

Chapter 14

# **HOMELESSNESS: PREVENTION AND SERVICES**

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# HOMELESSNESS: PREVENTION AND SERVICES

## Introduction

The traditional stereotype of the homeless person—that of the white, older, skid-row alcoholic—no longer describes the “typical” homeless person. During the last 10 to 15 years, the characteristics of the homeless have changed. Today, the homeless are younger, include a larger portion of women, and include more people who suffer from mental disorders (59). Perhaps the most alarming change in the homeless population in recent years has been the dramatic rise in the numbers of homeless families with children.

This chapter focuses on the problems and service needs of homeless adolescents and on the services available to address the needs of these individuals. First, it discusses the causes of homelessness for adolescents and the problems and service needs of homeless adolescents. Then it presents information on Federal programs and the recent legislative history of congressional efforts to address the homelessness crisis. The chapter ends with a discussion of conclusions and policy implications pertaining to homelessness among adolescents.

Nobody really knows how many children and adolescents are homeless, either living in homeless families or on their own. The U.S. Department of Health and Human Services (DHHS) estimated in 1984 (on the basis of 1976 data) that there are as many as 1 million homeless and runaway adolescents each year (71), and in the absence of more recent national data, this estimate continues to be used (71). Efforts were made by the U.S. Bureau of the Census to count homeless people in the 1990 census, but even those efforts are unlikely to result in an accurate count of the number of homeless and runaway adolescents.

## Background on Hopelessness Among Adolescents

As suggested above, some adolescents become homeless with their families and others become



Photo credit: Sasha Bruce Youthworks Inc.

**Homeless adolescents can be homeless on their own or with their families. Children in some States may be removed from families that are homeless on the grounds of abuse or neglect, because being unable to provide a home may be perceived to be evidence of neglect.**

homeless on their own. The etiology of homelessness among these two groups of adolescents and the service needs of adolescents in the two groups are somewhat different.

## *Causes of Hopelessness Among Adolescents*

### Hopelessness for Adolescents in Families

Adolescents who become homeless with their families become homeless because of situations that

<sup>1</sup>As discussed below, definitions used for “runaway” and “homeless” adolescents vary. Generally, homelessness denotes a long-term situation, while “runaway” is used to characterize those adolescents who have left home overnight without permission. In fact, the population is a dynamic one. In addition, both runaway and homeless populations include adolescents who have been asked or ordered to leave home and have nowhere else to live (so-called “throwaway” or “throwaways.”)

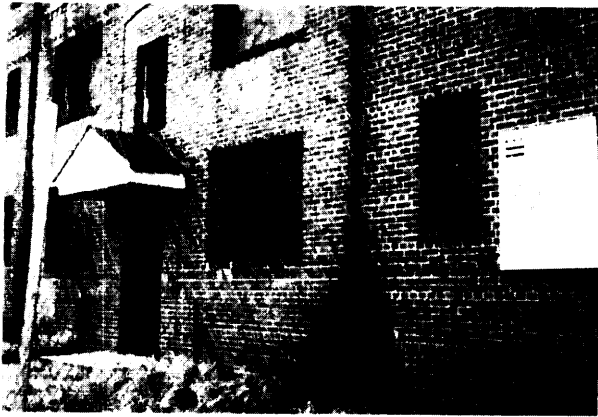


Photo credit: Office of Technology Assessment

The decreasing availability of safe, affordable, accessible low-income housing in this country is believed to have contributed substantially to the increase in the numbers of homeless families.

affect their family as a whole. Various events can precipitate hopelessness for families, just as they can for individuals or couples.

Broad social and economic developments leading to hopelessness include inflation and unemployment coupled with reductions in funding of social and human service programs (59). Furthermore, the availability of low-income housing has generally decreased as a consequence of factors such as gentrification of inner cities (77).<sup>2</sup> The specific incidents precipitating hopelessness for a family are as varied as eviction from housing, estrangement from family members, criminal victimization, illness, loss of employment, and disaster (e.g., fire).

Once an adolescent's family becomes homeless, shelter rules and restrictions may result in the adolescent's separation from his or her family. Some communities lack family shelters, and as a result, families may have to separate in order to receive shelter. Another problem that arises is that some shelters do not allow adolescent males to enter with their mothers (15,66).

Young adolescents whose families are homeless may sometimes be placed in foster care.<sup>3</sup> In some cases, the placement of a child from a homeless family in foster care is the parent's choice, and in others it is the result of the intervention of child welfare authorities. A parent may choose to place children in foster care temporarily, believing that the children will be better provided for in foster care while the parent gets back on his or her feet. Guidelines recently developed by the National Association of Public Child Welfare Administrators discourage child welfare intervention in cases where, in the absence of other apparent abuse or neglect, parents are unable to support their children adequately despite the use of all available resources, such as in the case of hopelessness (76). The States of California, Texas, and Maryland all prohibit child welfare intervention on the basis of hopelessness alone (76). Still, children in some States may be removed from families that are homeless on the grounds of abuse or neglect—because being unable to provide a home may be perceived to be evidence of neglect. In New Jersey in 1986, 18 percent of the children in foster care (ages not specified) were in foster homes because their families could not find a place to live (24). Hopelessness was the primary or secondary reason for foster care placement for 40 percent of the children in foster care in New Jersey.

The removal of children from the custody of their parent or parents may result in the loss of eligibility for welfare benefits under Aid to Families With Dependent Children (AFDC),<sup>4</sup> further reducing the parents' ability to secure housing. Furthermore, the parents may not be allowed to regain custody of the children until they demonstrate that they have obtained adequate housing. Thus, it may be extremely difficult for a parent to regain custody of a child who has been placed in foster care, even in cases where there has been no evidence of parental abuse or neglect. Visits to see children also become difficult for parents who are moving from shelter to shelter, and the reduced contact between parents and children may further erode family relationships (76).

<sup>2</sup>*Gentrification* refers to the "back to the city" movement by middle- and upper-class suburbanites that began in the 1970s. This has resulted in the conversion of many low-income dwellings to more expensive housing (e.g., condominiums) no longer affordable to their former tenants. A particularly harmful cost of this movement for the poor has been the dramatic decrease in single-room occupancy hotel rooms; nearly half of the Nation's total stock has disappeared since the early 1970s (27).

<sup>3</sup>For more information about foster care, see ch. 3, "Parents and Families' Influence on Adolescent Health," in this volume.

<sup>4</sup>The AFDC program is a program established under the Social Security Act that provides cash welfare payments to families with dependent children who have been deprived of parental support or care as a result of the death, incapacitation, unemployment, or continued absence of a parent and who meet income and resource criteria specified by the State. It is administered by the Family Support Administration of DHHS.

Recently, Title V, Subtitle B, Section 553 (Assistance To Promote Family Unification) of the Cranston-Gonzalez National Affordable Housing Act of 1990 (Public Law 101-625) authorized an additional \$35 million for each of fiscal years 1991 and 1992 to provide housing assistance for certain families in order to avert childrens' hopelessness and subsequent placement in foster care. The families affected by this provision of Public Law 101-625 would be those: 1) who are eligible for assistance under Section 8 of the United States Housing Act of 1937 and 2) whom the public child welfare agency for a jurisdiction has certified is a family for whom the lack of adequate housing is a primary factor in the imminent placement of the familys child or children in out-of-home care or the delayed discharge of a child or children to the family from out-of-home care. Allocations from the fund are to be made on the basis of a jurisdiction's demonstrated need.

### Hopelessness for Adolescents on Their Own

Definitions used for 'runaway' and 'homeless' adolescents vary. The National Network of Runaway and Youth Services differentiates among the following categories: 1) *runaways*, young people who are away from home at least overnight without the permission of a parent or caretaker; 2) *homeless youth*, youth who have no parental, substitute foster, or institutional home and who in some cases may have left (or been urged to leave) with the full knowledge or approval of a legal guardian; and 3) *street kids*, long-term runaway or homeless youth who have become adept at fending for themselves "on the street," usually by illegal activities (41).<sup>5</sup>

Homeless adolescents and street kids who have been forced out of their homes when they are no longer wanted by their families are sometimes called "throwaways," "thrownaways," or "pushouts." A recent report by the U.S. Department of Justice differentiated between: 1) *runaways*, children who leave home without permission and stay away overnight; and 2) *thrownaways*, children who have been told to leave the household, children who have

been abandoned or deserted, and children who run away and whose caretaker does not allow them to return, makes no effort to recover them, or does not care whether they return (74).

In fact, the population of homeless and runaway adolescents is a dynamic one, with at least some homeless adolescents having histories of being runaways and at least some runaway adolescents being just a step away from being more permanently homeless themselves. As a practical matter, therefore, the distinctions between homeless adolescents on their own and runaway adolescents are sometimes arbitrary. Furthermore, both groups are served through the same service system—namely, runaway and homeless youth centers, many of which are funded in part by the Federal Government.<sup>6</sup> Much of the information in this chapter on homeless adolescents on their own has been gathered from adolescents using runaway and homeless youth centers. Unless otherwise specified, when data on homeless adolescents are reported, this chapter does not make distinctions between adolescents who might be identified as runaways and those who are truly homeless and living on their own.

Adolescents become runaways or homeless on their own for many reasons. Very few report leaving home to have fun or to travel (33,71). Adolescents frequently run away from dysfunctional and abusive families (43,54,57,58,72,74).<sup>7</sup> Evidence suggests that the majority of these homeless adolescents have histories of being physically or sexually abused (31,33,42,57). Not surprisingly, conflict with family members is often cited as a primary reason for leaving home (2,66,72). Nearly two-thirds of the young people seen at federally funded runaway and homeless youth shelters cite a conflict with parents as their main reason for leaving home (30,66). For some homosexual or bisexual adolescents, family conflicts over their sexual orientation precipitate their running away (33,56). High rates of parental alcohol abuse have also been reported for families of homeless adolescents on their own, contributing to

<sup>5</sup>Although the term 'youth' is commonly used when discussing adolescent hopelessness, OTA prefers the term 'adolescent. The term Youth implies a broader undefined age range than the term adolescent and may include children younger than adolescents ages 10 through 18, as well as young adults. In this chapter, OTA uses the term adolescent except in those cases where youth is part of the actual name of a piece of legislation (e.g., Homeless and Runaway Youth Act), the actual name of a service organization or provider (e.g., homeless and runaway youth centers), or part of a definition provided by an organization or in legislation to describe a particular population (e.g., the definition of homeless youth provided by the National Network of Runaway and Youth Services).

<sup>6</sup>Federally funded runaway and homeless youth centers are locally controlled facilities that receive Federal funds under the Federal Runaway and Homeless Act to provide emergency shelter and other services to runaway or otherwise homeless youth.

<sup>7</sup>For further discussion of dysfunctional families, see ch. 3, "Parents and Families' Influence on Adolescent Health," in this volume.

family violence and conflict (47,51,57). Most runaways and homeless adolescents on their own come from single-parent or 'reconstituted' families (43).<sup>8</sup> A study of 536 homeless and runaway adolescents in New Jersey found that only 14 percent had left homes where both their biological parents resided (58).

In a sample of 118 adolescents entering runaway shelters during a 2-week period in New York City, Shaffer and Caton reported that unaccompanied homeless adolescents tend to have parents who are not homeless (57). It will be interesting to see if the number of unaccompanied homeless adolescents with homeless parents increases as the number of homeless families in general rises.

Adolescents leaving foster care or institutional settings (e.g., State psychiatric hospitals or juvenile justice facilities) may become homeless if proper discharge planning, including followup, is not performed, or if adolescents are placed in out-of-home settings that are inappropriate to their needs (1,39, 59,76). Adolescents leaving foster care or mental health institutions may have no place to live after they are no longer eligible for these residentially based services (15,39,59). About 10 percent of adolescents receiving ongoing services from runaway and homeless youth centers had spent most of the time during the previous year in an institutional setting (72).

In their study of adolescents entering runaway shelters in New York City, Shaffer and Caton found that half of 118 young people interviewed in shelters serving runaway and homeless adolescents had spent some time in foster care; a fifth had most recently lived in an institutional setting (57). Those with a history of foster care placement had more transient residential histories in general than adolescents who had not been in the foster care system.

In a study of 93 homeless adolescents in various settings in the Hollywood, California area (e.g., shelters, soup kitchens, and informal congregate sites such as street corners), Robertson found that substantial percentages of homeless adolescents had been in various institutional settings previously—including foster care (40.9 percent), group homes (38.2 percent), and juvenile detention or jail (55.9

percent) (47). About a third of these adolescents, Robertson found, had gone to a shelter or the streets after their most recent separation from an institutional setting. Many of these adolescents (all of whom were ages 12 to 17) had simply runaway from their last placement; others had been discharged to the custody of their parents, but returned to the streets after a fight or by mutual agreement (48).

Another recent study of young adults who had been out of foster care for at least 2 years also reported that one-third had spent their first night after discharge on the streets; 29 percent had experienced periods of hopelessness since leaving the system at age 18 (76).

### ***Service Needs of Homeless Adolescents***

Homeless adolescents have a wide range of service needs. The problems and service needs of homeless adolescents living with their families differ in some ways from the problems and needs of adolescents homeless on their own.

### **Homeless Adolescents in Families**

How Many of the Homeless Are Families With Children?—Most of what is known about homeless adolescents in families has come from surveys of families in shelters. Virtually nothing is known about homeless families who survive living in vacant buildings, their cars, or temporarily 'doubled up' with friends or relatives.<sup>9</sup> Cities surveyed by the U.S. Conference of Mayors in 1987 reported that an average of one-third of their homeless populations were families with children. Some cities surveyed (e.g., New York) reported that homeless families with children made up nearly two-thirds of their homeless population (63). The vast majority (over 70 percent) of the cities surveyed reported that homeless families were the largest group for whom emergency shelter and other needed services were most lacking.

There is a broad consensus that the numbers of homeless families are growing, and that children (including adolescents) may be the fastest growing group of homeless people. The U.S. Conference of Mayors, in its 1986 survey of 25 cities, reported that the most significant change in the homeless population during 1986 was the growing number of

<sup>8</sup> 'Reconstituted' families are typically those in which a child lives with two adults who function as the child's parents, only one of whom is a biological parent (e.g., stepfamilies).

<sup>9</sup> The U.S. General Accounting Office estimated that 186,000 children and adolescents lived in "shared housing" at any given time during 1987 (65).

families with children; 80 percent of the cities surveyed reported an increase in the number of homeless families 'with children (62). The 1987 survey of cities by the U.S. Conference of Mayors reported that the numbers of homeless families and children were continuing to increase (64). On average, the number of homeless families with children had increased by one-third during the previous year (Charleston, South Carolina, reported an increase of 144 percent). It must be noted, however, that these figures do not reflect actual counts by the U.S. Bureau of the Census. During the 1990 census, new efforts were made to include homeless persons in the census count by surveying shelters and observing individuals in places where homeless people tend to congregate (e.g., under bridges, in parks). The findings based on this one-night count may provide some important information on the numbers of homeless families (and adolescents). Given the many methodological problems involved in counting homeless persons and the many "hidden" homeless who may not be observed by census interviewers, however, it is unlikely that the 1990 effort will produce a truly accurate assessment of the numbers of homeless families with adolescents.<sup>10</sup>

**How Many Homeless Families Include Adolescents?**—Data on the numbers of homeless adolescents ages 10 to 18 who are living with their families are not available. Estimates of the numbers of homeless children in families vary. Available literature, which is based exclusively on studies of families staying in shelters, suggests that homeless families typically consist of women on their own (usually single) with their young children—usually under the age of 5 (7,8,9,10,25,37,63). To OTA's knowledge, there are no studies that look exclusively at adolescents living with their families in shelters. There are studies that *include* adolescents ages 10 to 18, but these studies do not examine adolescents separately. The story of one adolescent who lived with his family in a homeless shelter is recounted in box 14-A.

A 1989 U.S. General Accounting Office (GAO) report estimated that, on any given night, there are 68,000 children and adolescents age 16 and under who are members of homeless families (65). Of those 68,000, an estimated 12 percent (8,160 adolescents) are ages 13 through 16 and an estimated 36 percent (24,480 children and adolescents) are ages 6 through 12.

Other studies, although using somewhat different age breakdowns, have found results roughly consistent with the GAO study. Two studies reporting age breakdowns of children living with their families in shelters found that fewer than 10 percent of one study sample were ages 12 to 16 (8), and that 26.6 percent of another sample of sheltered children were ages 11 to 17 (37). A study of homeless adolescents using meal programs in Alameda County, California found that 17 percent of children in recently homeless families were ages 13 to 17 (50). Differences in the percentages of children who are adolescents in any given shelter probably depend on a number of factors, including shelter regulations that restrict the sheltering of older children and the composition of the local homeless population.

**Service Needs of Homeless Adolescents in Families**—The limited research that has been conducted on children (including adolescents) who are homeless in families indicates that these children experience a broad range of problems, including physical and mental health problems and school problems (3,39,41a). Some of these problems and the service needs of these children are discussed below.<sup>11</sup>

*Physical Health-studies* indicate that homeless children are at higher risk for virtually all medical disorders experienced by children in general (37,39, 41a,77). They are particularly vulnerable to ailments that result from environmental exposure and unsanitary living conditions, including problems such as upper respiratory and ear infections, gastrointestinal problems, lice infestations, burns and trauma (37,41a, 77). They also experience high rates of dental problems.<sup>12</sup> Data from the 19 Health Care for the Homeless projects funded by the Robert Wood

<sup>10</sup>In the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (Public Law 101-645, sec. 402), Congress requested the U.S. Government Accounting Office to study the methodology and procedures used by the Bureau of the Census in their count of homeless people.

<sup>11</sup>Here and in the remainder of the discussion that follows, the term "children" is used to refer to children up to the age of 18 unless otherwise specified. Data sources generally do not break out adolescents ages 10 to 18; consequently, it is often not possible to describe their needs specifically.

<sup>12</sup>For a general discussion of dental problems experienced by low-income adolescents, see ch. 8, "Dental and Oral Health Problems: Prevention and Services," in this volume.

**Box 14-A—A 13-Year-Old's Recollection of Life in a Homeless Shelter**

My mother and my four brothers and sisters and I spent 21/2 years in the shelter. We moved there when I was 11 because my mother wanted to keep the family together, and not send us all to separate foster homes. Our old one room house that we were renting was condemned. It shouldn't have been lived in or rented; it had a cracked window that kept it cold during the winter. My little brother caught pneumonia and was in the hospital for 2 months and almost died. Our social worker said that we must move out and go to a shelter, or she would put us all in a foster home--my mother did not want to separate us, so we decided to move to a shelter.

Life in the shelter was very hard to get used to. When we first got there, we had to stand in line outside in the cold to eat. We couldn't have visitors; not even relatives could come to the room to see us. There were times when there were mice and rats in our room. Sometimes we didn't have any heat and in the summer you couldn't open the windows to get air when the air conditioners broke down. I had to get up really early, because I had to take three buses so I could get to school. At school some of the kids would make fun of me about living in the shelter, but I would just ignore them. The food at the shelter tasted like plastic or paper cardboard. We saw the cooks stealing food that we were supposed to eat. People were getting sick from the food that we got at the cafeteria. There were no doctors to look after those who were sick. People were breaking into rooms when no one was in them. There were security guards there, but they were often as afraid as we were. One security guard shot himself. Drugs started to take over some of the people, and they would blame their children outside why they were doing drugs. I once saw some people come and throw a man off a balcony, because he owed them money. There was a lot of shooting and even children dying. One man who was shooting someone at the shelter almost hit a baby.

Soon after all of this stuff we got a doctor to come and be on the property, we got new guards to work there, and even the food got better. They made it so that the people ate food by sections so there wouldn't be too long of a line to stand in. People started to come and go when they wanted so that they didn't feel like prisoners. We could even have visitors. My mother got a chance to get a trade as a carpenter. She and some other parents started a children's watch so that all of the children would be in their rooms at a certain time. The best part of the shelter was that there were always kids to play with. Only families were allowed to stay at the shelter. A photographer came to the shelter to teach photography and my mom said it would be a good idea to go, even though I didn't really want to. Now I take lots of pictures, and some have even been published in *Life Magazine* and *The Washington Post*.

There were people who only stayed in the shelter for a little while, but some stay forever. Luckily we finally got out and now we live in our own home and we are doing very well. Thanks to the shelter we had some place to go and we were all able to stay together as a family.

Johnson Foundation and the Pew Memorial Trust (39) indicate that children who are homeless experience chronic health problems at about twice the rate reported in the National Ambulatory Medical Care Survey<sup>13</sup> for children in general (77). Inadequate facilities for daily hygiene increase risk of disease and make it nearly impossible to follow prescribed medical regimens. Living in close quarters, particularly in communal shelters, can increase the risk of disease transmission (26).

Children who are homeless have been found to experience nutritional deficits, such as iron deficiencies (39), and visual problems (41a).<sup>14</sup> Shelters and other emergency food assistance facilities report that they are often unable to provide nutritionally bal-

anced meals to residents and that they view lack of food and poor nutrition as serious problems for homeless families (63).

**Mental Health**—Information about the mental health of older children in shelters with their families is extremely limited. However, in studies of the children of homeless families in Boston, Massachusetts, researchers found that children had serious developmental and emotional problems (7,8,9,10). These studies assessed school-aged children living in shelters in Boston--of whom about one-third were ages 12 to 16 and two-thirds were ages 6 to 11--on the Children's Depression Inventory and the Children's Manifest Anxiety Scale and found that they manifested high degrees of distress. Despite

<sup>13</sup>The National Ambulatory Medical Care Survey is an ongoing survey conducted by DHHS of ambulatory visits to office-based physicians. See ch. 6, "Chronic Physical Illnesses: Prevention and Services," in this volume, for additional information about the survey.

<sup>14</sup>For a general discussion of the nutritional problems of adolescents, see ch. 7, "Nutrition and Fitness Problems: Prevention and Services," in this volume.



their methodological limitations, the studies in Boston do substantiate the generally high levels of distress that children living in shelters can experience (9). Many of the difficulties experienced by the Boston children (e.g., poverty, residential instability), however, predated their current episode of hopelessness, indicating that the lives of these children may have been disrupted for some time (9). In contrast, a Philadelphia study of 43 shelter children ages 6 to 12 found that only 9 percent had scores in “the clinical range” on an index of emotional and behavioral problems; another 7 children ages 6 to 12 (16 percent) in this study had scores near the clinical range (41a). These findings could have been a result of having parents rather than children or professionals assess the children state of psychological health (41a). In general, the researchers in this study seemed surprised at parents’ favorable ratings of their children’s health. When the researchers used projective measures of emotional status, such as making three wishes and house-tree-person drawings, the 6- to 12-year-olds showed “a strong tendency to wish for major changes in their life situation, indicating an intense awareness of their plight as homeless poor people” (41a). In contrast, younger children seemed less aware of their and their families’ plight (41a).

The experience of hopelessness puts families as a whole under high levels of stress, and children in families that are homeless may be at greater risk of child abuse and neglect than similar domiciled children. In one Boston court, homeless children account for one-third of the abuse or neglect cases (22).

*Access to Health Care*---Children who are homeless are frequently without adequate or any health insurance coverage.<sup>15</sup> A Washington State study found that 35 percent of a sample of homeless

children had no insurance coverage; 40 percent were covered by Medicaid. One-third of the homeless children in this study did not have a usual site of health care (e.g., public clinic, hospital clinic, or emergency room), and over half (58.9 percent) did not have a usual health provider (e.g., doctor, nurse, or nurse practitioner). Lack of money or insurance coverage of dental care frequently prevented families from seeking this care when it was needed for children. Rates of emergency room use by children who are homeless have been reported to be much higher than for children in general, either because care for homeless children is not sought until problems become acute or because such children have no regular health provider (37,41a).<sup>16</sup>

*Education*---The U.S. Department of Education, in a recent report to Congress on school-aged homeless children and adolescents, estimated that there are 272,773 school-aged homeless children throughout the United States (70).<sup>17</sup> Estimates were made using a variety of methods, including actual 1-day counts, data based on estimation, and partial data where information was not available for all parts of a State. One State, Hawaii, did not provide data for the report. Because of these methodological concerns, caution is advised when interpreting the data.<sup>18</sup>

About three-quarters (about 72 percent) of school-aged homeless children and adolescents are estimated by the U.S. Department of Education to be attending school; more than one-quarter (about 28 percent) of school-aged homeless children and adolescents are not thought to be attending school.<sup>19</sup> The U.S. Department of Education reports that about 47 percent of homeless school-aged children and adolescents who are attending school are in grades 7 through 12 (26 percent in grades 10 through 12 and

<sup>15</sup>For a general discussion of health insurance coverage among adolescents, see ch. 16, “Financial Access to Health Services,” in Vol. III.

<sup>16</sup>For a discussion of issues pertaining to the delivery of care to adolescents, see ch.15, “Major Issues Pertaining to the Delivery of Primary and Comprehensive Health Services to Adolescents,” in Vol. III.

<sup>17</sup>Estimates include figures for the Virgin Islands, American Samoa, and Puerto Rico. These territories account for an estimated 3,000 homeless school-aged children and adolescents.

<sup>18</sup>This study was submitted to Congress in response to section 724(b)(2) of the Stewart B. McKinney Homeless Assistance Act (Public Law 100-77). Recent amendments to the act (the Stewart B. McKinney Homeless Assistance Amendments Act of 1990-Public Law 101-645) require an additional study by the U.S. Department of Education to “determine the best means of identifying, locating, and counting homeless children and youth”. . . “to create as accurate an account as possible of the number, location, and living circumstances of such children and youth that are attending school regularly, part-time, or not at all, and reasons for the non-attendance of such children and youth.”

<sup>19</sup>Data were not provided to the U.S. Department of Education by Alabama, the District of Columbia, Louisiana, Mississippi, New York, or the Virgin Islands.

21 percent in grades 7 through 9), and about 49 percent in kindergarten through grade 6 (70).<sup>20</sup>

New York City data reveal that about two-thirds (64 percent) of homeless junior-high-school-aged adolescents and half of homeless high-school-aged adolescents in the city attend school (44,45).

The National Coalition for the Homeless estimates that 40 percent of homeless school-aged children do not attend school (40).

Bassuk and her colleagues report that by the time they reach the shelter, children have frequently already experienced problems in school (9,10). For example, 43 percent of homeless school-aged children in a Boston study were found to have repeated a grade by the time they were surveyed in the shelter. Not surprisingly, the study of 6- to 12-year-old children in Philadelphia shelters found that the children tended to have low scores on standardized tests of expressive vocabulary and word decoding (41a).

Homeless children face a number of barriers to continuing their schooling (45). Because shelters rarely have day-care facilities, older children will often stay out of school to care for younger children while parents are out job hunting or looking for housing (11). Similarly, school-aged parents may be prevented from attending school (70). Even if they had been attending school regularly prior to entering the shelter, adolescents are frequently unable to continue to attend their “home” school, as the shelter is rarely in the same area. Until Federal laws were changed recently with the Stewart B. McKinney Act (discussed below), homeless children were often refused enrollment in schools because they lacked a permanent address (23); even with the change in law, resistance from school personnel continues in some areas (55).

Lack of appropriate documents, such as birth certificates and immunization records, may also make it difficult for homeless families to register children for school (63,70). Families moving from place to place may find it particularly difficult to keep important personal records securely with them. Without transportation, they find it extremely difficult to file requests for copies of birth certificates personally, and by the time copies have come



Photo credit: Office of Technology Assessment

**Recent changes in Federal law prohibiting exclusion of children from school because they have no permanent address, and special schools and programs for homeless children in difficulty in school, are ways in which policy makers and educators are addressing the educational needs of homeless children in families.**

through mail requests, families may have relocated. Significant delays can also be experienced when records are transferred from schools where children were previously enrolled (70). If children are living separately from their parents (e.g., with friends or family), the unavailability of a legal guardian can prevent school registration (40).<sup>21</sup>

Even when they are enrolled in school, homeless children face barriers to school attendance. Attendance at a child's “old” school may require long daily trips on public transportation; and money is not always available to pay for transportation (40,70). Many homeless children find that they must face ridicule from their classmates when it is discovered that they are homeless (23,55). Another problem is that homeless shelters are often lacking in the privacy and quiet needed for children to complete their homework (40). Educators who work with homeless children indicate that it often takes special effort to keep homeless children in school, even knocking on shelter doors every day to ensure attendance (55).

One response to this problem has been to create special schools for homeless children where they will not be ostracized and educators understand their needs (23). Special schools for homeless children

<sup>20</sup>Data on grade level were not available for 4 percent of children and adolescents.

<sup>21</sup>Title VI of the 1990 amendments to the McKinney Act (Public Law 101-645) addresses these barriers to school enrollment (discussed below).

have been created in Tacoma, Washington; Santa Clara, California; and Salt Lake City, Utah (23). Homeless children and adolescents often have special educational needs that include remediation in basic skills, support services such as counselors and social workers, after-school programs to address basic needs including food and shelter, and sensitivity and awareness training for school personnel (70).

### Homeless Adolescents on Their Own

Recent concern about homeless children has focused primarily on the needs of children who are part of homeless families. As noted earlier, however, many, if not most, homeless adolescents are living on their own. In many ways, the problems of homeless adolescents on their own raise more difficult policy issues.

**How Many Adolescents Are Homeless on Their Own?** —Estimates of the number of unaccompanied homeless adolescents ages 10 to 18 vary. Among the cities surveyed by the U.S. Conference of Mayors in 1987, 12 cities reported on numbers of unaccompanied homeless adolescents. These cities reported that unaccompanied adolescents (ages not specified) represented 4 percent of their homeless population (64). Nine of twelve cities reporting on the numbers of unaccompanied homeless adolescents reported that homeless adolescents were a group that was increasing in size.

Title V of the Stewart B. McKinney Homeless Assistance Act of 1987 provided funding for the Primary Health Care and Substance Abuse Program (the Health Care for the Homeless Program) by adding a new Section 340 to the Public Health Service Act (34). The federally funded Health Care for the Homeless Program provides direct health care services to homeless persons and is administered by the Bureau of Health Care Delivery and Assistance within DHHS. In 1988, during the first year of operation of the program, 1.8 percent of the contacts were with runaway or homeless adolescents (ages not specified) (34).

DHHS, in the 1984 annual report on runaway youth centers, estimated that about one-third (or 100,000) of the young people receiving services under the Runaway and Homeless Youth Act (discussed below) were homeless (71). DHHS further estimated in 1984 that there are more than a



Photo reedit: Sasha Bruce Youthworks, Inc.

**In many ways, the problems of homeless adolescents on their own raise more difficult policy issues than do the problems of homeless children with their families.**

million runaway and homeless adolescents ages 10 to 17 each year (72). Because of the lack of more recent national data, these estimates, based upon a 1976 National Statistical Survey of Runaway Youth mandated by Congress in the original Runaway Youth Act (Public Law 93-4 15), continue to be used (72).

In a 1990 study sponsored by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice\*\* to determine the numbers of children who are missing each year, researchers used a variety of methods to develop estimates-including a national telephone survey of over 10,000 randomly selected households to develop estimates of the numbers of children who had run away, been thrown away, been abducted, been lost, or were otherwise missing; a survey of juvenile facilities (e.g., group foster homes, juvenile correctional facilities, mental health facilities, and drug abuse rehabilitation facilities) to determine the number of runaways from these facilities; an interview study with children who had run away and returned home; and a study of a national sample of agencies having contact with children to determine the numbers of children known to these agencies who had been abandoned or thrown away.

According to the U.S. Department of Justice study:

- . There are approximately 450,700 *children* and adolescents who run away in the United States

<sup>22</sup>This study was mandated by the 1984 Missing Children's Assistance Act (Public Law 98-443, sec. 404 (b)(3)) (75).

each year; and about 133,500 of them are without a place to sleep during some night while they are away from home (75).

- There are approximately 127,100 “thrown-away” children and adolescents in the United States each year; and about 59,200 of them are without a familiar and secure place to stay at some point during their throwaway experience (75).
- About 45,900 children and adolescents in the United States in 1988 qualified as both runaways and throwaways (75).<sup>23</sup>

All of these estimates include high proportions of adolescents. The U.S. Department of Justice study found that nearly all of the estimated 112,600 “throwaways” who were identified through the household survey were ages 13 to 17; about one-quarter of the estimated 14,500 “abandoned” children identified through a community survey of child-serving agencies were ages 11 to 17; and 98 percent of the estimated 446,700 “runaways” identified through the household study were ages 11 to 17 (75). The researchers consider these estimates of the numbers of throwaway and abandoned adolescents and children to be conservative because they rely on interviews with caretakers (who might be more likely than their children to report an incident as running away rather than being thrown away) and because estimates of the numbers of abandoned children relied on limited data from providers (75).

The U.S. Department of Justice study, on the basis of the household survey only—i.e., excluding estimates of the numbers of abandoned children and adolescents and the numbers of runaways from juvenile facilities<sup>24</sup>--estimated that 513,400 children and adolescents become runaways or throwaways in the United States each year (75).<sup>25</sup> One cannot determine from the data how many of these 513,400 children and adolescents could be classified as homeless during their runaway or throwaway experience. The data clearly indicate, though, that tens of thousands of adolescents in the United States

each year have the experience of being without a familiar and secure place to sleep.

In fiscal year 1987, 10.1 percent of the 56,000 adolescents who received shelter or counseling through federally funded runaway and homeless youth centers were classified as homeless (72). That year, however, only about half of the adolescents who received such services at these centers were reunited with their families, a fact which suggests that the percentage of adolescents who are homeless may be much higher. Of the adolescents receiving services, 35.2 percent were placed in alternative living arrangements, 9.2 percent had no planned destination, and 5.4 percent returned to the streets. In general, younger and runaway adolescents tended to return home; older and homeless adolescents tended to pursue alternate arrangements. GAO estimates that 70,000 unaccompanied young people may have been served by federally funded and other runaway shelters in 1987; there may be another 64,000 to 208,000 homeless adolescents who are not seen in shelters (65).

A study of adolescents using shelters in Los Angeles County reported that 35 percent had no home to which they could return; another quarter were chronic runaways who were unlikely to be returned home (35). Two-thirds of the adolescents seen by outreach agencies (e.g., drop-in centers or street workers) were truly homeless; most were staying on the street.

There is little information available about homeless adolescents on their own who do *not* use available shelter and runaway services (i.e., adolescents who stay, for example, in cars, abandoned buildings, parks, or all-night restaurants).<sup>26</sup> Homeless adolescents living on their own who do use the runaway and homeless youth shelter system, however, tend to be non-Hispanic white (although blacks represent a disproportionate share), ages 16 or 17 (generally older than homeless adolescents with their families), and are more likely to be male than

<sup>23</sup>Individuals could qualify as both, for example, if they had had more than one incident of leaving home, or if, after running away, they had become throwaways when their caretaker refused to allow their return home.

<sup>24</sup>The authors of the study caution against simply adding together estimates of the numbers of different types of “inking” children (e.g., runaways with throwaways) because of the potential for overlap between categories, and because it may not make conceptual sense to combine categories (75).

<sup>25</sup>Because of the ~@ proportion of adolescents identified as runaways or throwaways in the household survey, one would expect a very high proportion of these 513,000 runaways/throwaways to be adolescent.

<sup>26</sup>The proportion of unaccompanied homeless adolescents who use shelter services is unknown. One study, which sampled homeless adolescents from a variety of sites other than shelters in Hollywood, California, found that only 40 percent reported that they had stayed in a shelter during the previous month (52).

female (55 percent of homeless adolescents using runaway and homeless youth shelters are male) (66). The ethnic mix of adolescents who use the runaway and homeless youth shelter system, however, tends to vary depending on the greater community. In their sample of adolescents entering runaway shelters during a 2-week period in New York City, for example, Shaffer and Caton reported that about half were black and more than one-third were Hispanic (57). The numbers of male adolescents from Central America who have entered the country illegally and are now homeless may be increasing (43).

According to data collected from runaway and homeless youth centers, most homeless adolescents using runaway and homeless youth centers are from the local area (49,66,72). DHHS reported in 1987 that nearly nine-tenths (87.4 percent) of adolescents receiving services from federally funded runaway and homeless youth centers had last lived within 50 miles of the runaway shelter; more than half (52.2 percent) of the adolescents receiving such services had last lived within 10 miles of the shelter (66,72). Some geographic areas, such as Los Angeles and San Francisco, report relatively higher proportions of homeless adolescents coming from other areas (33,60). Of the adolescents using federally funded runaway and homeless youth shelters, about half have run away previously (72),

**Service Needs of Homeless Adolescents on Their Own**—Adolescents who are homeless and on their own are at greater risk than those in the general population for a number of health problems, including physical and mental health problems, substance abuse, pregnancy, sexually transmitted diseases, and physical and sexual abuse.

**Physical Health**—Few specifics are known about the physical health status and health care needs of unaccompanied homeless adolescents (4). Existing data suggest that many of the problems they experience are similar to those experienced by homeless children in families. For example, even when homeless adolescents find it relatively easy to find food (either through soup kitchens and shelters, or by purchasing food), their diets are often nutritionally deficient (42), and their poor diets may exacerbate medical problems (21).

In addition, the American Medical Association Council on Scientific Affairs notes that living on the streets makes it particularly difficult for homeless adolescents to perform routine tasks associated with personal hygiene (4). Thus, it is nearly impossible to follow treatment protocols such as keeping a wound clean. Resistance to disease is lower under the stressful conditions of living on the streets, so the chances of contracting infectious diseases are increased (57). Two-thirds of homeless adolescents in one study reported recent health problems (no further information available) (47). More than half had received medical treatment during the past year; about a fifth said that their health had become worse since becoming homeless.

Homeless adolescents ages 13 to 19 who were seen by 17 of the 19 Health Care for the Homeless projects funded by the Robert Wood Johnson Foundation and the Pew Memorial Trust suffered higher rates of nearly all acute disorders (e.g., upper respiratory infections, genitourinary problems, minor skin problems) and trauma as compared to adolescents included in the National Ambulatory Medical Care Survey (78). Homeless adolescents in this clinical sample also experienced chronic disorders (e.g., eye disorders such as poor vision, gastrointestinal disorders, ear problems such as otitis media (middle-ear infections) or impaired hearing, and dental problems) at nearly twice the rate of similarly aged adolescents in the National Ambulatory Medical Care Survey study. Nutritional disorders were also more common among the homeless adolescents (78).

Homeless adolescents on their own, as well as those with their families, face a number of barriers to receiving appropriate services. Older adolescents, in particular, may fall “between the cracks” as they fall outside of the jurisdiction of programs designed to serve children but do not yet have the full rights of adults. Such adolescents may not be eligible to receive public assistance (welfare) if they have not been legally emancipated through the court, may be excluded from shelters serving families or single adults, and may have difficulty gaining access to medical services without parental consent (4,5,59).<sup>27</sup>

<sup>27</sup>For a general discussion of how parental consent requirements may affect adolescents’ access to health care, see ch.17, “Consent and Confidentiality in Adolescent Health Care Decisionmaking,” in Vol. III.

Most homeless adolescents have no medical insurance coverage (46).<sup>28</sup> Often, adolescents believe that without money, they are ineligible to receive services such as medical care (4,5). Hospitals, including emergency rooms, are frequently the most common source of regular care. Greater use of hospital v. ambulatory care results in costly utilization patterns (46).

*Mental Health*—Homeless adolescents on their own frequently experience higher rates of mental health problems than adolescents in the general population.<sup>29</sup> There are anecdotal reports that the population of young people on the street is becoming younger, and more disturbed and dysfunctional (54).

Researchers report that homeless adolescents experience high rates of depression and are likely to have a history of suicide attempts. One study found that 83.6 percent of homeless and runaway adolescents were diagnosed as depressed through an interview by an examining physician (v. 24 percent of a sample of nonrunaway adolescents who also attended the same clinic), and 18.2 percent of homeless and runaway adolescents revealed a history of attempting suicide (as compared to 4 percent of nonrunaway adolescents) (79). Another study found that at least a third of the homeless adolescent females and 15 percent of the homeless adolescent males had previously attempted suicide (57). Another third of the homeless males and females had thought about attempting suicide. Other researchers report that nearly half of homeless adolescents had histories of suicide attempts, with 29 percent having attempted suicide in the previous year (38,53). Data from DHHS on adolescents served by federally funded runaway and homeless youth centers suggest that as many as 61 percent of these adolescents are depressed and that about 11 percent may be suicidal (72).

Almost a quarter of a sample of homeless adolescents in the Hollywood, California area had received inpatient mental health treatment at some time, although few had received any type of mental

health treatment during the year prior to their being surveyed (38,47,53). Rates of mental disorders listed in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) were found to be at least three times higher than those of a nonhomeless group of comparison adolescents (as assessed by items from the Diagnostic Interview Schedule and the Diagnostic Interview for Children and Adolescents, both of which are based on DSM-III). In addition to high levels of self-reported depression symptoms, a sizable portion (29 percent) reported four or more symptoms on a psychotic symptom index, further emphasizing the need that many of these adolescents have for mental health evaluation and possible treatment (38).

Adolescents in their sample of homeless and runaway adolescents in New York, Shaffer and Caton found, had a psychiatric profile similar to adolescents attending a psychiatric clinic (57). In addition, 38 percent of the adolescents Shaffer and Caton surveyed reported that they needed help for emotional problems; one-fifth had previously received psychiatric treatment. Shaffer and Caton concluded that much of the current psychiatric disturbance was present before the current runaway or homeless episode.

*Substance Abuse*—Various studies have reported high rates of substance abuse among homeless adolescents.<sup>30</sup>

Yates et al. found, for example, that 83.6 percent of the 110 homeless and runaway adolescents and young adults<sup>31</sup> using an outpatient medical clinic in Hollywood, California reported that they used drugs or alcohol (as compared to 67.0 percent of the 665 nonrunaway clients seen at the clinic) (79). These researchers also found that 34.5 percent of the homeless and runaway adolescents using the clinic had used intravenous drugs (as compared to 3.7 percent of their nonrunaway peers) (79).

A survey of adolescents and young adults ages 10 to 24 visiting an outpatient medical clinic in Los

<sup>28</sup>For a general discussion of adolescents' problems with respect to health insurance, see ch. 16, "Financial Access to Health Services," in Vol. III.

<sup>29</sup>For a general discussion of mental health problems among adolescents, see ch. 11, "Mental Health Problems: Prevention and Services," in this volume.

<sup>30</sup>For a general discussion of substance abuse among adolescents, see ch. 12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," in this volume.

<sup>31</sup>Fifty-two percent of the runaway clients were ages 10 to 17 (as were 34 percent of the nonrunaway clients), 40 percent of the runaways were ages 18 to 21 (as were 57 percent of the nonrunaways), and 8 percent of the runaways were ages 22 to 24 or of an unknown age (as were 9 percent of the nonrunaways).

Angeles found that an estimated half of the homeless and runaway adolescents seen were involved in drug abuse (54).

Shaffer and Caton reported that 70 percent of the homeless and runaway adolescents entering runaway shelters in New York City used drugs (57).

Robertson found that more than one-third of the 93 homeless adolescents interviewed in a study in the Hollywood, California area met DSM-III diagnostic criteria for drug abuse (47). This drug abuse rate among homeless adolescents (1 in 3) was five times greater than the rate reported for adolescents who were not homeless (47). About one-quarter of the homeless adolescents surveyed by Robertson reported having used drugs (e.g., heroin, cocaine) intravenously at least once (47). Robertson and her colleagues also found that more than one-third (38 percent) of the 93 homeless adolescents they interviewed in the Hollywood, California, area met the DSM-III criteria for alcohol abuse or dependence in the previous year and that nearly half (48 percent) of the 93 had an elevated lifetime prevalence of alcohol dependence or abuse (47,51,52). Robertson and her colleagues found that overall, 7.5 percent of the 93 homeless adolescents (13 percent of those diagnosed as alcohol abusers and 2 percent of the nonabusers) had ever received alcohol inpatient treatment. Only 18 percent of the homeless adolescent alcohol abusers had received treatment of any type in the previous year. The fact that so few received treatment was probably due in part to the fact that relatively few of the adolescents perceived their alcohol use to be a problem. Homeless adolescents with alcohol abuse problems were more likely to be male, white, and older than other homeless adolescents (mean age = 16.1 years; range: ages 13 to 17) (47,52). These adolescents also had more chronic histories of hopelessness, were less likely to utilize shelters, and experienced greater difficulty in meeting other subsistence needs (e.g., food and clothing). These adolescents were more likely to have left home because of physical or sexual abuse, to have had a more chronic and extensive history of institutional contact, to have more mental health problems, and to abuse drugs.

*Sexual and Reproductive Health--* Several studies have found that most homeless and runaway adolescents have higher rates of sexual experience than other adolescents.

Yates et al. reported that nearly all of the 110 10- to 24-year-old runaway adolescents seen at an outpatient medical clinic in Hollywood, California (46.9 percent were ages 15 to 17, and 41.6 percent were ages 18 to 21) had had sexual intercourse (79). These investigators found that more than one-half (57.3 percent) of the runaway street adolescents and young adults in their Los Angeles study had had sexual intercourse before the age of 15 (as compared to 31.0 percent of the nonrunaways) and that almost 20 percent of the runaway street adolescents and young adults in their study had had sexual intercourse before age 10 (as compared to 2.1 percent of the nonrunaways) (79).

Robertson similarly found that nearly all (92.3 percent) of the 93 homeless adolescents she surveyed in various settings in the Hollywood, California area reported being sexually active (mean age = 16.1 years) (47). Forty percent of the homeless adolescents Robertson surveyed reported being sexually active by age 13 (47).

Furthermore, Shaffer and Caton, in their study of 118 adolescents entering runaway shelters during a 2-week period in New York City, found that three-quarters of adolescents under the age of 18 reported that they had engaged in sexual intercourse (57).

Even though most homeless adolescents are sexually active, few of them report consistent use of contraceptives (46,57). Homeless adolescents who engage in unprotected sexual intercourse are at increased risk of pregnancy and sexually transmitted diseases (STDs).<sup>32</sup> Various studies have reported high rates of pregnancy for homeless female adolescents.<sup>33</sup> In their sample of adolescents entering runaway shelters during a 2-week period in New York City, for example, Shaffer and Caton found that one-third of the homeless female adolescents they interviewed (mean age = 15.7 years old) had been pregnant (57). Almost half (44.4 percent) of the homeless female adolescents surveyed by Robertson in the Hollywood, California area had been pregnant

<sup>32</sup>For a general discussion of adolescent pregnancy, see ch.10, "Pregnancy and Parenting: Prevention and Services," in this volume. The risk of STDs among adolescents is discussed in ch.9, "AIDS and Other Sexually Transmitted Diseases: Prevention and Services," in this volume.

<sup>33</sup>For a general discussion of pregnancy rates among adolescents, see ch.10, "Pregnancy and Parenting: Prevention and Services," in this volume.

(47). National data indicate that about 40 percent of all young black women and a fifth of young white women have been pregnant before the age of 18—older than the adolescent females in these samples (29).

Of homeless females ages 13 to 15 seen by Health Care for the Homeless projects funded by the Robert Wood Johnson Foundation and the Pew Memorial Trust, 14 percent were pregnant at or after their first contact with the project, as were 31 percent of females ages 16 to 19 (data are not reported on lifetime pregnancies) (78). The pregnancy rate among these homeless females was more than 10 times the pregnancy rate reported for females ages 13 to 15 in the National Ambulatory Medical Care Survey; in fact, it was at least 3 times the pregnancy rate reported for females ages 16 to 19 in that survey.

Homeless and runaway adolescents participate in street prostitution (often for ‘survival,’ i.e., in exchange for food, shelter, or money with which to purchase food or shelter) at relatively high rates.

Nearly 30 percent of homeless adolescents (31 percent of females; 28 percent of males) surveyed by Robertson in the Hollywood, California area reported that they engaged in prostitution; they were more likely to engage in prostitution during periods of hopelessness than when they were housed (46).

Similarly, 35 percent of those seen at the Larkin Street Youth Center in San Francisco reported that they had engaged in prostitution, primarily for economic reasons (33).

Yates et al. reported that 26 percent of runaway street adolescents seen at an outpatient medical clinic in Hollywood, California engaged in prostitution (as compared to only 0.2 percent of nonrunaway adolescents seen at the same clinic) (79).

Lower rates of prostitution among homeless adolescents are reported for clients of The Bridge, a multiservice agency in Boston, Massachusetts. There, less than 20 percent of homeless adolescents are reported to have resorted to prostitution (43),

Particularly in some areas, such as San Francisco and Los Angeles, relatively high numbers of homeless adolescents are reported to be homosexual (32,80). A Seattle survey found that 40 percent of a sample of street adolescents identified themselves as gay, lesbian, or bisexual (56). A fifth of males using a New York City shelter reported that they were gay

(61). Frequently, these adolescents have been rejected by their families because of their sexual orientation. Once on the streets, they are particularly vulnerable to violence and victimization (1,80).

Because they are more frequently involved in sexual activity (including both homosexual and heterosexual prostitution) and intravenous drug use, homeless adolescents are at higher risk for infection with human immunodeficiency virus (HIV), the virus that causes AIDS (16,28,80). An ongoing study at Covenant House shelter in New York City, in which clients receive a health assessment upon admission to the facility, indicates that 6 to 7 percent of adolescents (ages 15 to 20) screened tested positive for AIDS antibodies (61).

Runaway and homeless youth centers in all 10 Federal regions report that one of their primary health concerns is the prevention of STDs and care for victims of STDs and AIDS among runaway and homeless youth (72). DHHS, with the involvement of its National Institute on Drug Abuse, has begun to provide AIDS prevention training to staffs of federally funded runaway and homeless youth centers (30).

*Physical and Sexual Abuse*—Researchers report that large numbers of homeless adolescents were subjected to physical or sexual abuse prior to becoming homeless (6,21,31,36,47,58).

More than 60 percent of a sample of 75 homeless adolescents surveyed in San Francisco, reported that they had been sexually abused before leaving home (28). A study of 187 Canadian adolescents and young adults ages 16 to 21 who were receiving services at a shelter for runaway and homeless youth revealed that 81 percent experienced severe physical abuse at home (6). This abuse was most frequently perpetrated by a parent.

In the fiscal year 1984 annual report on federally funded runaway and homeless youth centers, DHHS reported that for about one-third of young female adolescents and one-fifth of young male adolescents using centers, physical or sexual abuse by family members or others was a problem that led to their running away (71).

Over one-third (37.2 percent) of the sample of 93 homeless adolescents surveyed by Robertson in the Hollywood, California area reported that they had left home at least once because of physical abuse; 10.7 percent reported that they had left home



because of sexual abuse (47). A fifth of the homeless adolescents in this sample had been removed from their homes at some time because of abuse or neglect—an observation that corroborates the belief that many of these homeless adolescents had, in fact, come from abusive households,

In a New Jersey sample of 536 adolescents using runaway and homeless youth center services (of whom 60 percent were considered to actually be homeless), almost half reported physical or emotional abuse, and over 10 percent reported sexual abuse at home (58).

Sexual and physical victimization continue to be a fact of life for many adolescents living on the street (79). Yates et al. reported that 3.6 percent of the 110 runaway and homeless adolescents seen at an outpatient medical clinic in Hollywood, California (as compared to 1.4 percent of the 655 nonrunaway adolescents seen at the clinic) were treated for trauma (79). They also reported that 1.8 percent of the runaway and homeless adolescents seen at this clinic were treated for rape (as compared to 0.5 percent of nonrunaway adolescents seen at the clinic) (79).

Robertson found that 42 percent of the 92 homeless adolescents in her study in the Hollywood, California area reported physical abuse, and 13 percent reported sexual abuse in the past year (46). The fact that the number of homeless adolescents reporting sexual abuse in Robertson's study (13 percent) is low in comparison to the number reporting that they engaged in prostitution (29.7 percent) suggests that the homeless adolescents Robertson surveyed did not perceive the exchange of sexual favors for food, shelter, or protection (survival sex) as constituting sexual abuse. Consequently, the self-reports of sexual abuse among these adolescents may be low.

A survey of young people using Los Angeles County shelters found that about half of them had a history of abuse and neglect (35).

*Education*—A recent GAO study found that 37 percent of adolescents receiving shelter services at federally funded runaway and homeless youth centers between October 1985 and June 1988 were not attending school (66). Half of those age 16 or older

had either dropped out of school, been expelled, or been suspended.

Several researchers have reported that most homeless adolescents have poor histories of school adjustment (42). Shaffer and Caton, for example, reported in their study of 118 adolescents entering runaway shelters during a 2-week period in New York City, found that three-quarters of the males and one-half of the females they interviewed had been expelled from school at some time, most for fighting or drug use (57). About half of the adolescents they interviewed had repeated a grade (57). Data from DHHS on runaway and homeless adolescents using federally funded runaway and homeless youth centers indicate that more than one-fourth of these adolescents had problems with school attendance, about a quarter had poor grades, and almost 10 percent had difficulties with teachers (72).

Staying in school after leaving home can be very difficult for runaway and homeless adolescents. Adolescents on their own face significant problems (e.g., finding places to study, obtaining appropriate records, need for day-care facilities if they are young parents) similar to those described for homeless adolescents staying with their families in shelters. They face additional problems if they do not have a guardian who can enroll them in a school. If they wish to enroll in a new school district, for example, it may be particularly difficult for them to obtain appropriate records and signatures if they are estranged from their guardian(s) (40). A survey of young people in Los Angeles County reported the need for services to help homeless adolescents return to school, including the need for testing to determine any need for special services (35).

*Illegal Activity/Juvenile Justice System Involvement*—As noted above, some homeless and runaway adolescents use illegal drugs, engage in prostitution, or participate in other types of illegal activities that may bring them into contact with the juvenile justice system.<sup>34</sup>

Adolescent males, in particular, are reported to have experienced contact with the justice system (72). For nearly a quarter (23.7 percent) of adolescent males receiving ongoing services from runaway and homeless youth centers in fiscal year 1987,

<sup>34</sup> For a discussion of offenses that may bring adolescents into contact with the juvenile justice system, see ch. 13, "Delinquency: Prevention and Services," in this volume. As noted in that chapter, running away itself may bring adolescents into contact with this system.

being “in trouble with the justice system” was cited as a problem that had contributed to their leaving their last residence (as compared to 9.7 percent of the adolescent females). Over 10 percent (11.8 percent) of males and less than 5 percent (3.8 percent) of females receiving services from the centers cited “being in trouble with the juvenile justice system” or law enforcement as being their *primary* reason for seeking services at the center. Furthermore, 1.9 percent of the adolescents served by the runaway and homeless youth centers (2.6 percent of males; 1.4 percent of females) were expected to reside in correctional institutions after receiving services at the centers.

Many of the adolescents in Robertson’s sample of 93 homeless adolescents in the Hollywood, California area reported that they obtained income from illegal activities such as panhandling, prostitution, and drug dealing (46). Some of these activities were adaptive behaviors in which homeless adolescents engaged to provide for basic needs (e.g., breaking and entering to get a place to stay). Many adolescents in this study reported that they only engaged in these behaviors when they were homeless or that they engaged in these behaviors more frequently when they were homeless.

Robertson found that homeless adolescents who abused alcohol were more likely than other homeless adolescents to engage in illegal and problem behaviors (46). They were almost twice as likely to have sold drugs (half of those doing so to support their own drug habit), and more likely to trade sex for drugs or money.

More than one-third (37 percent) of the males and almost a fifth (19 percent) of the females surveyed by Shaffer and Caton in their study of adolescents entering runaway shelters during a 2-week period in New York City reported that they had been charged with an offense (e.g., assault or robbery) at some time (57). A minority (22 percent of males; 10 percent of females) had been in a detention center previously; 12 percent of the males had been in a work camp or prison. About a quarter of the males (28 percent) and 12 percent of the females reported that they had stolen something in the previous 3 months. Males were significantly more likely than females to have been charged with an offense, gone to court, and to have been convicted or incarcerated.

*Training in Independent Living*—In addition to needing physical and mental health services, home-

less adolescents often have a need for training in independent living skills, including vocational training (19).

In 1985, the Hollywood Homeless Youth Project in Hollywood, California, reported that 86 percent of the adolescents requesting services wanted job training and placement, half wanted help in finding shelter, and half requested school services (54). Shaffer and Caton also reported that adolescents most wanted help in finding a job (57). Another half wanted counseling for problems with thoughts and feelings. Other homeless adolescents have reported that a primary goal was to find their own apartment (19). This goal can be particularly difficult to achieve because unemancipated minors cannot legally enter into a contract such as a lease (49).

## Major Federal Policies and Programs Pertaining to Hopelessness

**Primary** responsibility for addressing the needs of the homeless has traditionally been held by various private charities, religious groups, and nonprofit agencies. Through missions, private shelters, clothing closets and the like, the private sector has responded to meet the most basic needs of society’s poorest individuals. While few deny that the Federal Government must make some response, there is controversy as to whether the Federal Government should take a primary role in responding to the problem. Some believe that alleviating the homelessness crisis requires solutions that have to be implemented at the national level. Others believe that discretion for programming should be retained at the State or community level, with private and civic groups working together to solve what are essentially local problems.

The primary mechanism for providing direct services to homeless families is through temporary shelters. Although shelters for the homeless increasingly serve as sites for the provision of services beyond simple shelter (e.g., mental health services, health care services), they generally do *not fully* address the multiplicity of needs of sheltered families and individuals. Shelters where homeless families with adolescents stay are often squalid and dangerous. Privacy is sometimes totally lacking, and families may be housed barracks style with dozens of other families (20). Welfare hotels, where families are housed together in one room, sometimes for a year or longer, are frequently in the worst parts of



Photo credit: Office of Technology Assessment

**Traditionally, the private sector has taken primary responsibility in addressing the needs of the homeless through private charities, religious groups, and nonprofit agencies. Whether the Federal Government should assume a primary role in providing for the homeless, including adolescents, is a controversial topic.**

the cities, expose children to the dangers of substance abuse and crime, and may contain such environmental risks as lead-based paint and exposed wiring. Shelters and hotels rarely have a place where adolescents may play, either inside or outdoors. Cooking and refrigeration facilities are often lacking. Families may resort to prohibited hotplates for cooking; perishable items may be kept in coolers or toilet tanks (1 1,25).

A number of existing Federal programs seek to address the emergency needs of poor people, including the homeless. Until budgets were severely cut during the 1980s, the Federal Government took a rather active role in developing a national stock of low-income housing. Traditional welfare programs such as AFDC provide some income security for needy children and their parent(s). Medical care is available for low-income persons through the Medicaid program and federally funded community health centers.<sup>35</sup> Nutritional assistance is available through enrollment in the Food Stamp Program, the Temporary Emergency Food Assistance program, and participation in the Supplemental Food Program for Women, Infants, and Children.<sup>36</sup> A variety of

Federal block grant funds may be used to fund services or fund programs that are utilized by the homeless (e.g., the alcohol, drug abuse, and mental health services block grant; maternal and child health block grants; community development block grant funding; and the social services block grant).<sup>37</sup>

As the need for emergency housing has become more acute, many States have taken advantage of the “emergency assistance” and “special needs” funds available under the AFDC program to help families at risk of becoming homeless (69,69a). This program, in which States may voluntarily participate, allows for the limited use of Federal matching funds to secure temporary shelter and other emergency assistance for needy families with children who are at risk of becoming homeless. Though the funds are designed to provide critical aid to at-risk families, however, they are now being used in some areas to shelter families for extended periods of time in “welfare hotels. Because of Federal restrictions on the use of the funds, they may not be used for permanent housing even when this housing would be far less costly. In 1990, the Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625) addressed this problem by authorizing the use of grants to help eligible families make the transition to permanent housing (see below).

In addition to Federal programs intended to address the needs of poor people in general, there are a number of Federal programs designed to address the needs of homeless people specifically. Several of these are discussed below. The majority of these programs focus on the emergency needs of the homeless population as a whole rather than the specific needs of homeless adolescents.

### ***Emergency Aid to the Homeless and the McKinney Homeless Assistance Act***

Congress has a relatively short history of dealing directly with the problem of hopelessness. For the most part, the legislative response has focused on the homeless population in general and has not specifically targeted the needs of homeless adolescents. Initially, because hopelessness was thought to be a

<sup>35</sup>For information on the Medicaid program, see ch. 16, “Financial Access to Health Care,” in Vol. III. Federally funded community health centers are discussed in ch. 18, “Issues in the Delivery of Services to Selected Groups of Adolescents,” in Vol. III.

<sup>36</sup>For information on the Food Stamp Program and the Supplemental Food Program for Women, Infants, and Children, see ch. 7, “Nutrition and Fitness Problems: Prevention and Services,” in this volume.

<sup>37</sup>Several block grant programs are discussed in ch. 19, “The Role of Federal Agencies in Adolescent Health,” in Vol. III.

temporary crisis, legislative efforts were of a short-term or emergency nature (69).

In 1983, Congress appropriated \$100 million for the Emergency Food and Shelter Program to be funded through the Federal Emergency Management Agency (Public Law 98-8). This legislation allowed locally created boards consisting of representatives of charitable organizations and community leaders to distribute funds to local groups providing emergency services to the needy, including the homeless. It also appropriated \$125 million for the Temporary Emergency Food Assistance Program, which provided for the distribution of surplus food commodities to the needy through the U.S. Department of Agriculture. Subsequent legislation, including legislation in 1987, extended funding for the Emergency Food and Shelter Program and the Temporary Emergency Food Assistance Program (Public Law 98-92, Public Law 99-198, Public Law 100-77).

During the 100th Congress, 1987 through 1988, the problem of hopelessness was elevated to a higher priority on the legislative agenda. In 1987, Congress passed a supplemental appropriations act providing \$50 million in emergency relief funds for the homeless (Public Law 100-6). Then Congress began work on a comprehensive homeless aid package, the Stewart B. McKinney Homeless Assistance Act, which was signed into law in July 1987 (Public Law 100-77). The 1987 McKinney Homeless Assistance Act authorized funds for a comprehensive range of health, mental health, transitional housing, emergency food and shelter, education, substance abuse, and social services for homeless people. One section of the act (section 613) added a new section (512(c)) to the Public Health Service Act, which authorized funds for a new program of demonstration projects for alcohol and other drug treatment for homeless individuals. Companion legislation passed by Congress provided \$355 million for funding McKinney Act programs in fiscal year 1987 appropriations (Public Law 100-71); \$358 million was appropriated for fiscal year 1988 (Public Law 100-202).

The 1987 McKinney Homeless Assistance Act contains a number of provisions pertaining to housing, including a provision that authorizes funding for emergency shelter and supportive housing

demonstration projects (including special funding of at least \$20 million for projects serving homeless families with children); and a provision that authorizes the conversion of unused government buildings into homeless shelters. A number of programs under the U.S. Department of Agriculture were authorized by the 1987 McKinney Act, including outreach programs to inform homeless persons about food stamps, expedited service for homeless persons applying for food stamps, and extended funding for the Temporary Emergency Food Assistance Program. In addition, the legislation established a 3-year Interagency Council on the Homeless at the Federal level.

To ensure access to public education for homeless children, the 1987 McKinney Homeless Assistance Act provided for grants for each State to establish an Office of Coordinator of Education for Homeless Children and Youth. All States but one, plus the District of Columbia, the Virgin Islands, American Samoa, and Puerto Rico, received fiscal year 1988 funds under the program (69).<sup>38</sup> The Office of Coordinator of Education for Homeless Children and Youth in each State is responsible for the following:

- gathering data on the extent of child and adolescent hopelessness in the State,
- determining what problems homeless children and adolescents have in gaining access to public schools,
- identifying special educational needs of homeless children and adolescents, and
- developing State plans for providing educational services to all homeless children and adolescents in the State.

The McKinney Act also provided grants for programs that “successfully” address the needs of homeless elementary and secondary students, and authorized up to \$50,000 for demonstration grants to study the underlying causes of adolescent homelessness.

In 1988, Congress reauthorized and expanded the McKinney Act (Public Law 100-628). The 1988 law included provisions requiring DHHS to recommend legislative and regulatory changes designed to eliminate the use of emergency assistance funds to pay for sheltering families in welfare hotels and authorized funding for at least two (but not more

<sup>38</sup>Hawaii did not apply for fiscal year 1988 funds, but did apply for fiscal year 1989 funds under the program.

than three) demonstration projects designed to reduce the number of homeless families in welfare hotels. Funded demonstration projects would be required to make transition facilities available, reducing permanently the number of rooms used to house families in welfare hotels by the number of units made available in transition facilities. In 1988, Congress appropriated a total of \$78 million for McKinney Act service programs through the U.S. Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act (Public Law 100-436); it appropriated \$285 million for Federal Emergency Management Agency and U.S. Department of Housing and Urban Development programs authorized by the McKinney Act (Public Law 100-404).

In 1989, Congress appropriated \$151.6 million for McKinney Act service programs through the U.S. Departments of Labor, Health and Human Services, Education, and related agencies (Public Law 101-166). It appropriated \$414.5 million for Federal Emergency Management Agency and U.S. Department of Housing and Urban Development programs authorized by the McKinney Act (Public Law 101-144). In 1990, an additional \$3.2 million was appropriated for health services for the homeless (Public Law 101-302).

Congress reauthorized and further expanded the McKinney Act provisions in the Stewart B. McKinney Homeless Assistance Act Amendments of 1990 (Public Law 101-645). These amendments provided grants for demonstration programs to enhance comprehensive primary health services for homeless adolescents and their families through various mechanisms. Title V of the amendments provides for comprehensive primary health services for homeless children that may be delivered by some providers without Medicaid status. Title VII provides for grants to establish Family Support Centers, which would serve to enhance the physical, social, and educational development of children, including nutritional services, screening and referral, drop-out prevention services, job training services, and for parents' supportive services. Title VI of the amendments expands the educational components of the 1988 amendments, stressing the importance of coordination between the various State and local agencies that come in contact with homeless children (e.g., departments of education and social services, shelters, and youth centers), and the removal of school enrollment barriers (e.g., immuni-

zation, residency, school documents, and guardianship issues).

In December 1988, with the addition of new McKinney funds, the National Institute of Mental Health within DHHS announced that it would make available grant funds for research and research demonstrations on homeless severely mentally ill adults and homeless families with children who were at risk of severe emotional disturbance (74). In fiscal year 1989, the National Institute of Mental Health made available approximately \$2.5 million to support new research grants, and up to \$2 million in additional funds were available to support new research demonstration grants to evaluate promising new programs for the homeless in actual service settings. Although homeless adolescents were identified as a possible focus for these grants in the December 1988 program announcement, no grants targeted toward adolescents were awarded in the first cycle of funding.

In January 1990, the National Institute on Alcohol Abuse and Alcoholism, in consultation with the National Institute on Drug Abuse, announced that it would be implementing a provision of the McKinney Homeless Assistance Act of 1988 by making available cooperative agreement awards for research demonstration projects for alcohol and/or other drug treatment of homeless people (73a). It urged applicants to give special attention to the inclusion of minorities and women in the research application and encouraged the submission of applications that addressed the special needs of homeless subpopulations such as women with children, adolescents, young adult males, chronic public inebriates, and individuals with alcohol and/or other drug problems concomitant with a mental illness.

### ***Cranston-Gonzalez National Affordable Housing Act***

*In* November 1990, Congress passed for the Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625). One of the provisions of the act makes funds available for implementing an approved housing policy strategy at the State and local levels. The act could benefit adolescents who are homeless with their families by providing further funding for low-income housing projects, providing additional support for first-time home buyers, and in other ways. The act specifically makes low-income housing available “to families identified as having

a lack of adequate housing that is a factor in the imminent placement of a child in foster care or in preventing the discharge of a child from foster care and reunification with his or her family. ”

The act also includes grants (given a 50-percent State or community funding match) for public housing youth sports programs which utilize community centers, parks or playgrounds, and provides for the salaries and expenses for staff. The maximum Federal grant amount annually for each housing project is \$125,000.

### ***Runaway and Homeless Youth Act***

*In* 1974, Congress passed and appropriated funds for the Runaway Youth Act as Title III of the Juvenile Justice and Delinquency Prevention Act of 1974 (Public Law 93-415). The Runaway Youth Act has since been reauthorized several times (Public Law 95-1 15; Public Law 96-509; Public Law 98-473; Public Law 100-690). The Runaway Youth Act authorized grants to community-based agencies to develop or support programs addressing the needs of runaway adolescents (ages not specified; however, in fiscal year 1987, 93.4 percent of the individuals receiving ongoing services at federally funded centers were ages 12 to 17 (72)). In 1977, Congress extended Title III of the Juvenile Justice and Delinquency Prevention Act of 1974 to serve homeless as well as runaway adolescents. Congress took this action in response to pleas from service providers and advocates that many of the “runaway” young people served by the programs could not be reunited with their families, and so were actually homeless (68).

Programs under the Runaway and Homeless Youth Act are administered by the Administration for Children, Youth, and Families within the Office of Human Development Services of DHHS. In April 1991, the Secretary of Health and Human Services announced a reorganization of some DHHS programs for children and families (70a). As announced, the reorganization would combine all programs currently in the Family Support Administration and the Office of Human Development Services, and the maternal and child health block grant program in the Health Resources and Services Administration of the Public Health Service, into a new “Administration for Children and Families” (70a). In general, programs funded through the Runaway and Homeless Youth Act are intended to

meet short-term emergency needs. The four general purposes of programs described in the act are as follows:

- to alleviate the problems of runaway and homeless youth;
- to reunite children with their families and to encourage the resolution of intrafamily problems through counseling and other services;
- to strengthen family relationships and encourage stable living conditions for children; and
- to help youth decide on a future course of action.

Runaway and homeless youth centers funded under the Runaway and Homeless Youth Act provide emergency shelter for up to 15 days, with the goal of reuniting adolescents with their families. The centers also provide services that include individual and family counseling, outreach, and referrals and aftercare assistance in areas such as health, employment, and education (66,71).

During fiscal year 1987, Runaway and Homeless Youth Act funds were used to make awards to 307 runaway and homeless youth centers, an increase from the 286 centers funded the year before (71). Funds were transferred from the Administration for Native Americans for funding of an additional four centers in fiscal year 1987 to serve Native American adolescents. In fiscal year 1989, financial support was provided to 343 grantees (30). Many of these grantees actually operate more than one service site; the actual number of service sites may be almost double the number of grantees. The Runaway and Homeless Youth Act also provides for limited funding of demonstration projects, including options such as transitional living programs for homeless and runaway adolescents.

During fiscal year 1987, federally funded runaway and homeless youth centers provided services to an estimated 340,000 adolescents, 56,000 of whom were provided shelter, ongoing counseling, or other services (72). Although the mandate of the Runaway and Homeless Youth Act now includes the provision of services to adolescents who are homeless, homeless adolescents frequently require more intensive services than those that can be provided through the centers. Homeless adolescents can rarely secure a positive living arrangement after only 15 days at a runaway shelter because, for example, family reunification is not always a viable option. A Los Angeles study found that only 19 percent of

adolescents seen in shelters were good candidates for immediate family reunification (35).

Federal Runaway and Homeless Youth Act funds provide only a portion of the funds used by runaway and homeless youth centers. Such centers also receive funds from a number of other sources, including State and local governments, local United Ways, religious groups, foundations, corporations, and other private sources (41). Many also rely heavily on the use of volunteers. A 1985 survey of 210 agencies serving runaway and homeless adolescents found that 75 percent received some funding from Runaway and Homeless Youth Act funds, which covered about a third of their budgets. Shelters relied on an average of five public and private funding sources in addition to these funds (see box 14-B).

In addition to supporting runaway and homeless youth centers, the Runaway and Homeless Youth Act supports a National Runaway Switchboard. This switchboard, which provides counseling and referral services to adolescents and their parents, handles some 250,000 calls per year, 90 percent of them from young people (about 20 percent of these callers used the service to contact their families) (72). Since fiscal year 1985, the National Runaway Switchboard has also served as the Adolescent Suicide Hotline; it gets about 2,500 suicide-related calls per month.<sup>39</sup>

In 1988, the Runaway and Homeless Youth Act (H.R. 1801) was incorporated into the Anti-Drug Abuse Act of 1988 (H.R. 5210) and reauthorized during the 100th Congress (Public Law 100-690). Congress appropriated \$26.9 million for the Runaway and Homeless Youth Act for 1989 (Public Law 100-690); it appropriated \$28.8 million for 1990 (Public Law 101-204). In addition to continuing authorization for funding of shelter programs and runaway hot lines, the law reauthorizing Runaway and Homeless Youth Act programs authorized anew transitional living program for homeless adolescents and young adults ages 16 to 21, provided other runaway programs are fully funded. Transitional living programs are structured programs that provide shelter while helping young people develop the skills they need to live on their own. Transitional living programs would provide a variety of services, including counseling in interpersonal and life skills. No more than 20 young people would be served at



Photo credit Sasha Bruce Youthworks

**Transitional living programs are structured programs that provide shelter to young people while helping them develop the skills they need to live on their own.**

one time by each program, and shelter and services would not be provided for more than 18 months. It was not until 1990 that a total of \$19.8 million was appropriated for transitional living program grants to be made in fiscal years 1990 and 1991 (41). Evaluation of funded programs was to begin late in 1991, and grantees are required to submit annual reports to DHHS on their activities and achievements (42 U.S.C. 5714-2). The Young Americans Act of 1990 (Public Law 101-501) also allows for, but does not require, grants to be made for transitional living services to young individuals who are homeless, with no age restriction specified.

### **Barriers to Care Under the Runaway and Homeless Youth Act**

Organizations that provide services to homeless and runaway adolescents face a number of barriers to providing effective services (35,41) and shelter providers report that they cannot always provide services for all adolescents in need. A survey of shelter agencies in Los Angeles County found, for example, that providers turn away six young people for every five they serve. Los Angeles County has only 112 shelter beds, despite a homeless and runaway adolescent population that may be as great as 10,000 at any one time (35).

Staff turnover in shelters is reported to be high, in part because of the low salary base. While shelter providers function to link adolescents with other community services, they report a lack of a contin-

<sup>39</sup>For a discussion of suicide hot lines, see ch. 11, "Mental Health Problems: Prevention and Services," in this volume.

**Box 14-B—Bridge Over Troubled Waters: An Agency Serving Runaways and Homeless Street Youth**

Bridge Over Troubled Waters is a multiservice agency in Boston, Massachusetts, that is designed to meet the shelter and service needs of runaways and homeless street youth. It currently serves some 4,000 young people ages 13 to 25—most of them are ages 16 to 21—each year (14). As noted further below, Bridge receives funds from a combination of public and private sources.

**Programs and Services**

When it was founded in 1970, Bridge consisted of three programs:

- a streetworker outreach program,
- medical van services, and
- counseling (14).

Over the years, Bridge programs have been expanded to include:

- a free dental clinic,
- a runaway program,
- an education/pre-employment program,
- a Family Life Center for pregnant and parenting young women, and
- the Bridge Houses and several other residential programs that offer housing options for targeted groups of homeless adolescents (e.g., single parents, long-term street youth with substance abuse problems, and high school-aged runaways).

All Bridge services are provided without cost to recipients.

**Outreach—Bridge uses streetworkers to make informal contact with** homeless and runaway young people and to inform them of the services available through Bridge (14). The goal of the outreach program is to establish a trusting relationship with homeless and runaway young people, so that those in need of service will eventually feel safe and comfortable asking for the services they need. Bridge streetworkers conduct outreach on weekday afternoons and evenings in a range of areas where young people are known to gather. In 1989, streetworkers contacted over 3,000 homeless and runaway young people.

**Medical and Dental Services—**Bridge provides free medical services through its free medical van and in-house clinic (14). The Bridge medical van is staffed by volunteer physicians and nurses. Each weeknight, the van makes stops at places where young people gather and provides onsite medical care. The in-house clinic operates 1 day per week and is staffed by a nurse practitioner. In 1989, approximately 2,000 individuals received medical services through the free medical van, and the nurse practitioner at the in-house clinic saw 187 patients.

Since 1972, Bridge has provided free dental services at the dental clinic located at the agency's downtown facility (14). Complete treatment and restorative services are provided by a pool of volunteer dentists, hygienists, and dental assistants. In 1989, 482 young people received services at the dental clinic.

**Counseling—**Bridge provides a range of counseling services to its clients (14). On the basis of the results of an intake assessment to determine their service needs, clients are assigned to a long-term counselor. The counselor then works with the client to identify issues of concern and to develop a treatment plan to address those issues. Treatment plans are reviewed frequently by the client and his or her counselor, and are updated at least every 6 months. In 1989, 2,158 clients received services through the counseling program.

**Runaway Program—**Through its runaway program, Bridge provides crisis services to adolescents under age 18 who have left home and are on the streets with no place to go (14). The runaway program provides food, clothing, and shelter in the home of an emergency shelter care volunteer. Efforts are made through the program to reunite runaway adolescents with their parents; where family reunification is not appropriate (e.g., where there is a risk of physical or sexual abuse, or there is severe family dysfunction), however, efforts are made to find alternative housing, sometimes in the Bridge Houses (see below) operated by Bridge. Each year, runaway program services are provided to over 400 adolescents.

**Education/Pre-Employment Services—**Through the Education/Pre-Employment Program, Bridge staff provide tutoring for young people working toward completing the general educational development (GED) program (14). A job developer works with these students, as well as other interested clients, to develop job readiness and interviewing skills. The Bridge Family Life Center provides support to pregnant and parenting young women, including providing instruction in prenatal care, child development, and health and nutrition (14). Individual



counseling is also provided, along with life skills education. Child care is available to enable mothers to attend GED classes.

**Residential Programs**—Bridge has several residential programs (14). The two Bridge Houses provide shelter to a total of 32 residents for a period of 6 to 8 months. The Bridge Houses target different groups of homeless: adolescents and young adults reside in one Bridge House, and single parents and their children reside in another (12). Residents participate in programs focusing on education and building independent living skills; they are required to participate in weekly group counseling, individual counseling, and daily cooking and cleaning (14). They must attend high school or a GED program and hold a job. Residents are also required to pay rent based on their income. Staff, who are responsible for supervising residents' activities, coordinating job development and recreational activities, and providing counseling on house-related issues, are on duty 24 hours per day. Six Bridge transitional apartments provide housing for 15 graduates of Bridge Houses, along with an additional year of informal supervision and support services (14). Bridge staff provide support to aid residents in their final transition to independent living.

### **Funding**

Program expenses for Bridge in 1989 were \$1,481,214. Residential programs accounted for the largest portion of expenses (42 percent). Runaway, counseling, and streetwork outreach accounted for the next largest portion (31 percent) (13). In 1988, program expenses exceeded revenue by nearly \$60,000. In 1989, however, increases in funding, primarily from grants and contracts from foundations and additional funding from United Way, allowed Bridge to show a surplus of revenue.

Bridge receives funding from a combination of sources (13). Funding for 1990 was from the following sources:

- . 40 percent from public grants and contracts (13 percent of total funding is from Federal sources, 23 percent from the State, and 5 percent from the city);
- . 22 percent in the form of grants and contributions from foundations,
- . 25 percent from United Way,
- . 7 percent from individual contributions, and
- . 5 percent from other sources such as local charities.

Federal funding for Bridge comes through the the Runaway and Homeless Youth Act administered by the U.S. Department of Health and Human Services, and includes discretionary funding for a 3-year demonstration grant to Bridge for the single-parent house and the transitional apartments.

uum of needed services. In particular, they report a lack of drug detoxification and inpatient drug abuse treatment facilities, and of acute mental health beds and programs to provide followup services after discharge from inpatient care. Service providers also cite the lack of transitional living programs to help adolescents learn important skills for living on their own (e. g., managing finances, problemsolving, and employment and training) (35,41).

Shelter staff are supposed to develop plans for living arrangements and other needs of clients served by runaway and homeless youth centers. According to a study by GAO, however, no aftercare plans are made for almost half of homeless adolescents using the shelters. Furthermore, the plans that are made may be insufficient to fully address the needs of the homeless adolescent (66). For example, although drug or alcohol abuse problems were reported for over a fifth of homeless adolescents

served during the study period, drug or alcohol treatment was planned for only 4 percent,

### **Effectiveness of Runaway and Homeless Youth Services**

In part because of the barriers to service discussed above, shelters have shown mixed success in placing homeless adolescents in more stable living situations. A recent GAO study reported that about one-third of the homeless adolescents (as compared to 58 percent of runaway adolescents) using federally funded runaway and homeless youth shelters between October 1985 and June 1988 planned to live with a parent or other relative upon leaving the shelter (66). Approximately 20 percent of the homeless adolescents using these shelters expected to enter foster or group homes, and 6 percent expected to enter independent living. On the other hand, 14 percent expected to live with friends or on the street, 6 percent expected to live in another

HOUSE ORGANIZATION AND MAINTENANCE POLICIES

We have established the following policies in order to maintain the house, get meals prepared, and meet individual needs for privacy, order, and time.

- 1) Residents will assist with daily house chores as assigned, and on Saturdays all residents will assist in major house-cleaning chores. Daily chores must be done before you leave in the morning or by 9:30 a.m. There will be no use of telephones or radios until completion of chores.
- 2) Residents are expected to maintain their bedrooms. They are to be cleaned in the morning before leaving the house or by 9:30 a.m. All clothing and shoes must be in closets or drawers and off the floor. The bedrooms are to be kept neat.
- 3) Residents are responsible for their own personal hygiene and laundry (clothing, sheets, towels, etc.)
- 4) No pets are allowed in the house, nor are they permitted to be kept at the house.
- 5) Items of value (wallets, money, IDs, etc.) are to be locked in the office. Stepping Stone will not accept liability/responsibility for residents' personal belongs. Loss and/or damage to personal property is assumed by the resident.
- 6) Residents are required to sit down at the diner table for the evening meal and also participate in evening group sessions.
- 7) Visiting hours for guests: Monday through Friday - 2:00 p.m. to 5:00 p.m.  
Saturday and Sunday - 12:00 noon to 6:00 p.m.  
Parents and family members may visit at any reasonable time with prior counselor and youth notification.
- 8) The "Emergency Only - Do Not Disturb" sign on the office door means do not knock or open the door unless what you need absolutely cannot wait. Please be thoughtful when sessions are going on.
- 9) Every resident except the assigned cook must help clean up the dining room and kitchen after the evening meal.
- 10) Dishes and utensils must be washed by hand and then placed in the dishwasher or in the drainer no matter what time of the day. Do not leave them in the sink or elsewhere. This may result in entertainment ban.
- 11) No sleeping allowed during the day. The TV is not to be on during the day. After group sessions or dinner the TV may be on with the OK from the staff.
- 12) The radio must be kept at a level that does not interfere with the telephones or people's conversations. Do not blast the radio please. Violations will result in entertainment ban.
- 13) Evaluations must be completed before 7:00 p.m. It is your responsibility to ask staff to do it with you.
- 14) Washers and dryers are not to be used between 10:00 p.m. and 8:00 a.m.

AGREEMENT: I have read and understand these policies. I voluntarily will participate in the Stepping Stone program and agree to abide by the above policies while at the house.

Resident \_\_\_\_\_

Witness \_\_\_\_\_

6/87

Date \_\_\_\_\_

Courtesy of Stepping Stone

House rules such as these of a California transitional living program help homeless adolescents develop the skills they need to live on their own.

runaway shelter, and 14 percent did not know where they would go. At least some of these adolescents probably chose to remain on the streets either because the alternatives they were offered (e.g., returning to live with an abusive parent or entering foster care environments) were not desirable to or appropriate for them; because desired alternatives (e.g., independent living) were not available to them; or because, given the lack of appropriate alternatives, they did not wish to leave the relative freedom of the streets and a supportive “community” of friends.

In one New Jersey study, one-third of adolescents receiving shelter services were able to return to their families after receiving services; another third went to foster care or a group home (58).

However, other studies have reported more positive results or effects of shelters. According to a report of the Los Angeles Task Force on Runaway and Homeless Adolescents, 70 percent of adolescents in Los Angeles County who received shelter services from October 1986 to September 1987 either returned to their families or went to other appropriate alternatives (e.g., foster care or independent living). Six months later, almost all of these adolescents (94 percent) were reported to have remained off the street (35).

A September 1983 report by GAO that assessed the role of runaway and homeless youth centers in reuniting families and resolving family conflicts, indicated that the great majority of adolescents who used their services (93 percent) and their parents (98 percent) believed that the services provided by the center had been helpful in resolving their family problems (64a).

Thus, while runaway and homeless youth shelter programs have proven to be extremely helpful to some adolescents, there are other adolescents for whom shelter services may not be adequate. The number of these adolescents is not known, but they seem likely to be those who are the most deeply troubled and for whom being reunited with a family is not a feasible option.

### ***Missing Children’s Assistance Act***

*In* 1984, Congress passed the Missing Children’s Assistance Act as Title IV of the Juvenile Justice and

Delinquency Prevention Act (Public Law 98-473). The Missing Children’s Assistance Act, which is administered by the Office of Juvenile Justice and Delinquency Prevention within the U.S. Department of Justice, authorizes Federal support for various activities designed to address issues related to the problem of missing children.

Programs funded under the Missing Children’s Assistance Act include a national toll-free telephone line for reporting information on missing children, a national resource center and clearinghouse, and funding of various research projects on and programs for missing and exploited children. These programs are focused primarily toward missing children—i. e., children whose whereabouts are unknown to their legal custodian in circumstances that indicate that the child was removed without the consent of their legal guardian—or children at high risk of being abused or sexually exploited.

Although homeless children per se are not the primary focus of the Missing Children’s Assistance Act, such children may be included as a focus for services if they fall under the definition of missing children as included in the Missing Children’s Assistance Act. The interpretation of what constitutes risk of abuse remains ambiguous under the act (75). The mere fact that a minor is living on the street is not enough to warrant an expectation that he or she has a strong likelihood of being abused or sexually exploited. Furthermore, the need for actual evidence of such abuse increases as the child becomes older (67).

In 1987, the U.S. Department of Justice funded a study under the Missing Children’s Assistance Act to develop reliable and valid national estimates of the numbers of missing children over the course of a year and to establish profiles of missing children. Runaways and throwaways are included in the study, as are family-abducted children and non-family-abducted children (75).

### ***Anti-Drug Abuse Act of 1988***

The Anti-Drug Abuse Act of 1988 (public Law 100-690) authorized \$15 million for drug abuse treatment and prevention programs for homeless and runaway adolescents (ages not specified)—including peer counseling programs; individual, family,

and group counseling; and community education activities.<sup>40</sup> This funding is available only when appropriations for the Runaway and Homeless Youth Act (see above) exceed the amount appropriated for the previous year.

Funding first became available in fiscal year 1989. Grants were awarded by the Administration of Children, Youth, and Families in DHHS to 104 organizations and agencies to address drug abuse problems among homeless and runaway adolescents (30).

### ***Collaborative Efforts Among Federal Agencies***

The Administration for Children, Youth, and Families, the agency in DHHS's Office of Human Development Services that administers the Runaway and Homeless Youth Act, has entered into collaborative arrangements with other Federal agencies to improve services to homeless adolescents. In fiscal year 1988, the Administration for Children, Youth, and Families signed a memorandum of understanding with the Public Health Service to facilitate the development of relationships between federally funded Health Care for the Homeless projects and runaway and homeless youth centers. The memorandum of understanding also includes a pilot program that enables medical students to volunteer their services in homeless and runaway youth centers.

The Administration for Children, Youth, and Families has also worked with the National Institute on Drug Abuse to develop an AIDS prevention curriculum for shelter staff. Training programs for shelter staff have now been initiated (30).

### **Conclusions and Policy Implications**

DHHS estimated in 1984 (on the basis of data from a 1976 survey mandated by Congress) that there are as many as 1 million homeless and runaway adolescents ages 10 through 17 each year, and this estimate continues to be used.

Information about the causes and consequences of adolescent hopelessness is limited.<sup>41</sup> Some homeless adolescents are homeless because their families are homeless; others are homeless on their own.

Adolescents who are homeless with their families are likely to be homeless because of lack of available housing, limited economic resources, family crises (e.g., divorce or separation of parents or of an adolescent and his or her partner, loss of family source of income, eviction). Adolescents who are homeless on their own are more likely to be homeless because they have left dysfunctional families in which there are high levels of conflict, because they have been abused, because they themselves are suffering from mental disorders or other problems, or because they have left foster care or institutional settings (e.g., juvenile justice facilities or mental health institutions) without arrangements for stable housing.

Whether in families or on their own, homeless adolescents experience a broad range of physical, mental, and school problems. Homeless adolescents on their own have high rates of substance abuse, sexual activity (including prostitution), and delinquency. Sometimes these activities are used as survival strategies (e.g., exchange of sexual favors for food or a place to stay). There is anecdotal evidence that the population of young people on the street is becoming younger and more dysfunctional.

Little is known about the health, education, or other needs of homeless adolescents who do not use the existing runaway and homeless youth shelter system. Most of the research that has been done to date has relied heavily on adolescents sampled from shelters in urban areas and does not follow adolescents over time. As a consequence, very little is known about homeless adolescents who do not utilize shelter services (or even what proportion do use services) or about the characteristics and service needs of homeless adolescents in nonurban areas.

There is strong evidence, however, that homeless adolescents are at high risk for physical health problems (including pregnancy and sexually transmitted diseases), mental health problems, and substance abuse. They are also at high risk for social problems such as dropping out of school, lack of employment skills, and criminal and delinquent behavior.

<sup>40</sup>For a general discussion of Federal policies pertaining to substance abuse among adolescents, see ch. 12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," in this volume.

<sup>41</sup>DHHS, as required by the Stewart B. McKinney Homeless Assistance Act (Public Law 100-77), funded a study of the underlying causes of youth hopelessness in 1988, and the results are expected in late 1991 (43a).

The approaches for preventing hopelessness among adolescents vary, depending in part on whether adolescents are living with their families or are in foster care or institutions. Clearly, one possible strategy for preventing hopelessness among adolescents living with their families would be to increase the Nation's supply of safe, affordable, accessible low-income housing. An additional strategy would be to support prevention, early identification, and supportive interventions to help resolve problems in dysfunctional families that contribute to adolescents' leaving home (e. g., parental substance abuse, physical or sexual abuse of a child, and family conflicts related to an adolescent's homosexuality). Adolescents living in foster care, group homes, or institutions such as State psychiatric hospitals or juvenile justice facilities are particularly important subjects for hopelessness prevention programs. Unless they receive adequate preparation for independent living and developmentally appropriate supportive services, adolescents who leave these settings are at high risk of becoming homeless. The Federal Government provides grants to States to develop model "independent living" programs to facilitate adolescents' transition to independent living after leaving the foster care system (76). Even adolescents who participate in independent living programs, however, may need various types of social, economic, and emotional support before they can become independent (76).

Many adolescents who become homeless, whether with their families or on their own, have physical, mental health, or social problems prior to becoming homeless. Once they become homeless, these problems may worsen and their need for services is likely to increase. Studies indicate that homeless adolescents are at extremely high risk for a multiplicity of physical health problems (e.g., nutritional deficiencies, sexually transmitted diseases, problems related to physical or sexual abuse), mental health problems (e.g., depression, substance abuse), and school problems (e.g., dropout). Because these problems cut across traditional *agency* boundaries, homeless adolescents are likely to be best served by a system that offers a continuum of coordinated and comprehensive services.

Comprehensive, developmentally appropriate services for homeless adolescents are practically nonexistent in this country. Even safe shelter is not always available. At the Federal level, the needs of homeless adolescents have been addressed most directly through the limited funding of the Runaway and Homeless Youth Act, which helps fund runaway and homeless youth centers. These centers provide 15 days of emergency shelter to homeless and runaway adolescents and aim to reunite the adolescents with their families. Unfortunately, the number of beds available is far outstripped by the number of adolescents in need. Furthermore, for adolescents who have run away from or been thrown out of abusive or severely dysfunctional families, the goal of family reunification may not be appropriate; these adolescents need far more than 15 days of emergency shelter.

In addition to needing emergency shelter, many adolescents who are homeless, whether with their families or on their own, need safe permanent housing and a variety of health, educational, and social support services. In most communities, services for homeless adolescents are fragmented and inadequate. Thus, for example, few communities have a full range of mental health and substance abuse programs to serve homeless adolescents, and the lack of residential substance abuse treatment programs for homeless adolescents, particularly those without health insurance, has been frequently noted (41,60).<sup>42</sup> Another point that should be made is that many adolescents who are homeless on their own face legal barriers to obtaining housing *or* other services. If they have not been emancipated, they may not be able to sign a lease, obtain Federal income support and health insurance benefits, obtain medical care, *or* enroll in school without permission of a guardian.<sup>43</sup> Policies that would enable homeless adolescents to more easily obtain the services they need would reduce their risk for further problems (e.g., by increasing the chances that they may finish school, by ensuring that they get appropriate health care, by allowing them to secure safe housing).

As a group, homeless adolescents are in need of targeted education and employment training programs that offer a range of options, including flexible day labor and part-time work. As noted

<sup>42</sup>Most homeless adolescents have no health insurance. The effectiveness of substance abuse treatment for adolescents is discussed in ch.12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," in this volume.

<sup>43</sup>Legal emancipation is discussed in ch.17, "Consent and Confidentiality in Adolescent Health Care Decisionmaking," in Vol. III.

earlier, Congress recently changed the McKinney Homeless Assistance Act to require States to ensure access to public education for homeless adolescents. The responses of States to this requirement should be carefully monitored. Working adolescents who have not completed high school may need alternative school programs in order to complete school; other adolescents who have experienced disruptions in their education while homeless may need special “catch-up” programs. Because they are likely to have few marketable skills, particularly if they have not completed high school, homeless adolescents may also need employment preparation and training.

Addressing the problems of homeless adolescents demands responses at the Federal, State, and local levels, and involvement of both the public and private sectors. Specific policy options related to the problems of runaway and homeless adolescents are listed in Volume I.

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