear to dim the untoward effects of living on the streets and serve as a significant personal barrier to treatment seeking among homeless youth.

Unlike prior research, rarely did homeless youth in this study comment on the usual systemic barriers to their seeking treatment, such as lack of insurance, lack of transportation, or concerns about confidentiality (De Rosa et al 1999; Ensign and Panke 2002). Rather, their identified barriers to treatment appeared to have a personal edge. Unfortunately, these attitudes are not uncommon, and evidence supports the fact that homeless youths are hesitant to seek help on their own due to their personal beliefs, perceived stigma, or their need to maintain important peer relationships (Christiani et al in press; MacLean et al 1999; Noell and Ochs 2001; Clatts et al 2005).

Our findings revealed that systematic or structural factors actually facilitated treatment. Several youth in this study reported that programs such as NA, mentoring programs, and support groups were helpful in their rehabilitation. Encountering the juvenile justice system also was an incentive for one homeless young person to participate in drug treatment, and another youth mentioned that the availability of physical and creative activities were positive alternatives to drug seeking. According to the National Coalition for the Homeless (2006), unsheltered youth benefit most from well-developed social programs organized through outreach and peer support. Consistent with our findings, these programs must meet homeless youths’ immediate needs first, and then subsequently address other issues in their lives (Woods et al 2003; Taylor-Seehafer 2004; Van Leeuwen 2004).

The impact that structural factors had on treatment in our sample is a crucial finding that merits further implementation of systems to enhance access, utilization, and health seeking behavior in homeless youth. From a policy perspective, it would be important to increase programming that utilizes peer advocacy, peer outreach, or other kinds of youth-linked structure. “Reaching out” might be considered required components of all youth-centered programs that promote access to care, as homeless youth tend not to seek help on their own initiative. Reaching out includes not only peer and mentoring support for drug rehabilitation among homeless youth, but support in

gaining access to education, job training, and employment (Tweddle 2007). These could be the very structural systems that reintegrates youth successfully into society.

Organizational policies that make support appealing and entertaining to homeless youth will facilitate their access to care. Innovative initiatives, such as “Vstreet.com” and “Poetry 4 Ya Mind,” are web-based interactive initiatives targeting at-risk youth that have demonstrated promising results in life-skills building and program retention as youth participate in their rehabilitation activities (Pacifi et al 2005). Another policy initiative is to include homeless youths’ perspectives in designing, implementing, and evaluating organizational programs and services (Crowe 2007). Current or former homeless youth can identify the contextual nuances that facilitate their access to care and make it more meaningful to them. Their perspectives on creating welcoming environments would be beneficial, such as playing hip hop music in the clinic waiting area or allowing friends and acquaintances to accompany youth during the clinic visit, if appropriate and desired by the patient, are some examples (Ensign and Panke 2001).

Because there are now considerable subpopulations of homeless and unstably-housed youth (“runaways,” “throwaways,” and “system youth”) at risk for substance abuse, research should be conducted on programs tailored to these homeless youth subgroups, as well as research conducted on programs adhering to and testing youth-based theoretical models (MacLean et al 1999). As this research explored facilitators and barriers to treatment in shelter youth, generalizability of findings to other populations of homeless youth is not recommended. Instead, this is a preliminary start driven by shelter-based and drop-in youth, who provided investigators examples of systems of care that should be in place to facilitate access to accessible, engaging, and supportive drug treatment programs for this population.

## Disclosure

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