

**The Perceived Discrimination of Homeless Individuals Within Healthcare**

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In the United States, there are over 1.5 million homeless individuals per year; likewise, in 2009 it was documented that over 650,000 individuals were homeless on any given night.<sup>1,2</sup> Homelessness characteristically involves having no permanent address or occupancy.<sup>3</sup> Since the cost of living in the United States continues to rise, homelessness is a progressing issue with limited effective interventions. Even though “homelessness” can be temporary, many experience chronic homelessness and are near helpless in their situation.

Various studies have exemplified higher rates of mortality and morbidity within this marginalized population, and specifically, the homeless are more likely to die young between 42 and 52 years of age.<sup>4</sup> Without the same resources as the general population, it is evidently impossible for them to receive the same healthcare benefits. While the general population has financial resources to aid them in overcoming illness, the homeless lack these means. Consequently, rather than severe illnesses, the homeless tend to die from common and treatable conditions. Likewise, within the population common comorbidities include mental illness, physical disparities, and substance abuse.<sup>5</sup> Significant data supports there being more instances of cardiovascular disease and its associated risk factors within the homeless population.<sup>6</sup> When cardiovascular disease goes untreated, there can be fatal consequences. As there are high rates of preventable and curable illnesses, the homeless tend to only seek medical help when their ailments become severe such as bronchitis or the flu.<sup>6</sup>

When one has a medical issue, typically they seek help from medical facilities. However, the homeless tend to not follow this trend. Generally, the attitude of an individual is shaped by their previous experiences.<sup>7</sup> Many homeless individuals feel that they have been discriminated

against and ultimately unwelcome in health care facilities.<sup>7</sup> Specifically, their major concerns are being rushed or even ignored during medical care.<sup>7</sup> There also seems to be a significant hierarchy between the physician and patient which leads to more feelings of discomfort or bias.<sup>7</sup> Due to these presumptions, the homeless are less willing to get healthcare services and may not trust their providers since the care they receive is seemingly unacceptable.<sup>7,8</sup> These conditions can also lead to nonadherence to physician recommendations and an overall poor health of the individual.<sup>8</sup> Further, such actions can be detrimental to their health as it introduces the cycle of chronic illness and needing medical attention, refusing treatment, and thus becoming sicker. In hopes of increasing the health of the homeless population, it is critical to understand that current literature does not address whether the homeless are justified in claiming that they are discriminated within healthcare.

In this paper, the term “discrimination” is used lightly and used to portray that the homeless population overall reports prejudice and unequal treatment within the healthcare system. In this context, it can also be synonymous with marginalization. The homeless population collectively feels marginalized when they sense that their medical conditions are not given the same attention as those of people with greater financial resources. However, discrimination is in the eye of the beholder. If one perceives that others are treating them differently, then they will have a heightened sense of being discriminated against. Further, when one frequently experiences discrimination in different settings, it is more likely that they will start to expect to be discriminated against.

Clearly, the homeless face a multitude of barriers that prevent them from getting medical aid and can further cost them their lives. By evaluating the sociological and psychological barriers that the homeless population faces, it can be determined whether their reports of

discrimination within the healthcare system are legitimate or unwarranted. As demonstrated in this paper, this marginalized population consistently claims to be discriminated against and these accusations are likely the repercussions of the barriers they face. This ultimately can lead to false allegations of discrimination. By extrapolating from these considerations, the opportunities to aid this marginalized population can be explored. My goal is to ultimately propose solutions later in this paper that improve the delivery of healthcare to the United States' homeless population.

### **The Sociological Barriers of the Homeless**

#### *Insurance Considerations*

There are various mental, physical, and financial barriers that prevent homeless individuals from getting medical help when needed. It has been found that having a healthcare insurance plan increases the likelihood of seeking medical assistance when necessary and also being able to maintain overall better health.<sup>4</sup> There are ultimately three options regarding health insurance nationwide: private health insurance plans, Medicaid, and Medicare. Yet, private health insurance plans tend to have significant costs. Even with the Affordable Care Act (ACA) put in place by President Barack Obama, the homeless population still does not necessarily benefit. The main goal of the ACA is to reduce the number of uninsured Americans by offering health insurance at an affordable price.<sup>9</sup> However, the act only applies to private health insurance plans. Generally, individuals have a form of health insurance that covers a majority of their medical costs. However, the homeless population does not have this luxury since the cost of private health insurance per state averages around \$3,000 annually.<sup>10</sup> To many homeless persons, this expense is too significant and not worth the perceived benefits. If one's budget is tight, health insurance is typically not a priority. Without health insurance, the average expense of a

primary care visit is about \$160.<sup>11</sup> From these considerations, it is apparent that private health insurance plans are unrealistic for homeless individuals due to excessive cost.

Medicaid is a government run, state and federal healthcare plan available to low income individuals.<sup>12</sup> There are strict eligibility requirements including a maximum income and the number of individuals per family. Realistically, this plan is extremely difficult to qualify for and is not an option for many low income individuals.<sup>12</sup> However, Medicaid has specific benefits for those who are chronically homeless. Specifically, behavioral health services that target the mentally-ill and substance-abuse populations are offered under Medicaid.<sup>12</sup> There are also third party sources of assistance that homeless individuals can use to apply for Medicaid. However, because the Medicaid application process frequently involves a large amount of documentation and multiple visits to various locations, it can be especially difficult and intimidating for the homeless population.<sup>12</sup>

Medicare is another federal plan put in place to help the needy. Qualifiers for Medicare are those who over the age of 65 or have a disability, which can include a large population. Qualifications do not involve income level and this plan is theoretically available to everyone who meets either one or both of the qualifications.<sup>13</sup> Even though these plans are set in place, they are not necessarily applicable to the homeless population. Many homeless individuals tend to stray away from government officials or facilities due to the fear of getting in trouble.<sup>14</sup> Applying for health insurance is difficult for a homeless individual due to the excessive necessary documentation and the anxiety associated with being linked to the government.

### *Related Fears and Concerns*

Many homeless individuals claim to be afraid of getting medical help. Common fears are related to confidentiality matters, interacting with police officers, and interventions by social services.<sup>14</sup> These are valid fears, as one's life could be severely altered by federal agencies that are linked to the medical services being acquired. Social services can intervene with families, fines can be given, and arrests can be made. To the homeless, sometimes the safest action is to remain unnoticed. There is also typically a fear of discrimination and supplementary shame within healthcare facilities.<sup>14</sup> Discrimination can make an individual feel inhumane and subordinate to others; in addition, it is embarrassing that some can be financially stable while others are not. When one is homeless, it is realistic to have a fear of not having ample resources to be able to pay for medical care and fulfill the recommendations of the health provider.<sup>14</sup> In one study, it was found that 59% of the homeless individuals that were unable to see a doctor, could not do so because they were unable to afford the visit.<sup>4</sup> Other leading causes of not being able to seek effective medical attention were not having transportation or the proper identification documentation needed for the healthcare visit.<sup>4</sup> Lastly, many have claimed that it is frustrating to not be taken seriously.<sup>14</sup> When one is not taken seriously, then they are typically unsatisfied with their experience and possibly even their diagnosis. It is impossible for an individual to feel confident in their health care provider if they perceive that they are being treated as unworthy. Due to lacking sociological supports, the homeless population has far reduced means to seek effective medical care.

### *Cycle of Illness and Non-Treatment*

Illness does not discriminate according to affluence, however, if one does not have the financial means to overcome ailment, it is unlikely that they will recover. Rather than acute care

outpatient clinics, homeless individuals are more likely to be found in emergency departments than those who are not homeless.<sup>1,4</sup> These actions commonly result from the previously stated feelings of shame or embarrassment which prevent individuals from going to outpatient clinics when they have minor issues.<sup>1,4</sup> This is not because the homeless are more severely ill to start, but rather since they fail to get help for acute problems. Without a diagnosis and proper treatment, these individuals are not given the tools to regain health and to overcome more minor illnesses. Thus, their ailments progress until they do not have any choice other than going to the emergency department. Homeless individuals were 7.65 times more likely than the general population to return to emergency departments 30 days after discharge.<sup>15</sup> They were also nearly 11 times more likely to return to emergency departments after one year after being discharged.<sup>15</sup> Therefore, this population is not receiving the care that they need. Even when they receive medical care, they are unable to abide by the recommendations of the doctors to preserve their health post-emergency room visit due to financial limitations. Overall, it can be especially frustrating to the homeless to consistently undergo the cycle of being sick but unable to afford the treatment which can ultimately lead to negative emotions towards healthcare. These negative emotions can persist and eventually evolve into unwarranted feelings of discrimination.

### **The Psychiatric Barriers of the Homeless**

In addition to the sociological barriers that the homeless face, there are also a multitude of psychiatric barriers that can lead to non-legitimate claims of discrimination. This includes psychiatric issues that stem from the homeless experience itself and the fact that the homeless have a higher tendency of being mentally ill. These conditions essentially feedback on themselves which can contribute to higher rates of anxiety. Between 1/3 and 1/4 of the homeless

population suffers from severe mental illness.<sup>16</sup> There are strong correlations between certain mental illnesses and homelessness; specifically, schizophrenic and bipolar patients have higher rates of homelessness than those who are chronically depressed.<sup>16</sup> Schizophrenia is characterized by extreme paranoia that leads to information processing deficits.<sup>17</sup> Delusions and hallucinations are also common to this disorder due to the excessive paranoia and evidently create false experiences within an individual's mind.<sup>18</sup> Further, those who suffer from Schizophrenia can have a poor understanding of external information if they are not properly medicated. Similarly, individuals who are bipolar are characterized by manic and depressive states.<sup>19</sup> Those in the depressive state are more likely to have an overall negative mood and feel hopeless; in addition, they are more likely to worry.<sup>19</sup> Bipolar Disorder is also commonly diagnosed along with anxiety disorders and the combination of the two can lead to excessively delusional thoughts.<sup>19</sup>

Although Schizophrenia and Bipolar Disorder can be managed with medication, medication may not be a realistic possibility for the homeless. Within the homeless population, a cycle of nonadherence and the inability to overcome illness and disease has been found.<sup>1</sup> In one study, over 30% of homeless subjects did not adhere to their prescribed medication; those with psychiatric diseases were found in the pool of individuals who were especially nonadherent.<sup>1</sup> Many times, food and shelter can be a greater priority than medication. When looking at those who needed to be medicated, the aforementioned reason can explain why about half of the population is unable to have this necessity.<sup>1,4</sup> If the homeless individuals with Schizophrenia and Bipolar Disorder are not being properly medicated, their psychiatric symptoms will not improve. Further, they will continue to be delusional, hopeless, and unable to understand the world properly. When combined with the anxiety that the homeless commonly experience, their symptoms can escalate. Frankly, their perception is compromised and the individuals who are

both homeless and mentally ill are not always truly aware of reality.<sup>8</sup> When one is not medicated for their psychological ailments, they are more apt to have skewed views of reality. Thus, they are more likely to have false claims of discrimination.

When looking at the instances of self-reported discrimination, there is a correlation with mental illness. When one is mentally ill, they are more apt to experience and observe stigmas differently. Another element to consider is that the individuals who are homeless and mentally ill face stigmas and connotations associated with both statuses. Consequently, it is unfortunate that the emotional effects that come with discrimination and stigmas regarding mental illness can be worse than those specifically from the disease itself.<sup>8</sup> Ultimately, due to a high prevalence of mental illness and the stresses supplementary to homelessness, the actual perceptions and understanding of the homeless population could be impeded.

Even without the presence of mental illness, the homeless can still have a compromised mental health due to their basic human needs not being satisfied.<sup>20</sup> According to the self-determination theory, when people experience autonomy, relatedness, and competence, they are more easily able to function optimally, have purposeful growth, and establish an overall better wellbeing.<sup>20</sup> These three basic needs - relatedness, autonomy, and competence - are necessary to human flourishing; an individual without them is at a greater risk for ailments of the mind and body.<sup>20</sup> When one cannot feel autonomous in their own life, they feel as though they must rely on others for their own wellbeing. Essentially, this can lead to feelings of being unable to live at one's own discretion. Further, there is a sense of negative reliance and loss of control. Relatedness is necessary since it goes hand in hand with social support.<sup>20</sup> Relatedness can create a sense of community and the understanding that one is not facing life alone. Without relatedness, one can be more apt to have negative feelings associated with anxiety, loneliness,



and sadness due to no personal connections with others. Lastly, if one does not feel competent, they lose their sense of self-efficacy. If one does not feel confident in their abilities to succeed, it is likely that they will not. Thus, when one does not fulfill these basic needs, they cannot thrive and are more apt to have compromised mental states.<sup>20</sup>

Unfortunately, the homeless are in a state of life in which it is difficult to attain these basic needs. Many times, they do not have much choice regarding how they should go about their medical decisions, for they have minimal financial flexibility. If the patient feels as though they are able to change their provider at their discretion, they are more likely to have a better experience. This makes them feel autonomous and gives them the confidence to make their own decisions.<sup>21</sup> In terms of relatedness, by having the choice in health providers, better patient-physician relationships can be made. Financial limitations hinder one's sense of competency as they cannot provide financial support for themselves and others. Thus, those who do not meet these needs go through similar mental states of those with psychological disorders.<sup>20</sup> They can lack purpose, have increased rates of anxiety and negative feelings, and have an overall pessimistic view of the world.<sup>20</sup> Since the homeless can view the world pessimistically, they are more apt to believe that they are being mistreated.

### **The Reports of Discrimination**

By evaluating the specific claims of discrimination from the homeless population, the validity of their accusations can be established. In one study, it was found that about 30% of the subjects felt that they were discriminated against due to their homelessness and poverty level.<sup>8</sup> When one believes that they are being discriminated against, then they are less likely to seek help, have an increased perception of marginalization, and thus have decreased access to

healthcare.<sup>8</sup> Because of these increased perceptions of marginalization, homeless individuals can create their own expectations of the non-homeless population. These assumptions are dangerous because they can enable biases towards those who are not homeless. Unwarranted claims of discrimination in response to homelessness correlates to social status because when individuals feel as though they are being treated badly for their social status, they may feel that others think similarly.<sup>8</sup> This can create an internal sense of hostility since believing that others think negatively of you is detrimental to an individual's self-confidence. Homeless individuals and other marginalized populations also tend to be aware of discrimination against themselves in many settings other than medical facilities which can overall make them more aware of discriminatory cues in all of their interactions with other individuals.<sup>7</sup> If these individuals are aware of others judging them in a plethora of situations, they may begin to naturally assume that they will be judged in all environments.

Within the specific setting of the healthcare system, many homeless individuals feel ignored, rushed, treated disrespectfully, and overall “unwelcome” in medical facilities.<sup>7</sup> However, these actions by physicians can be typical and may not actually be directed towards the homeless patients themselves. When one goes into a medical clinic, it is hoped, and even assumed, that they will be treated in a specific manner. However, since all humans are different, some doctors have a less nurturing character than others. In addition, many homeless claim to be viewed as “freeloaders” however, this thought can be explained by their own anxiety regarding their personal situation.<sup>7</sup>

When examining the homeless' specific claims of discrimination, there were no explicit examples of anecdotal slurs that others had said to them.<sup>7</sup> Instead, what the homeless were explaining seemed to be internal feelings of discomfort and untrue perceptions of discrimination.

When interacting with medical professionals, homeless individuals recognized the emotional difference of being treated with an I-You attitude versus an I-It attitude.<sup>7</sup> The I-You attitude is practiced when one is treated respectfully, equally, and has a say in their healthcare.<sup>7</sup> This experience was not common within the sample of homeless individuals, but it was noted that this is the preferred way to be treated in healthcare.<sup>7</sup> Likewise, the I-It attitude essentially degrades individuals and epitomizes a hierarchy between the doctor and the patient.<sup>7</sup> Further, experiences with the I-It principle lead many to feel dehumanized and a devalued self-worth. As these are specific claims of homeless individuals, it is important to note that such experiences can happen within any population and are not just restricted to the homeless.

When evaluating the views of the medical professionals that specifically interact with homeless individuals, many logical explanations refer to the difficulty of interacting with this population. On the basic educational level, general practitioners have little to no training specific to treating the homeless population.<sup>22</sup> If they do not have sufficient experience in caring for the homeless, their ability to provide effective healthcare is hindered. What seems to be the largest difficulty when treating the homeless is the uncertainty associated with their adherence to medication as well as their truthfulness in describing their situation.<sup>22</sup> If a doctor is unsure of the trustworthiness of their patient, they may be more hesitant to prescribe medicinal treatments. There are significant levels of substance abuse within the homeless population.<sup>5</sup> When one is not truthful regarding their drug history, administering medication becomes dangerous. If a patient is a drug user and untruthful of the drugs that are currently in their system, then there is no knowing if the physician will be administering a fatal dose or not.<sup>23</sup> When dealing with the homeless population, specifically drug users, the chance of an accidental overdose is higher.<sup>23</sup> That is not to say that all homeless individuals are drug users, but rather that the prevalence of

drug use in the homeless population is higher and some individuals may feel uncomfortable discussing their drug use with medical professionals. If they admitted their drug use, which is technically illegal, the individual could face police involvement.<sup>14</sup> Overall, it does not seem as though physicians are discriminating against the homeless; rather, the physicians themselves face a range of barriers when treating this marginalized population that impedes their quality of treatment.

### **What Has Been Done to Aid the Homeless?**

Limited action has been taken to enhance the homeless population's medical experiences. There has been the introduction of homeless-tailored medical facilities in some communities, however, they are limited. These facilities are staffed with nurses, physicians, social workers, and few specialty care physicians.<sup>3</sup> All staff are extremely familiar with working with the homeless population.<sup>21</sup> Likewise, tailored medical facilities are essentially extensions of hospitals or community health clinics that are specifically available to the homeless population.<sup>3</sup> Even though these facilities do not provide emergency services, they give the homeless a safe and reliable place for acute medical care. By having these resources available, disease and illness prevalence will hopefully decrease. Since experience levels are highly affected by patient housing status and whether a facility is tailored to the homeless population, it is critical to address the right components of the problem.<sup>21</sup> When trying to make productive changes to help the homeless, it is unlikely that they will miraculously become housed. However, a more beneficial change is making more homeless-tailored facilities available to a greater population.

Tailored medical programs seem to significantly correlate with positive experiences; verses when in a typical outpatient setting, the homeless were twice as likely to have a negative

experience.<sup>1</sup> However, the act itself of going to a tailored facility as opposed to a non-tailored facility did not affect the general health outcome of that patient; the only outcome affected was the patient's experience.<sup>1</sup> By increasing positive experience rates, the general health of the homeless population may be influenced. This conclusion can be extrapolated because with higher rates of positive experiences with healthcare, homeless individuals are more likely to return to get medical help regularly before their ailments get too significant. Likewise, with a larger number of positive medical experiences, the homeless can eventually have less claims of discrimination in healthcare due to a potential increase in optimism.

Another option for the homeless population is a "fixed outreach program." Such is a health facility in a non-typical location specifically accessible to the homeless. These clinics are ordinarily within easy access of shelters and have late operating hours to make access easier.<sup>3</sup> Such programs are similar to tailored facilities except they are stationed in a variety of locations such as shelters, schools, community centers.<sup>3</sup> These locations are significant to the homeless population because they are more accessible and possibly less intimidating than a typical medical clinic. Care and medication are provided at little to no cost.<sup>3</sup> One benefit to the low cost of medication is that it could potentially increase medication-adherence rates. By giving free care for acute needs, those medical problems are less likely to grow into chronic or severe illnesses. This ultimately decreases emergency care utilization and gives the homeless population a better opportunity to improve their health. As these services are affiliated with major hospitals and public health units, they are well staffed and educationally prepared to interact with the homeless.<sup>3</sup> Even though these facilities have shown great results in providing effective healthcare to the homeless, they are seldom used in the United States. Increasing their availability could have a significant impact on the homeless healthcare needs in our country.

Fixed outreach programs are a great step in improving the health of the homeless since care can be given quickly and at almost no cost to the patient for their acute medical needs.<sup>3</sup> Unfortunately, this opportunity does not seem to be taken advantage of by the homeless as seen by the low return rates.<sup>3</sup> The underlying psychological struggles of the homeless may be the reason to the low rate of returners to the fixed outreach programs. Additionally, it could also be possible that the homeless are especially cautious of medical settings due to a lack of trust for medical professionals and their overwhelming fears.

Similar to fixed outreach programs, there are mobile outreach programs stationed within vehicles that travel to the homeless.<sup>3</sup> Being mobile brings the healthcare to the people instead of asking the homeless to go out of their way and make sacrifices to get medical care. This program essentially targets the convenience of healthcare to the homeless. These programs are another form of non-emergent services given by nurses, physicians, and social workers.<sup>3</sup> Overall, these services are a positive start to aiding the homeless while improving their medical experiences. However, in order to make greater expansions, they will need to be brought to the federal level for adequate funding and support.

### **What Should be Done Next?**

There is great evidence supporting the theory that the discrimination the homeless population experiences within healthcare may be misconceived. However, it is crucial to remember that their claims of discrimination in other settings are likely legitimate. It is due to the various barriers that they face daily that the homeless are more apt to believe that they are being discriminated against. Even though they may not be facing true discrimination within this

setting, there are still many changes that can be made to benefit the homeless' experiences with healthcare.

Generally, the barriers the homeless face should be addressed and improved. There are at least two initiatives for public health policy to address. Since there is a cycle of nonadherence to medication with negative physiological and psychological effects, the prices of medication need to be altered. If medicine becomes more affordable, then the homeless people may be more willing to buy it, thus adherence rates could possibly increase. Legislation should be put in place to make medication more affordable and readily available so that it can be a realistic method of care for the homeless. As a result, the homeless' physical and psychological ailments can be better managed. This can help reduce psychological symptoms such as anxiety and delusional tendencies. Since the psychiatric population is specifically benefited by cheaper medication, then their perceptions of discrimination could decrease.

Second, the experiences of the homeless in healthcare should be revisited. Since the homeless population's experiences were generally more positive in tailored settings and with medical professionals who were well-practiced in caring for this population, such facilities should be created nationwide. As another option, hospitals and government agencies can look into funding outreach programs - both fixed and mobile - that are in locations more available to the homeless. These facilities can improve the homeless' likelihood of getting medical help when needed which will eventually benefit their overall health. Conclusively, these options have shown promise and if we as a country want to have an impact on this population, then things need to be done differently.

There is no one solution to this issue and the list of barriers that the homeless experience should continue to be revisited. It is also possible that even with a solution, there will still be a

number of individuals who will not be helped. The homeless seem to have an underlying mistrust of the healthcare system and also the general population. There may never be a true solution to diminishing their feelings of being discriminated against, but hopefully these occurrences will eventually be minimal. By having a large number of barriers to overcome, I speculate that the homeless feel that the rest of the world does not support them. Due to these feelings, any experiences of hostility from others may lead to an overall negative view on life. When looking at the marginalized homeless population, it should be remembered that all people on the earth have the right to be healthy. Unfortunately, some do not have the means to do so. As Medcalf et. al has previously stated, “perhaps the true measure of greatness in a healthcare system is how it provides health for its weakest citizens.”<sup>5</sup> It should be the goal of the healthcare system to benefit as many lives possible and by targeting the barriers that the homeless population faces, an even greater number of lives can be saved.



## **Bibliography**

1. Kertesz, Stefan G., Cheryl L. Holt, Jocelyn L. Steward, Richard N. Jones, David L. Roth, Erin Stringfellow, Adam J. Gordon, et al. "Comparing Homeless Persons' Care Experiences in Tailored Versus Nontailored Primary Care Programs." *American Journal of Public Health* 103, no. Suppl 2 (December 2013): S331–39.
2. Chong, Mok Thoong, Jason Yamaki, Megan Harwood, Richard d'Assalenaux, Ettie Rosenberg, Okezie Aruoma, and Anupam Bishayee. "Assessing Health Conditions and Medication Use among the Homeless Community in Long Beach, California." *Journal of Research in Pharmacy Practice* 3, no. 2 (2014): 56–61.
3. Shortt, S.E.D., Stephen Hwang, Heather Stuart, Melanie Bedore, Nadia Zurba, and Margaret Darling. "Delivering Primary Care to Homeless Persons: A Policy Analysis Approach to Evaluating the Options." *Healthcare Policy* 4, no. 1 (August 2008): 108–22. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645199/>.
4. Maness, David L., and Muneeza Khan. "Care of the Homeless: An Overview." *American Family Physician* 89, no. 8 (April 15, 2014): 634–40. <https://www.aafp.org/afp/2014/0415/p634.html>.
5. Medcalf, Pippa, and Georgina K. Russell. "Homeless Healthcare: Raising the Standards." *Clinical Medicine* 14, no. 4 (August 1, 2014): 349–53.
6. Winetrobe, H., E. Rice, H. Rhoades, and N. Milburn. "Health Insurance Coverage and Healthcare Utilization among Homeless Young Adults in Venice, CA." *Journal of Public Health* 38, no. 1 (March 2016): 147–55.
7. Wen, Chuck K., Pamela L. Hudak, and Stephen W. Hwang. "Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters." *Journal of General Internal Medicine; New York* 22, no. 7 (July 2007): 1011–17.
8. Skosireva, Anna, Patricia O'Campo, Suzanne Zerger, Catharine Chambers, Susan Gapka, and Vicky Stergiopoulos. "Different Faces of Discrimination: Perceived Discrimination among Homeless Adults with Mental Illness in Healthcare Settings." *BMC Health Services Research* 14 (September 7, 2014).
9. Sofija Rak, and Janis Coffin. "Affordable Care Act." Research Gate, 2013. [https://www.researchgate.net/profile/Janis\\_Coffin/publication/239943452\\_Affordable\\_Care\\_Act/links/589b619a92851c942ddad86a/Affordable-Care-Act.pdf](https://www.researchgate.net/profile/Janis_Coffin/publication/239943452_Affordable_Care_Act/links/589b619a92851c942ddad86a/Affordable-Care-Act.pdf).
10. "Average Cost Of Health Insurance (2018)." ValuePenguin. Accessed October 22, 2018. <https://www.valuepenguin.com/average-cost-of-health-insurance>.
11. Benham, Barbara, and JH Bloomberg School of Public Health. "Primary Care Visits Available to Most Uninsured But at a High Price." Johns Hopkins Bloomberg School of Public Health. Accessed October 22, 2018. <https://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html>.
12. Evaluation (ASPE), Assistant Secretary for Planning and. "How to Use Medicaid to Assist Homeless Persons." Text. HHS.gov, September 26, 2007. <https://www.hhs.gov/programs/social-services/homelessness/research/how-to-use-medicaid-to-assist-homeless-persons/index.html>.
13. Division (DCD), Digital Communications. "What Is the Difference between Medicare and Medicaid?" Text. HHS.gov, June 7, 2015. <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html>.

14. Feldmann, Jennifer, and Amy B. Middleman. "Homeless Adolescents: Common Clinical Concerns." *Seminars in Pediatric Infectious Diseases* 14, no. 1 (January 1, 2003): 6–11.
15. Amato, Stas, Flavia Nobay, David Petty Amato, Beau Abar, and David Adler. "Sick and Unsheltered: Homelessness as a Major Risk Factor for Emergency Care Utilization." *The American Journal of Emergency Medicine*, June 2, 2018.
16. Folsom, David P., William Hawthorne, Laurie Lindamer, Todd Gilmer, Anne Bailey, Shahrokh Golshan, Piedad Garcia, Jürgen Unützer, Richard Hough, and Dilip V. Jeste. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients With Serious Mental Illness in a Large Public Mental Health System." *American Journal of Psychiatry* 162, no. 2 (February 1, 2005): 370–76.
17. Tam, Wai-Cheong Carl, Kenneth Sewell, and Hwei-Chuang Deng. "Information Processing in Schizophrenia and Bipolar Disorder: A Discriminant Analysis | Ovid." *Williams and Wilkins 1998* 186, no. 10: 597–603. Accessed October 22, 2018. <https://oce.ovid.com/article/00005053-199810000-00002>.
18. "NIMH » Schizophrenia." Accessed October 22, 2018. <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>.
19. "NIMH » Bipolar Disorder." Accessed October 22, 2018. <https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml>.
20. Ryan, Richard M., and Edward L. Deci. "Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being." *American Psychologist, Positive Psychology*, 55, no. 1 (January 2000): 68–78.
21. Chrystal, Joya G., Dawn L. Glover, Alexander S. Young, Fiona Whelan, Erika L. Austin, Nancy K. Johnson, David E. Pollio, et al. "Experience of Primary Care among Homeless Individuals with Mental Health Conditions." *PLoS ONE* 10, no. 2 (February 6, 2015).
22. Lester, Helen, and Colin P Bradley. "Barriers to Primary Healthcare for the Homeless: The General Practitioner's Perspective." *European Journal of General Practice* 7, no. 1 (January 2001): 6–12.
23. McNeil, Ryan, and Manal Guirguis-Younger. "Illicit Drug Use as a Challenge to the Delivery of End-of-Life Care Services to Homeless Persons: Perceptions of Health and Social Services Professionals." *Palliative Medicine; London* 26, no. 4 (June 2012): 350–59.