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Entrepreneurial development for U.S. minority homeless and unstably housed youth: A qualitative inquiry on value, barriers, and impact on health

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ABSTRACT

Background: Homeless and unstably housed youth in the U.S. have high rates of unemployment and often rely on survival strategies that negatively impact their economic, emotional, and physical health. While integrated health and entrepreneurial development initiatives targeting the poor have been successfully implemented in developing countries, little is known regarding interests in similar initiatives among vulnerable U.S. youth, particularly racial minorities who are disproportionately impacted by poverty and homelessness. This study examined African-American homeless and unstably housed youth's interests in entrepreneurial development programming to enhance economic self-sufficiency and health-related outcomes.

Methods: Qualitative methods using nine focus groups and one in-depth interview were conducted from December 2013 to March 2014 with 52 purposively-selected youth, aged 15 to 24, who had experienced homelessness within the prior 18 months in Baltimore, Maryland and Washington, D.C. An emergent, open-ended topic guide was used to examine reasons why youth may want to participate in entrepreneurial development initiatives, what barriers they anticipated in becoming an entrepreneur, and how engaging in entrepreneurial and other economic empowerment activities might impact their physical and emotional well-being. All focus groups and interviews were recorded, transcribed, and analyzed.

Results: The majority of youth were unemployed in the formal sector, but actively engaged in income generating activities in the informal sector. Four themes related to youth's interest in entrepreneurial development initiatives: the perceived inadequacy of traditional income and educational pathways, wanting to be one's own boss, desires for alternatives to joblessness and illicit income risks, and interests in building on current entrepreneurial activities. Commonly perceived barriers were lack of business mentors and opportunities, not knowing "what was possible", difficulty in changing prior mindsets, and anticipated negative reactions from peers. Youth envisioned entrepreneurial development activities would inspire a range of health protective behaviors by minimizing poverty-related depression, hopelessness, and anxiety.

Conclusion: This study underscores the need to address the intersection of poverty and health outcomes. Integrated health and entrepreneurial development programs should target low-income U.S. minority youth, particularly those with the greatest housing, health, and economic needs. More research is needed in understanding the behavioral dynamics between economic empowerment and health risk reduction among disadvantaged youth.

1. Introduction

An estimated 1.7 million youth under the age of 18 experience homelessness each year in the United States (U.S.) (United States Department of Health and Human Services (DHHS), 2005; Levin-Epstein & Greenberg, 2003), and an additional 450,000 single young adults, aged 18 to 24 report being homeless and unstably housed (Runaway & Homeless Youth Act-Policy Brief, 2014). Research suggests that unemployment rates among homeless youth range from 66 to 75%, with an average of eight months of joblessness each year (Baron & Hartnagel, 1997; Ferguson, 2013; Ferguson, Bender, Thompson, Maccio, & Pollio, 2011). Recurring joblessness and income insecurity can result in detrimental effects on youth's physical and emotional well-being (Barman-Adhikari & Rice, 2014; Ferguson, 2013; Levin-Epstein & Greenberg, 2003). Integrated health and entrepreneurial development initiatives have been widely used in developing

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countries to address poverty-related health disparities (Agbenyiga & Ahmedani, 2008; Dunbar et al., 2010; Hamad & Fernald, 2012; Kim et al., 2009; Mohindra, Haddad, & Narayana, 2008; Norwood, 2011; Odek et al., 2009; Odutolu, Adedimeji, Odutolu, Baruwa, & Olatidoye, 2003; Pronyk et al., 2008; Rosenberg, Seavey, Jules, & Kershaw, 2011; Schuler, Hashemi, & Riley, 1997; Sherman et al., 2010). Such programs aim to improve the financial well-being of the poor by providing business education, small-scale financial investments, and technical support (Cui, Lee, Thirumurthy, Muessig, & Tucker, 2013; Prather et al., 2012). In the context of public health, entrepreneurial development initiatives also endeavor to reduce poverty-related morbidity and mortality by empowering the poor to make economic decisions that affect health and well-being (Dunbar et al., 2010; Hamad & Fernald, 2012; Kim et al., 2009; Mohindra et al., 2008; Norwood, 2011; Odek et al., 2009; Odutolu et al., 2003; Pronyk et al., 2008; Rosenberg et al., 2011; Schuler et al., 1997; Sherman et al., 2010). However, these interventions are under-developed in the U.S. public health sector (Jennings, 2014). Few strategies to-date have targeted homeless American youth disproportionately impacted by adverse health and economic outcomes, particularly racial minority youth who have higher rates of poverty and homelessness (Ferguson, 2013; Ferguson & Islam, 2008; Ferguson & Xie, 2008).

Homeless youth are typically defined as unaccompanied individuals aged 12 to 24 who are living apart from parents or guardians and who lack a fixed and adequate nighttime residence, including those living on the streets, in shelters, or in transitional houses (Astone & Pologe, 2011; Fernandes-Alcantara, 2013). While the pathways to homelessness vary, youth often become homeless as a result of running away from abusive living situations, being kicked out by family, “aging-out” of foster placements, or being discharged from detention facilities (Runaway & Homeless Youth Act-Policy Brief, 2014; Altena, Brilleslijper-Kater, & Wolf, 2010; National Coalition on Homelessness (NCH) (NCH), 2007; Halcon & Lifson, 2004). They may also experience high rates of residential instability as a result of non-street-based homelessness due to couch-surfing and brief departures from their families (Milburn et al., 2012; Perez & Romo, 2011; Tevendale, Comulada, & Lightfoot, 2011). As a result, compared to housed peers, homeless or unstably housed young people often have higher rates of mental illness (Solorio, Milburn, Andersen, Trifskin, & Rodriguez, 2006; Whitbeck, Hoyt, & Yoder, 1999), sexually transmitted disease (Bolvin, Roy, Haley, & Galbaud du Fort, 2005; Marshall et al., 2009; Rew, Grady, & Dunman, 2008; Roy et al., 2011; Tyler, Whitbeck, Chen, & Johnson, 2007), and drug addiction (McMorris, Tyler, Whitbeck, & Hoyt, 2002; Rice, Milburn, Rotheram-Borus, Mallett, & Rosenthal, 2005) which can further hinder their employability and job retention. In the absence of formal employment, many homeless youth also rely on illicit sources of income (prostitution, selling drugs, stealing, or panhandling) as a means of survival (Ferguson, 2013; Ferguson, Bender, Thompson, Xie, & Pollio, 2011; Gwadz et al., 2009; Hein, 2011; Sedlak, Schultz, Wiener, & Cohen, 1997). Such survival behaviors can increase youth's risk of recurring homelessness and negatively impact their health and social development (Ferguson, 2013; Gwadz et al., 2009). Several homeless youth agencies offer workforce development programs for individuals through the age of 24 (United States Department of Health and Human Services (DHHS), 2005). However, research suggests that homeless and unstably housed youth are less likely than non-homeless young people to utilize employment services (Barman-Adhikari & Rice, 2014; Hook & Courtney, 2011). Those who do acquire formal employment are often confined to low-paying labor markets that are increasingly viewed as inadequate to reduce homelessness and income scarcity (Gaetz & O'Grady, 2002; Gwadz et al., 2009).

Given the negative effects of poverty on youth's physical and social well-being, there is increasing political priority to develop new strategies to address the economic needs of homeless youth, including the additional 5.2 million disconnected youth in the U.S., aged 16 to 24, who are currently out of school and out of work (Levin-Epstein & Greenberg, 2003). In spite of high unemployment in the formal sector, homeless and disconnected youth are often actively engaged in earning income in the informal sector. One strategy may be to cultivate youth's entrepreneurial skills applied currently in street economies (selling handmade goods and services) towards positive youth development and economic self-sufficiency through small-scale entrepreneurial development interventions. According to asset theory, the process of asset generation for poor youth may deter delinquent behaviors (Bantchevska, Bartle-Haring, Dashora, Glebova, & Slesnick, 2008; Brownfield, Thompson, & Sorenson, 1997; Chapple, McQuillan, & Berdahl, 2005; Gwadz et al., 2009) by motivating future-oriented, protective attitudes to avoid negative health and social consequences (Sherraden, 1990; Ssewamala, Alicea, Bannon, & Ismayilova, 2008; Stratford, Mizuno, Williams, Courtenay-Quirk, & O'Leary, 2008; Yadama & Sherraden, 1995). Increased assets may enhance youth's ability to negotiate healthy choices, and minimize economic constraints and stressors that lead to risky behaviors, including time spent in high-risk survival activities (Dworkin & Blankenship, 2009; Stratford et al., 2008). Acquiring new business skills and assets may also enhance vulnerable youth's employability and income potential, and in turn, improve health outcomes (Ferguson, Bender, Thompson, Xie, & Pollio, 2011; Liang & Dunn, 2002; Palmer & Strayhorn, 2008). In addition, studies indicate that economic-strengthening interventions among poor youth may mitigate the psychological effects of poverty, such as loss of hope and limited future aspirations which can serve as a significant motivator of risk-taking (Barnett, 2007; Campbell, 2003; Kim et al., 2008; Lewis, 1975).

Yet, little is known regarding homeless and unstably housed youth's interests in entrepreneurial development interventions to improve economic and health-related outcomes, particularly among U.S. racial and ethnic minorities living in high-poverty urban settings. To address this gap, we examined homeless U.S. minority youth's perceptions on participating in entrepreneurial development programs to enhance financial self-sufficiency. We also explored youth's perceptions on the potential effects of such interventions on their physical and emotional health. Findings from the study will be used to inform the design of an integrated health and entrepreneurial development intervention for this population.

2. Methods

2.1. Study design

A qualitative study was conducted using focus group discussions with homeless and unstably-housed youth in two urban areas with high levels of homelessness and concentrated poverty in the cities of Baltimore, Maryland (MD) and Washington, District of Columbia (D.C.).

2.2. Sample recruitment

All study participants were purposively selected in collaboration with two community-based organizations (CBOs) serving homeless and unstably housed youth in the two cities. The CBOs provided emergency and supportive residential services, psychosocial counseling, and health education to marginally housed youth. To be eligible to participate, youth had to be aged 15 to 24, affiliated with one of the two participating CBOs, have experienced homelessness or unstable housing within 18 months prior to the study, and have provided oral informed consent/assent. The term “youth” referred to both enrolled minors aged 15 to 17 and young adults aged 18 to 24. Homeless and unstably housed youth were defined as any unaccompanied individual, aged 15 to 24, who lacked a regular or adequate nighttime residence and who was living primarily on their own, apart from parents or guardians. This likewise comprised of youth who were currently living in an emergency or transitional shelter and those who had lived in any place not ordinarily used for residence (hotel, street, vehicle), including living with a friend, relative or partner due to hardship during the last 18