Homeless Youth: Research, Intervention, and Policy

by

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Abstract

Homelessness among youth in the U.S. is disturbingly common, with an estimated annual prevalence of at least 5 percent for those ages 12 to 17. Although homeless youth appear throughout the nation, they are most visible in major cities. Rigorous research on this special population is sparse, making it difficult to capture an accurate and complete picture. Despite its limitations, recent research describes homeless youth as a large and diverse group. Many homeless youth have multiple overlapping problems including medical, substance abuse, and emotional and mental problems. Literature suggests that comprehensive and tailored services are needed that address both the immediate and long-term needs of homeless youth. Where appropriate, services should include assistance with meeting basic needs as perceived by youth as a gateway to other needed services. In addition to serving those already homeless, interventions are needed to prevent homelessness among at-risk youth.

Lessons for Practitioners, Policy Makers, and Researchers

• As used here, the term “homeless youth” focuses on minors who have experienced literal homelessness on their own—i.e., who have spent at least one night either in a shelter or "on the streets" without adult supervision. On occasion, where warranted by the research being discussed, the term is also used to describe homeless young adults up to age 24.
• Homelessness among youth in the U.S. is disturbingly common. With an estimated annual prevalence of at least 5 percent for those ages 12 to 17, adolescents appear to be at greater risk for literal homelessness than adults. Although homeless youth appear throughout the nation, they are most visible in major cities.
• Research on homeless youth has major limitations. Rigorous research on this special population is sparse, making it difficult to capture an accurate and complete picture of homeless youth. Research would benefit from studies that include large representative samples, reliable and valid measures, comparison groups, and assessment of strengths as well as problems of homeless youth. Research with this special population would likely benefit from more input by service providers, policy makers, and the youth themselves.
• Despite limitations of the literature, it seems clear that homeless youth constitute a large and diverse group
• Many youth have multiple overlapping problems. Many youth come from homes where family conflict and child maltreatment are common. A wide range of health and behavior problems have been documented among homeless youth, including
substance abuse, emotional and mental problems, and medical problems. While some of these problems appear to be long-standing, others are probably exacerbated by the stressful experiences of homelessness. Homeless youth, especially those on the streets, sometimes resort to illegal activities such as prostitution or drug dealing in order to survive. Many youth are victimized while homeless.

- Few interventions with homeless youth have been formally evaluated. Careful program evaluation of services is sorely needed, especially based on rigorous experimental designs.
- The limited literature suggests that comprehensive and tailored services are needed that address the immediate and long-term needs of homeless youth. Where appropriate, services should include assistance with meeting basic needs as perceived by youth as a gateway to other needed services. Other needed services include screening and treatment for health, mental health, and substance use problems, reconciling family conflict, and educational or vocational training. In addition to serving those already homeless, interventions designed to prevent homelessness among at-risk youth are needed.

**Estimating Needs Based on Existing Research**

Homelessness among young people in the United States and other nations is a serious and complex problem.(1) The population of homeless youth seems to have disproportionately high rates of health problems, emotional and behavioral problems, and substance use. Homelessness itself potentially poses health risks to youth and can interrupt normal socialization and education, which likely affects a young person's future ability to live independently. This paper provides a profile of homeless youth in the US, documenting their diversity and their service needs. The paper then describes various intervention approaches for homeless youth and discusses relevant social policy. It ends with recommendations for future research.

**Limitations of Existing Literature**

The available literature on homeless adolescents has major limitations. Rigorous research on this special population is sparse. Much research and other information about homeless youth is fugitive and often dated. As a body of research, it is much less rigorous than contemporary research on homeless adults or families. Information on homeless youth in large urban areas is most prevalent but may not generalize to other areas, and different definitions and methods often prohibit meaningful comparisons. Cross-sectional samples over represent longer-term homeless youth, which results in an over-reporting of factors related to chronic homelessness. In addition, many studies lack rigorous sampling strategies, which limits their generalizability.

Capturing a complete picture of homeless youth is difficult. In some cases, what is known about a particular characteristic of homeless youth may be based on a single study. Where multiple studies are available, findings may be contradictory.
Often contradictory findings occur because the results from a study depend very much on the source of its sample. Recent literature has relied on four basic approaches to sampling. One surveys large groups of teens in the general population and identifies youth from this pool who have a history of homelessness (e.g., Ringwalt et al., 1998; Windle, 1989). These approaches under-represent youth who have longer histories of homelessness or institutional histories. The second approach draws youth from shelters (e.g., McCaskill et al., 1998) who are often younger and less likely to have previous histories of homelessness. The third draws a sample from clinical settings such as medical clinics (Yates et al., 1988). Such studies describe youth seeking treatment and who are often very different from youth who do not seek treatment. The fourth involves sampling from street locations where homeless youth are known to congregate (e.g., Cauce et al., 1994a; Kipke et al., 1995; Robertson, 1989). This street-sampling method, especially if it includes youth who are 18 or older, generally yields a much more "deviant" profile of homeless youth.

Despite its limitations, recent literature suggests that homeless youth constitute a large and very diverse population.

**Definitions**

Defining what constitutes a "homeless youth" may seem fairly straightforward but, in fact, the issues involved in the task are rather complicated. Most researchers studying homeless persons tend to focus on persons who are "literally homeless" (Rossi, 1989). In this paper, we take a similar approach, using the term "homeless youth" to refer primarily to minors on their own who have spent at least one night either in emergency shelter or "on the streets"—that is, in places outdoors or in improvised shelter without parental supervision.(2)

An important decision to be made in defining "homeless youth" involves age. Across the existing literature on homeless youth, the age range has varied widely. In this paper, we will generally use the term "homeless youth" to refer to those between the ages of 12 and 17. However, many studies of homeless youth have also included young adults up to age 24. We will still review studies of youth that also include young adults, but we will note the extended age range involved.(3)

The target population for this review is heterogeneous and includes youth described with a variety of terms in research and popular literature (Kennedy et al., 1990; Robertson, 1996). These terms include "runaways," who have left home without parental permission, "throwaways," who have been forced to leave home by their parents, and "street youth," who have spent at least some time living on the streets. All studies reviewed here include youth who have spent at least one night literally homeless, regardless of the conditions of separation from their last home. It is important to note that some homeless youth have experienced long or repeated episodes of homelessness, while others are having their first experience with homelessness or have been homeless only for a few days.
To avoid the sort of terminological confusion common in the existing literature, throughout this paper we will refer to this overall group as "homeless youth." However, when referring to specific reports or studies, we may use the language of their authors specifically to identify the subgroup of homeless youth they studied.

**How Many Homeless Youth Are There?**

The methodological problems in estimating the prevalence of homelessness have been widely discussed and debated (Appelbaum, 1990; Blau, 1992; Burt, 1994, 1998; Culhane, Dejowski, Ibanez, Needham, & Macchia, 1994; Foscarinis, 1991; Kondratas, 1991, 1994; Link, Susser, Struve, Phelan, Moore & Struening, 1994; Robertson, 1991; Rossi, 1989, 1994; Solarz, 1988; Toro & Warren, 1999; Wright, Rubin, & Devine, 1998). Though most of this debate has involved homeless adults, many of the controversies and methodological problems identified in the literature apply to homeless youth.

Notwithstanding the debates, evidence suggests that the size of the homeless youth population is substantial and widespread. A recent large-scale survey of U.S. adolescents provides the most comprehensive data to date on the extent of homelessness among youth (Ringwalt, Greene, Robertson, and McPheeters, 1998). In 1992 and 1993, researchers interviewed a nationally representative household survey of 6,496 youth, ages 12 to 17, as part of the National Health Interview Study (NHIS) sponsored by the Centers for Disease Control and Prevention. To assess literal homelessness in the previous 12 months, youth were asked whether they had spent one or more nights in specific types of places. These included: a youth or adult shelter; any of several locations not intended to be dwelling places (i.e., in a public place such as a train or bus station or restaurant; in an abandoned building; outside in a park, on the street, under a bridge, or on a rooftop; in a subway or other public place underground); or where their safety would be compromised (i.e., with someone they did not know because they needed a place to stay). Based on these estimates, researchers estimated the annual prevalence of literal homelessness among this age group to be 7.6 percent (or 1.6 million youth in a given year). Even after revising their estimate down, removing youth whose only experience with homelessness was in a "shelter" (a potentially ambiguous term used in the interview), they still estimated that 5 percent had experienced literal homelessness in the previous year (or more than 1 million youth in a given year). The prevalence of homelessness did not vary significantly by family poverty status (determined by parent’s reported income), geographic area, or sociodemographic factors other than by gender (i.e., with significantly higher rates of homelessness for males than females).

These estimates suggest that adolescents under age 18 may be at higher risk for homelessness than adults. In 1990, researchers surveyed a nationally representative sample of 1507 adults in households with telephones (Link, Susser, Stueve, Phelan, Moore, & Struening, 1994). To assess literal homelessness, adults were asked if they had ever considered themselves to be homeless. Next they were asked if, while homeless, they had ever slept in a shelter for homeless people or another temporary residence because they did not have a place to stay, or in a park in an abandoned building, in the street, or in a train or bus station. Among those who reported literal homelessness, those
who had been homeless within the previous five years were identified. Among US adults, five-year prevalence of self-reported homelessness among those ever literally homeless was estimated at 3.1 percent (or 5.7 million adults in a five-year period) and lifetime prevalence was estimated at 7.4 percent (or 13.5 million adults). Other studies report similar lifetime rates (8%; Manrique & Toro, 1994).

**Geographic Distribution and Patterns of Homelessness**

Based on the national survey of housed youth described above, those with a history of recent homelessness were found throughout the nation and across urban, suburban, and rural areas (Ringwalt et al., 1998). Nevertheless, homeless youth appear to be most concentrated and visible in major cities (as is the case for homeless adults and families). It is hard to determine whether this apparent concentration in urban areas is a function of where researchers are located or a "true" over-representation of homeless youth in urban areas.

**Street Youth.** The research literature documents significant numbers of youth actually living “on the streets” (i.e., not in shelters), primarily in certain large metropolitan areas on the east and west coasts. While street youth have been studied in areas such as Los Angeles, San Francisco, Seattle, and New York City, such youth have rarely been documented in Midwestern and southern communities. While street youth represent an unknown proportion of all homeless youth, this subgroup is of obvious concern and much research has focused on it. As we will document in this review, street youth generally show the most disturbing histories of life disruptions and personal problems. This subgroup also often has longer histories of homelessness and is less likely to use traditional services.

**Local Residents.** Contrary to popular stereotypes, several older studies show that most homeless youth are in fact "local kids." For example, the majority (72%) of youths served in 17 runaway and homeless youth programs nationally were from the immediate geographical area in which the program was located (van Houten & Golembiewski, 1978). Most New York City shelter clients were born in the city (Citizens' Committee for Children of New York, 1983; New York State Council on Children and Families, 1984). In Albany, New York, the majority were from Albany or other parts of the Capital District (58%); only about one-quarter were from out of state (Council of Community Services, 1984). Service providers in Los Angeles County reported that the majority of their clients are from within the county (67%) or within the state (18%; Rothman & David, 1985). Even in Hollywood, California, where one might expect a more transient population, three-quarters of a sample of street youth had been residents of the surrounding county for more than a year (Robertson, 1989). Although most homeless youth seem to be local residents, many homeless youth (25-42%) are not local.

**History of Homelessness.** History of homelessness seems to vary by whether youth are sampled from shelters or from the streets. Studies of homeless youth obtained from shelters generally find that most homeless youth have been homeless for relatively short periods of time and have not experienced prior homeless episodes. For example, in a
probability sample of 118 adolescents (ages 12-17) from all six major youth shelters in the Detroit metropolitan area, two-thirds had never been homeless before, and most (86%) had been homeless for four weeks or less in their current episode (McCaskill, Toro, & Wolfe, 1998). In contrast, in one Hollywood street sample (ages 13 to 17), most youth demonstrated patterns of episodic (i.e., multiple episodes adding up to less than one year; 44%) or chronic homelessness (i.e., being homeless for one year or longer; 39%) (Greenblatt & Robertson, 1993).

Characteristics of Homeless Youth

There is no typical homeless youth, and there is no single cause for youth homelessness. The literature describes youth who experience homelessness and offers varied explanations for why youth become homeless in the first place or why they may remain so. Yet, it is difficult to determine the degree to which any particular characteristic or experience might be a primary cause or a contributing factor to youth homelessness. Below, we review these findings and highlight the diversity of the homeless youth population.

Background Characteristics

Gender and Age. In a national survey of youth (Ringwalt et al., 1998) males were significantly more likely than females to report recent homelessness. In local studies of homeless youth, gender representation seems to vary depending on the source and age of the sample (Robertson, 1996). Samples from shelters suggest either even numbers or more females. In contrast, samples of street youth or older youth tend to include more males.

Based on recent studies, the vast majority of homeless youth appear to be age 13 or older, although several studies have identified small numbers of youth homeless on their own who are as young as nine (Clark & Robertson, 1996; Robertson, 1991).

Race or Ethnicity. A national survey of youth found no differences in rates of recent homelessness by racial or ethnic group (Ringwalt, et al., 1998). While local studies tend to document that homeless youth generally reflect the racial and ethnic make-up of their local areas, three local studies also report over-representation of members of racial or ethnic minorities relative to the local community. For example, African Americans were over represented in a probability sample from shelters throughout metropolitan Detroit, where 46 percent of 118 homeless youth were African-American compared to 22 percent in the area’s general population (McCaskill et al., 1998). Both African Americans and Native Americans were reported to be over-represented in a street sample from Seattle (N=229; ages 13-21; Cauce et al., 1994a) and a statewide sample from Minnesota (N=165, ages 11-17; Owen et al., 1998).

Sexual Orientation. The rate of gay or bisexual orientation among homeless youth varies across studies. In several studies with shelter and street samples, 3 to 10 percent of youth have reported their sexual orientation as gay, lesbian or bisexual (Greenblatt &
Robertson, 1993; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Rotheram-Borus et al., 1992b; Toro et al., 1998; Wolfe et al., 1994). Such rates suggest that homeless youth are no more likely than non-homeless youth to report gay or bisexual orientation when compared to the national rate of about 10 percent (Dempsey, 1994). However, higher rates of gay or bisexual identity (16 to 38%) are reported in another set of studies.(5) The higher rates in these studies (16 to 38%) can be accounted for by samples that came from street or clinical sites; tended to be older; included more men (who generally have higher rates than women for gay or bisexual orientation); or came from areas with significant concentrations of gay or bisexual persons in the larger community.

**Family Poverty and Youth Homelessness.** Youth who experience literal homelessness seem to come from less impoverished backgrounds than homeless adults. For example, sheltered youth came from significantly better socioeconomic circumstances than the sheltered adults in Detroit (Bukowski & Toro, 1996). In a representative national sample of youth (ages 12 to 17), those living with families in poverty were not more likely than other youth to have experienced homelessness in the previous year (Ringwalt et al., 1998b). In contrast, among adults in a representative national sample, those with lower socioeconomic status (SES) were more likely to experience homelessness in the previous five years (i.e., lower SES was defined by less than high school education; history of public assistance; or current annual income of $20,000 or less) (Link et al., 1994).

Some state and local studies suggest that disproportionate numbers of homeless youth may come from lower-income or working-class families and neighborhoods. For instance, for a broad four-state Midwestern sample of 602 homeless youth, two-thirds of the youths' parents (68%) reported family incomes under $35,000 (ages 12-22, obtained from shelters, street sites, and drop-in centers in urban, rural and suburban areas) (Whitbeck et al., 1997b). In a Detroit shelter, most youth (69%) came from families in which the parents held unskilled or blue-collar jobs (McCaskill et al., 1998). Most youth also (80%) came from neighborhoods where the median family income was under $40,000 (which was the approximate 1990 median family income for the total Detroit metropolitan area). A more recent study in Detroit, with a broader probability sample of 176 homeless youth (ages 13-17), obtained similar findings (Toro et al., 1998).(6)

The profile of homeless youth observed in the literature is highly dependent on the source of the sample (as observed for homeless adults by Link and colleagues, 1994). Findings suggest that while family poverty may not be related to homelessness among youth per se (given findings from the national household survey), family poverty may be related to more chronic or repeated homelessness (given recent local cross-sectional studies). Household surveys of formerly homeless youth may be more useful for setting lower-bound estimates of the extent of homelessness among youth within a given period of time. Such household surveys also likely present a more complete picture of the larger homeless youth population and of factors that put a youth at risk for homelessness. However, because of their method, they under-represent youth with longer histories of homelessness or institutional stays. On the other hand, the profile of currently homeless youth from studies with cross-sectional samples is a “snap-shot” of homeless youth on a given day, a population which likely over-represents youth with more chronic histories of
homelessness. Since they represent the potential service population, such cross-sectional profiles may be more useful for assessing needs and service planning.

**Family Conflict and Abuse.** Youth consistently report family conflict as the primary reason for their homelessness. Sources of conflict vary but include conflicts with parents over a youth's relationship with a step-parent, sexual activity and sexual orientation, pregnancy, school problems, and alcohol and drug use (Owen et al., 1998; Robertson, 1996; Toro, Goldstein, & Rowland, 1998; Whitbeck, Hoyt, Tyler, Ackley, & Fields, 1997b).

Neglect and physical or sexual abuse in the home are also common experiences. Across studies of homeless youth, rates of sexual abuse range from 17 to 35 percent, and physical abuse ranges from 40 to 60 percent (Busen & Beech, 1997; Robertson, 1989; Rothman & David, 1985). For example, most (75%) of 122 sheltered homeless youth (ages 12-17) in Detroit reported some form of maltreatment (Boesky, Toro, & Wright, 1995). Neglect was most common (57%), though many also reported physical (40%) and sexual abuse (31%). Many experienced multiple forms of maltreatment as well (e.g., 16% reported all three). When compared to housed peers, these homeless youth reported more maltreatment and received higher scores on the standardized measures of family conflict (Wolfe, Toro, & McCaskill, 1999). Homeless youth reported that their parents were more physically and verbally aggressive toward them, and that they were more verbally aggressive toward their parents. While violence from these youth may very well have been in response to the parent's initial violence, violence in these families seemed to occur in a context where both the youth and their parents may be engaging in violent or provocative behavior and where escalation is a dangerous prospect.

There is evidence that neglect and abuse may actually precipitate separations of many youth from their homes. In a Hollywood street sample (ages 13-17), many youth specifically reported leaving their homes in the past because of physical abuse (37%) or sexual abuse (11%). One-fifth of the sample (20%) had at some earlier point been removed from their homes by the authorities because of neglect or abuse (Robertson, 1989). Similarly, a study of 356 street youth (ages 13-21) in Seattle found that 18 percent had been removed from their homes (MacLean et al., 1999).

**Families of Origin.** Many homeless youth report disrupted family histories, which may contribute to the risk for homelessness. In a Hollywood street sample (ages 13-17), many homeless youth never knew their father (16%) or their mother (9%). Among the parents who were known, almost three-quarters had been either divorced or never married (Greenblatt & Robertson, 1993). In a probability sample of 122 sheltered homeless youth from Detroit (ages 12-17), most grew up in single-parent (34%) or "blended" (32%) families, many (22%) had been formally placed outside the home by officials, and about half (48%) had lived with relatives (not parents) for a substantial amount of time (Reed, 1994).

**Residential Instability.** For many youth, homelessness appears to be part of a long pattern of residential instability (Robertson, 1996). Consistently, homeless youth report
repeated moves during their lifetimes. For example, three quarters (73%) of a probability sample of 176 homeless youth in Detroit and surrounding counties had experienced at least one move during the prior 12 months, and 55 percent had move twice in this time period (ages 13-17; sampled from shelter, juvenile justice, and mental health agencies) (Toro, 1998).

Many studies report that many homeless youth have repeated contacts with public social service systems, many of which occurred at very early ages. Across several studies, rates of foster care placements have ranged from 21 percent to 53 percent (Cauce, Paradise, Embry, Morgan, Lohr, Theofelis et al., 1997; Owen et al., 1998; Robertson, 1989, 1991; Toro et al., 1998). Many homeless youth also report stays in psychiatric facilities and criminal justice facilities. For example, one-quarter of a Hollywood street sample (24%) reported previous psychiatric hospitalizations (Robertson, 1989). Majorities in two street youth samples in San Francisco and Hollywood reported stays in juvenile detention facilities, and most had multiple detentions (Clark & Robertson, 1996; Robertson, 1989).

Similarly, many adolescents in public systems have histories of homelessness or residential instability. Adolescent psychiatric inpatients in Los Angeles were found to have histories of high residential instability, with an average of 3 runaway episodes; most (70%) also had a history of placement into foster care or with an alternative caregiver (Mundy, Robertson, Robertson, & Greenblatt, 1989). In Albany County, New York, between 33 percent and 40 percent of jail inmates (ages 16 to 20), were homeless (Council of Community Services, 1984).

Evidence from two studies suggests that youth in residential placements or in institutional settings risk becoming homeless upon separation from those settings. In studies of street youth in Hollywood and San Francisco, more than one-quarter of those who had been in foster care, group homes, or juvenile detention became homeless upon their most recent separation. These youth reported that they had spent their first night after leaving the respective sites either in a shelter or on the streets (Clark & Robertson, 1996; Robertson, 1989). (However, it is unclear whether these moves into homelessness were the result of "running away" from the institutional placement or running away from the discharge site after leaving the placement.)

Some providers suggest that youth who are returned inappropriately to their prior homes due to lack of more appropriate alternative long-term placements may also be at risk. A 1985 Boston report suggested that the lack of available out-of-home resources (e.g., foster and group homes) is often more influential in service planning than the needs of the adolescents and their families. Half of the cases of first-time, out-of-home placements in one setting were returned home despite the assessment of the emergency shelter staff that this was an inappropriate placement decision (Greater Boston Emergency Network, 1985).

Additionally, some youth "age out" of the foster-care system with limited alternatives in place. One recent follow-up of such youth found that, in the 12 months after "aging out,"
a full 12 percent of the youth had spent at least some time homeless (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 1998).

According to an older survey of providers, less than half (47%) of youth in Los Angeles shelters were considered to have a realistic prospect of returning to their homes (Rothman & David, 1985). Only 19 percent were good candidates for immediate family reunification; and 25 percent were chronic runaways who were very unlikely to be returned home or to placement. In contrast to these findings, the majority of youth in federally funded shelters nationally (57%) were reunited with families or placed in a safe living environment (National Network of Runaway and Youth Services Inc., 1985).

**School and Learning Difficulties.** Consistently, studies suggest that many homeless youth have had interrupted or difficult school histories, and many are currently not attending school. In several studies, 25 to 35 percent of youth report being held back a year in school (Clark & Robertson, 1996; Robertson, 1989; Upshur, 1986; Young, Godfrey, Matthew, & Adams, 1983). In two studies of street youth, about one-quarter report participation in special or remedial classes (Clark & Robertson, 1996; Robertson, 1989). In a Detroit sample of 176 homeless youth, 85 percent had at some point been suspended from school, 26 percent had been expelled, and 15 percent had dropped out of school (Toro et al., 1998). One study found a high rate (28%) of attention deficit disorder (Cauce et al., 1997). While a history of school problems is prominent in the literature, its contribution to homelessness is unclear. School problems are often hypothesized to be a precipitant of family conflict that results in a runaway response. Others suggest that school difficulties are merely symptoms of more pervasive family problems.

**Emotional and Mental Problems**

**Mental Disorders.** As for homeless adults, the assessment of mental health status among homeless adolescents poses a number of problems (Robertson, 1992; Toro, 1998). It is difficult to determine whether a homeless youth's emotional disturbance at a given point in time is more causally associated with an underlying emotional or mental disorder, the exigencies of homelessness; chronic stresses such as family violence or parental substance abuse; the youth's own use of alcohol or other drugs; or combinations of these (Robertson, 1996).

In any event, several studies have documented high rates of emotional and mental health problems among homeless youth. Rates of serious disorders assessed with standardized instruments with diagnostic criteria range from 19 to 50 percent. For example, half of a sample of 150 youth from a New York City shelter (50%) had at least one major affective disorder as assessed by the DISC (Feitel et al., 1992). Among street youth in Hollywood (ages 13-17), 26 percent met DSM-III criteria for major depression compared to 4-9 percent of community and school samples of adolescents (Russell, 1996). In addition, many youth reported serious psychotic symptoms (Mundy, Robertson, Greenblatt, & Robertson, 1989). In another street sample (ages 13-21), 45 percent of the youth received at least one DSM-III-R diagnosis for a mental disorder (Cauce et al., 1997). These disorders included depression (19%), dysthymia (14%), mania (13%), hypomania (9%),
and psychosis (9%). In two different probability samples from throughout metropolitan Detroit (one from shelters only, N=122; the other from a variety of sites, including shelters, juvenile justice facilities, and mental health centers, N=180), similar rates for these same mental disorders were obtained (McCaskill et al., 1998; Toro et al., 1998).

It should be noted that in a rare study that included a carefully-matched comparison group of housed youth, McCaskill and colleagues found that the rates for many mental disorders were not significantly different, although homeless youth did have significantly higher rates of disruptive behavior disorders and alcohol abuse or dependence. Such findings highlight the need for appropriate comparison groups when attempting to identify distinctive characteristics of homeless youth.

As in the adult homeless population, the co-occurrence of substance abuse disorders and serious mental health problems has also been documented in several studies (Robertson, 1989; Rotheram-Borus, 1993; Russell, 1998; Shaffer & Caton, 1984; Upshur, 1986; Yates, MacKenzie, Pennbridge, & Cohen, 1988).

In San Francisco, two-thirds of a street sample met DSM-III-R diagnostic criteria for post-traumatic stress disorder (PTSD) (Clark & Robertson, 1996). Almost half of the sample (46%) had experienced PTSD symptoms related to their disorders within the previous two weeks. Most frequently reported traumatic events included seeing another person hurt or killed or being physically or sexually assaulted themselves.

**Suicide Attempts.** Studies of homeless youth consistently report suicide attempt rates that are higher than rates for normative groups. In a study of homeless youth in New York City shelters, more than one-third (37%) had ever attempted suicide, and one-third of these had made repeated attempts (Rotheram-Borus, 1993). Many in the sample (16%) reported suicide attempts in the previous month. Nearly one-quarter (24%) of runaways in New York City shelters (Shaffer and Caton, 1984) and 18 percent of runaways using an outpatient health clinic in Los Angeles (Yates et al., 1988) reported suicide attempts. About half (48%) of a Hollywood street sample (age 13-17) had attempted suicide, and more than half of these had repeated attempts. More than one-quarter of the sample (27%) had attempted suicide during the previous 12 months (Robertson, 1989). Other studies have reported equally high rates (Ackley & Hoyt, 1997; Feitel et al., 1992; Powers, Eckenrode, & Jaklitsch, 1990). All reported rates of suicide attempts for homeless youth are higher than the lifetime rate for adults reported in the LA ECA project which was 4 percent (Russell, 1998).

**Conduct Problems.** A wide range of conduct problems are reported for homeless youth. Though it appears that many such problems are of long duration, some may develop or become exacerbated by experiences while homeless. In three studies of homeless youth, rates of conduct disorder ranged from 48 percent to 93 percent (Cauce et al., 1997; Feitel, Margetson, Chama, & Lipman, 1992; Robertson, 1989) using the Diagnostic Interview Schedule for Children (DISC) (Fisher, Wicks, Shaffer, Piacentini, & Lapkin, 1992). It is important to note that current diagnostic criteria, in fact, consider the experience of running away or being homeless, itself, as a key sign of conduct disorder. However, even
excluding such criteria, the rate of conduct disorder among homeless youth is high. For instance, in a study of sheltered youth (ages 12-17) that used the DISC but excluded such criteria, the rate of disruptive behavior disorders (primarily conduct disorder) was still high (39%) and significantly greater than that in a matched housed sample (20%) (McCaskill et al., 1998).

Research suggests that homeless youth may have associations with deviant peers, some of whom may themselves be homeless. Gang activity appears common among homeless youth. Across several studies on homeless youth, a history of gang participation has ranged from 14 percent to 53 percent (Kipke, O'Conner, Palmer, & MacKenzie, 1995; Robertson, 1989; Toro et al., 1998; Whitbeck et al., 1997a).

Substance Use and Abuse

Youth Substance Use. Though it is not possible to determine from existing research the extent to which alcohol or other drug use may contribute to youth homelessness, many youth report substance use themselves and by their parents. Based on DSM-III criteria, most youth in a Hollywood street sample (ages 13-17) met diagnostic criteria for substance use disorders [i.e., alcohol disorders (48%), other drug disorders (39%), or both (26%)] (Robertson, 1989; Robertson, Koegel, & Ferguson, 1989; Russell, 1998). About one-quarter (26%) reported a history of injection drug use (IDU). The majority used illicit drugs before they experienced homelessness the first time (74.7%), and several reported that their own drug use had contributed to their leaving home (17.7%).

In a study of clients of a Hollywood outpatient clinic (ages 12-24), recent alcohol and other drug use was significantly higher among homeless compared to non-homeless youth using the same clinic (48% vs. 19%, respectively). Many reported IDU (8% compared to 0.1% of non-homeless clients) (Kipke, Montgomery, & MacKenzie, 1993). About half of youth in New York City shelters (ages 11-19) reported physical symptoms of substance abuse, and 17 percent reported addiction symptoms (Koopman, Rosario, and Rotheram-Borus, 1994). In a probability sample of sheltered homeless youth, 21 percent met DSM-III-R criteria for alcohol abuse or dependence and 24 percent for drug abuse or dependence (McCaskill et al., 1998).

Rates of substance use seem to vary dramatically by history of homelessness. In three large national samples, street youth showed the highest rates of substance use followed by sheltered youth and runaways and finally housed youth (Greene, Ennett, & Ringwalt, 1997). Comparing youth who reported having run away once, two or more times, or never, Windle (1989) found a similar pattern, with those having multiple homeless episodes showing the highest rates of substance use or abuse.

As with the general population, rates of substance use and abuse increase with age. Among homeless clients of a community-based clinic in Hollywood, older youth were significantly more likely to report use of alcohol, stimulants, narcotics, and injection drug use (Kipke, 1995). Among a probability sample of 122 youth in shelters in metropolitan Detroit (ages 12-17), older youth had significantly higher rates of DSM-III-R diagnoses
of drug abuse or dependence (Boesky et al., 1997). However, rates for the youth overall were significantly lower than homeless adults from shelters in the same city (Bukowski & Toro, 1996).

**Parental Substance Use.** One study suggests that parental alcohol use may contribute to youth homelessness. In a Hollywood street sample, 24 percent of the youth (ages 13-17) reported that they had "run away or left home" at least once because their parent or step-parent had an alcohol problem which caused frequent arguments or physical violence (Robertson, 1989). Other studies suggest high substance use by parent. For example, a study of intake records for over 44,000 youth in federally-supported shelters reported that drug abuse by the parent figure was the principal problem of 16 percent to 18 percent of youth (U.S. Government Accounting Office, 1989). For youth in 17 shelters across the nation, parental alcohol abuse was correlated significantly with runaway behavior (van Houten & Golembiewski, 1978). Miller, Hoffman, and Duggan (1980) found that 41 percent of runaways reported that one or both of their parents had a problem with alcohol and 17 percent reported that one or both parents had a serious drug problem. Toro et al. (1998) found that 44 percent of homeless youth reported that one or both of their parents had at some point received treatment for alcohol, drug, or psychological problems.

**Health Status.** Like homeless adults, homeless youth appear to be at greater risk than their domiciled counterparts for a variety of medical problems, and their health often deteriorates while homeless. Youth on the streets in particular often sleep too little, and when they do, it is often in an unsafe, unclean, or overcrowded environment (Clark & Robertson, 1996). They may have little money and eat poorly. They may have little opportunity to maintain adequate personal hygiene and are hard put to find the time or place to recuperate adequately from illness or injury. They suffer disproportionately from traumatic injury, skin infestations, infectious diseases, nutritional disorders, and other conditions (Kennedy et al., 1990; Yates et al., 1988). Because of the patient mix and the concentration of health problems that are less common in conventional medical practices, a specialization of sorts in "street medicine" has developed among health professionals who treat homeless youth, (Kennedy et al., 1990).

**Sexual Behavior.** The literature reveals high rates of sexual activity among homeless youth, but variable rates of protection against pregnancy or sexually transmitted diseases. Studies consistently report that the majority of youth (i.e., from 62% to 93%) are sexually active (i.e., had sex at least once). For example, in New York City shelters, most males (93%; ages 12 to 17) were sexually active (Rotheram-Borus, Meyer-Bahlburg, Koopman, Rosario, Exner, Henderson et al., 1992a; 1992b). Similarly, 92 percent a Hollywood street sample (ages 13 to 17) were sexually active. While most of these (82%) reported using birth control the last time they had sex, only about half reported condom use (Robertson, 1989). In another study of Hollywood street youth (ages 12-23), most (70%) reported recent (30 day) sexual activity (Kipke et al., 1995). In a sample of 602 homeless youth from 4 Midwestern states, Whitbeck et al. (1997b) found that most youth had intercourse prior to age 16 (70% of the males and 85% of the females, ages 12 to 22). Among those reporting intercourse in the past year, only one-third (36%) reported always using condoms. In Detroit, Wolfe, Levit, and Toro (1994) found that 71 percent of
homeless youth (age 12 to 17) in shelters had ever had intercourse and 43 percent reported being currently sexually active. In another Detroit study, Toro et al. (1998) found that 62 percent of 176 homeless youth (age 13 to 17) reported ever having had vaginal, anal, or oral sex. Both studies also found that, compared to matched housed youth, the homeless youth were significantly more sexually active.

**Pregnancy.** In four local studies, the lifetime rate of pregnancy for homeless girls has ranged from 27 to 44 percent, and 6 to 22 percent have reported having given birth (Cauce, Morgan, Wagner, Moore, Sy, Wurzbacher et al., 1994a; Owen et al., 1998; Robertson, 1989; Toro et al., 1998; Whitbeck et al., 1997b). Studies have identified as many as 10 to 20 percent of homeless young women who are currently pregnant (e.g., Toro et al., 1998; Robertson, 1996). Young women who are pregnant while homeless are at risk for low-birthweight babies and high infant-mortality because they are unlikely to get prenatal care and may not have adequate health and dietary habits (Kennedy et al., 1990; Sullivan & Damrosch, 1987).

**Risk for HIV and AIDS.** Homeless youth present a high-risk profile for human immunodeficiency virus (HIV) infection. Specific high-risk sexual and drug use behaviors including multiple sex partners, high-risk sexual partners, survival sex, minimal condom use, injection drug use, sharing needles, and having sex while high (Allen, Lehman, Green, Lindergren, Onorato, Forrester, Field Services Branch, 1994; Kipke et al., 1995; Greenblatt & Robertson, 1993; Rosenthal, Moore, & Buswell, 1994; Rotheram-Borus, 1991, 1992a, 1992b; Toro et al., 1998). Risk behaviors for HIV exposure are more common among youth who are older, homeless longer, and not staying in shelters. Despite knowledge about transmission modes, many homeless youth do not use protection against exposure.

Recent seroprevalence studies in clinical samples suggest that HIV is already a widespread health problem among homeless youth and young adults in some areas. In one study of HIV rates in clinical samples of homeless youth ages 15 to 24, the rate of HIV-positives across four cities was 2 percent. Rates were higher among youth over age 19, and they varied dramatically by site. These included Dallas (0%), Houston (1%), New York City (4%), and two sites in San Francisco (2% and 7%) (Allen et al., 1994). Similarly, in a medical clinic in Covenant House in New York City, 6 percent of "street kids" overall tested HIV-positive (6% of young men and 5% of young women; Kennedy et al., 1990). Covenant House health clinics also produced elevated rates in New Orleans (3%), Fort Lauderdale (3%) and Houston (2%). Because these communities have higher rates of HIV infection generally, the high rates of HIV in New York or San Francisco may not generalize to other areas. Yet the risk of exposure poses a real threat to homeless youth across geographic areas who report high-risk behaviors.

**Survival While Homeless**

**Shelter, Food, and Other Basics Needs**
Many youth have difficulty meeting basic needs. For example, in a San Francisco street sample (ages 15 to 19), most youth reported that they had spent the previous 30 nights outside, in abandoned buildings (or "squats"), traveling, and in public places such as doorways, allies, parks, beaches, and under bridges. Very few had stayed even one night in a shelter (15%). Several reported institutional stays including one young woman who had been in a hospital for childbirth. One youth reported spending three nights in a dumpster (Clark & Robertson, 1996). In this same study, youth who slept in public spaces often formed groups in which individuals took turns staying awake to keep guard. A few reported committing offenses that resulted in arrest in order to secure "shelter" for the night (Clark & Robertson, 1996). Providers occasionally report that minors sometimes misrepresent their age to gain access to adult shelters.

In a study of Hollywood street youth (ages 13-17), most (79%) identified "improvised shelter" as their usual sleeping place. This included abandoned buildings, vehicles, parks and beaches, loading docks, rooftops, and crawl spaces under houses. Relatively few in the sample had used shelters recently (15%) due largely to the scarcity of shelter beds in the area (i.e., at the time, 50 youth shelter beds throughout Los Angeles County) (Robertson, 1989; Greenblatt & Robertson, 1993). Shelters or meal programs were the most usual sources of food. Yet about half of the youth (48%) reported difficulty getting adequate food, and the majority (57%) had spent at least one day in the past month with nothing to eat. Many also reported difficulty finding a place to clean up, to obtain medical care, or to find clothing (Greenblatt & Robertson, 1993; Robertson, 1989). Youth reported little if any income, most of which came from legal sources such as odd jobs or family gifts. However, income from illegal activities was also common including sex work and drug dealing (Robertson, 1989).

Anecdotal reports from staff and youth suggest that staff at shelters and other sites sometimes exclude youth with severe emotional problems, those dangerous to themselves or others, those with alcohol or drug problems, or those with HIV infection.

**Resorting to Illegal Activities**

Many homeless adolescents report illegal behavior. However, some of this behavior may be part of their strategies for survival. Some illegal behaviors may provide for basic needs directly (for example, breaking into an abandoned building for a place to stay or trading sex for food or shelter) while others may generate income to meet basic needs (for example, selling drugs or sex). In a 4-state Midwestern sample of 602 homeless youth, 23 percent reported stealing, 14 percent forced entry to a residence, 20 percent dealt drugs, and 2 percent engaged in prostitution (Whitbeck et al., 1997b). In an unusual sample of 409 Los Angeles street youth (ages 12-23), which included many who were not literally homeless but who were "integrated" into the street economy, 43 percent of the sample (46% of young men and 32% of young women) reported ever engaging in survival sex, which included trading sex for food, a place to stay, drugs, or money (Kipke et al., 1995). Of these, 82 percent traded sex for money, 48 percent for food or a place to stay, and 22 percent for drugs. Almost one-quarter of the sample (22%) reported survival sex in the previous 30 days. Similarly, among clients of a Hollywood health clinic, 26
percent of runaway clients reported involvement in "survival sex" compared to only 0.2 percent among non-runaway clients (Yates et al., 1988). Similarly, about one-third of a Hollywood street sample (ages 13-17) reported ever trading sex for money, food, or shelter. Most of these (75%) reported doing so only when homeless. Sex also had been traded for drugs by 11 percent of the sample. About half of the sample had ever sold drugs (52%), although many reported doing so only when homeless (21%). Although generating cash income was the principal motive for drug sales, one-fifth of the sample also sold drugs to support their own drug use.

**Victimization**

Studies have reported high rates of victimization among homeless youth. Runaway clients of an outpatient clinic in Hollywood sought treatment for trauma (4%) and rape (2%) at rates which were two and one-half and three times higher than non-runaway clients (Yates et al., 1988). The majority of a Hollywood street sample had been victimized in the past twelve months, including high rates of physical assault (42%) and sexual assault (13%; Greenblatt & Robertson, 1993). In their 4-state Midwestern sample, Whitbeck et al. (1997b) documented a wide range of types of victimization. While homeless, 18 percent of the boys and 12 percent of the girls had been beaten up more than once, 11 percent and 7 percent had been robbed more than once, and 11 percent and 4 percent had been assaulted with a weapon more than once. These researchers have also found evidence for a "risk-amplification" model for understanding adolescent homelessness (see Ackley & Hoyt, 1997; Whitbeck, Hoyt, & Ackley, 1997a; Whitbeck & Simons, 1990). This model proposes that a variety of background characteristics, including maltreatment, poverty, parental psychopathology, and negative parenting, all put homeless youth at risk for poor outcomes. Homelessness also puts the youth in a context conducive to further negative outcomes (e.g., through experiences on the street and with deviant peers), which amplifies the impact of the background characteristics. In some recent and disturbing findings based on a 5-month follow-up of 354 street youth from Seattle, Hoyt and Ryan (1997) found that those with a prior history of victimization were the most likely to be victimized during the follow-up period.

**Long-Term Outcomes**

**Will These Youth Become Homeless Adults?**

Since the mid-1970s, scholars and service providers have expressed concern that homeless youth would become a new generation of homeless adults (Blumberg, Shipley, & Barsky, 1978; Miller, 1991). There is no longitudinal evidence that homeless youth are, in fact, at heightened risk for homelessness later in adulthood (although a few ongoing studies are investigating this; Cauce et al., 1994b; Toro et al., 1998). Nevertheless, recent evidence does indicate that 9 percent to 26 percent of homeless adults were first homeless as children or youth (Susser, Streuning, & Conover, 1987; McChesney, 1987; Zlotnick et al., in press). These rates are higher for homeless adults than adults in the general population among whom about 7 percent have ever experienced homelessness (Link et al., 1994; Manrique & Toro, 1995).
Other Long-term Outcomes

In a 30-year follow-up of clients from a child guidance clinic, Robins and O'Neal (1959) found that runaways had higher rates of mental disorder, divorce, and arrest than non-runaways. Olson et al. (1980) obtained similar results in a 12-year follow-up of 96 runaways from the Washington, DC area. Those who had run away more than once, as compared to their siblings or those who ran away only once, had poorer work histories, more involvement with the justice system, and were more likely to be single. More recently, Windle (1989) used the National Longitudinal Survey of Youth to compare 14-15 year olds who had never run away (n=1,139) to those who had run away once (n=61) or more times (n=41). After four years, he found that the repeat runaways reported more alcohol and drug use and abuse, more delinquent behaviors, lower self-esteem, and a higher rate of dropping out of school, while the one-time runaways fell about midway between the never and repeat runaways on most of these domains.

Intervention Strategies

Strategies are needed to reduce the amount of harm a youth encounters while homeless. In the short term, emergency and transitional services are needed for those who are currently homeless. Providers suggest that the younger youth and those in their first episode of homelessness are more likely to reconcile with families if the homeless episode is responded to with early intervention.

For the longer term, however, strategies are also needed to reduce the number of youth who become homeless. Homelessness itself presents physical and mental health risks to the youth. It may also represent an interruption of normative socialization and education, which will likely affect the ability to live independently in the future.

Providing Needed Services to Homeless Youth

There is little comprehensive information on model programs serving youth or young adults who are homeless or at risk of homelessness.

Comprehensive and Tailored Services

Homeless youth and young adults face many barriers to services in the larger community (Clark and Robertson, 1996). Most are survivors of difficult situations, and many are skeptical and distrustful toward adults. Many street youth in particular have become accustomed to taking care of themselves and some seem unwilling to come into service sites or eventually return to a family or foster home in which they could lose a great deal of control over their everyday lives. Many homeless youth have serious emotional or mental problems. In addition, interventions may have to take place in the context the youth's substance use and behavior problems. While many youth report only occasional drug or alcohol use, others cycle in and out of more hard core drug use, complicating any intervention effort (Clark & Robertson, 1996). In many cases providers first may want to
help homeless youth meet their immediate needs. Basic services can then provide a gateway to other needed services.

Providers have suggested that since homeless youth have diverse needs which cross agency jurisdictions, they require a comprehensive service array (New York State Council, 1984). Homeless youth need many services, including housing, education, vocational training, health care, mental health care, substance abuse services, and legal assistance. Coordination among providers is needed to strengthen their ability to serve the population. Interagency cooperation could be augmented by linkages with community non-profit agencies serving youth. Bringing together stakeholders from all parts of the youth-care community can help build the needed continuum of care for homeless youth by consolidating resources and to forging service alliances (Mangano, 1999).

Based on similar interventions designed for persons with mental disorders (Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992; Toro, Passero Rabideau, Bellavia, Baeschler, Wall et al., 1997), Cauce and colleagues (1993, 1994a, 1997) have developed a comprehensive approach to case management for street youth ages 13-21. The approach involves many components including careful assessment and treatment planning, linkage to a full range of needed community services, crisis counseling, flexible use of funds to support youth, small caseloads (no more than 12 cases per counselor), and open-ended service provision. Preliminary findings have suggested some modest positive gains over a 3-month follow-up period for the program youth in comparison to other street youth randomly assigned to "regular case management" (Cauce et al., 1994a).

Special Populations with Special Needs

There are many different groups among homeless youth with special needs. These include gay and bisexual youth; non-English speakers; those who have been homeless longer; those involved in sex work; pregnant teens; and youth with serious medical, emotional, behavioral, or substance use problems. Staff of shelters, drop-in centers, medical clinics and other programs might better be trained to deal with the particular circumstances, experiences, and special needs of such groups (Rotheram-Borus, 1991b; 1993). Young adults (e.g., ages 18 to 24) are another special group that often falls through the cracks between public systems of care because they are ineligible for treatment in children’s service systems at the same time that their developmental needs may not be met by adult service systems.

Shelters as Interventions Sites

Besides providing a safe place to spend the night, youth shelters have often served as sites from which to mount special programs and therapeutic interventions (Rotheram-Borus, 1991b). However, some homeless youth and young adults never use shelters or use them only intermittently (Kipke et al., 1995; Robertson, 1996). Shelters sometimes exclude youth most in need of intervention because they lack adequate staff or appropriate facilities to deal with youth who have special needs. According to anecdotal reports, youth most likely to be excluded from shelters are those who pose a threat to
institutional routine or safety (i.e., those who are actively psychotic, suicidal, or intoxicated; or those with HIV or other infectious diseases). At times, appropriate or accessible shelter beds for youth are not available. In addition, many youth may choose not to use shelters because there are too many demands on their behavior or the programs are too structured (Chelimsky, 1982; Clark & Robertson, 1996; Rotheram-Borus, 1991b; Rothman & David, 1985). To reach such youth, services can be provided in sites other than shelters. Educational and treatment interventions have been located successfully within low-demand community sites such as drop-in centers as well as through outreach programs to youth on the streets.

**Treatment Services**

A number of studies have documented high need for treatment but low utilization of formal treatment programs for medical, mental, and substance use services (Farrow, Deisher, Brown, Kulig, & Kipke, 1992; Kennedy, 1991; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Morey & Friedman, 1993; Robertson, Koegel, & Ferguson, 1989). In most states, minors may consent to some types of health care including treatment for alcohol, drug or mental health problems, true emergencies, or treatment for sexually transmitted diseases (Kennedy et al., 1990). Even so, few homeless youth have adequate contact with the health care system, which may result in delayed treatment for acute and chronic health problems.

Providers have identified specific barriers to treatment in formal settings. These include the youth's mistrust of health professionals, the lack of social skills to cooperate in their own care, failure to keep appointments for follow-up care, failure to follow-through in treatment once immediate distress has been relieved, and problems in transferring care when a youth gets moved to a different neighborhood (Kennedy et al., 1990). Aggressive screening of homeless youth can identify such health problems as a first step in providing proper treatment and health care. In designing treatment services, many of which have been developed for adults, it will be important to adapt the services to the specific needs of homeless youth and young adults.

Researchers have recommend that homeless youth and young adults be targeted for health education and prevention programs, given their high risk for exposure to and transmission of HIV, other STDs, and other infectious diseases (Rotheram-Borus, 1991a). Studies suggest that accessible HIV-testing services will be used by homeless youth (Greenblatt & Robertson, 1993). Because of high rates of prior suicide attempts, current ideation, plans for suicide, and depression, staff working with homeless youth should receive training in assessing suicidality (Rotheram-Borus, 1993).

**Education and Job Training Opportunities**

Once homeless on their own, homeless youth face extraordinary economic problems. Homeless youth and young adults often need to become part of the work force. Unfortunately, most are ill prepared for work, requiring extensive job training and placement services. Vocational and occupational programs are a fundamental part of the
transition from the streets to mainstream society. Providers recommend programs that enable these young people to complete high school, college, or some alternative education, and to develop marketable skills (Morey & Friedman, 1993; National Network of Runaway and Youth Services, Inc., 1985).

**Interventions to Prevent Homelessness**

Though there has been considerable discussion in the literature on services for youth who are already homeless, little attention has been given to how we might prevent homelessness in the first place. Below, we consider two basic approaches to accomplishing prevention of homelessness among youth.

**Preventing Repeated Homelessness.** For youth and young adults who have already experienced homelessness, an obvious goal of services should be to prevent any future homeless episodes. Such interventions could target youth early in their "homeless careers" (e.g., youth with a single short experience with homelessness or little or no time spent on the streets). Toro and Bukowski (1995) have recently advocated for an expanded service delivery model for youth shelters. This model would supplement the crisis intervention approach common in most youth shelters to provide a variety of long-term services for youth and their families. Many have recognized this need and have proposed intensive case management programs (e.g., Cauce et al., 1993), "full-service" shelters (e.g., Rotheram-Borus, 1991), transitional living programs for those who cannot be reunited with their families (MacAllum et al., 1997), and other ongoing services for youth after their brief stays in a shelter. Service providers often would like to offer such expanded services, but have limited resources to do so (Sedlak, Schultz, Wiener, & Cohen, 1997). Since most homeless youth eventually return to their families, providers might consider active outreach to all family members in addition to the youth themselves to help the families cope and remain intact.

**Primary Prevention.** Primary preventive interventions would attempt to prevent homelessness and other harmful outcomes among adolescents in the general population. Such interventions are generally consistent with a youth development approach to improving the lives of youth (Family & Youth Services Bureau, 1996) and have proven effective in dealing with a wide range of problems in children and youth (Durlak & Wells, 1997; Price, Cowen, Lorion, & Ramos-McKay, 1988). In the case of homelessness, interventions could identify youth at risk for residential instability and homelessness or could be targeted even more broadly. Based on research findings, there appear to be a number of risk factors for both youth and adult homelessness. These include socioeconomic status, problematic family environments (including family violence and substance abuse), and a history of conduct problems and delinquency. Implementation of family-based preventive interventions would be one useful approach. School-based interventions might also be effective at preventing homelessness and other harmful outcomes. Peer groups have been utilized in a number of existing effective prevention programs (e.g., Pedro-Carroll, Cowen, Hightower, & Guare, 1986) and could be useful in programs to prevent homelessness. Child-protective services in many localities, with often-limited resources, frequently seem to focus primarily on the removal
of youth from abusive homes and the prosecution of abusive parents. Intervening with families earlier might help prevent homelessness for many youth.

Recent longitudinal findings of Courtney et al. (1998) and others suggest that youth with histories of residential instability, foster care, and other out-of-home placements are at heightened risk for homelessness during both adolescence and in early adulthood. Such groups could be targeted for intervention. For youth in public institutions including foster care, juvenile detention, and psychiatric institutions, more careful and effective discharge planning may be helpful in preventing subsequent homelessness. However, more knowledge is needed about what specific elements might constitute. Furthermore, it is critical that youth be tracked for a substantial period of time following discharge, since homeless episodes may not be immediate but can occur months after the discharge.

Another way to prevent homelessness is to create more alternative residential settings for youth. Policies could continue to encourage foster placement with extended family members who would take in youth who have already (or who are about to) separate from their family of origin. Some homeless youth already make use of extended family members as an occasional housing resource, suggesting their desirability as a placement. This strategy may increase the ability or motivation of extended family members to house the youth.

For foster youth, independent living skills programs could be upgraded for youth in foster care preparing for independent living (e.g., those "aging out" of the foster care system at age 18). The age of eligibility for foster care or other placements could be extended to age 21 or later. Another strategy would be to extend support services one to two years beyond the exit from foster care. A striking number of homeless youth become homeless upon separation from foster or group home placements. We suggest that special training for foster parents dealing with high-risk youth, especially those who have already been homeless, might help extend periods of residential stability.

**Policy Issues**

**Residential Options.** As is true for homeless adults, long-term housing with independent-living services is needed. Transitional services also are needed. Most services for youth and young adults are emergency or short-term, with care limited to crisis periods. Youth who lack basic skills such as money management, education, and vocational training need intensive support to achieve independent living. A recent national evaluation of the Transitional Living Program (TLP) for Homeless Youth (based on a quasi-experimental design implemented in 10 sites with 175 homeless youth, most ages 18 to 21), found some positive program effects over a 6-month follow-up period (MacAllum, Kerttula, & Quinn, 1997).

**Youth Advocacy and Legal Issues.** Greater monitoring of foster homes and group homes may be needed to protect youth while they are in placement. Assigning caseworkers or special advocates to work with the individual youth may help identify and resolve problems before youth leave placements or institutional settings (English, 1991).
Homeless youth who are minors often are denied services because of their legal status and the consequent need for parental consent. State laws vary considerably regarding a minor's ability to give consent. In many states, it is technically illegal to be a homeless minor not under the supervision of a guardian. In most states, unemancipated minors can legally give consent for care for some services as mentioned earlier. However, legislative guarantees are needed to delineate circumstances under which homeless minors may consent to other types of services (English, 1991; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Kennedy et al., 1990). Requirements to establish emancipation could be simplified or could be changed to increase youth access to entitlement programs, health care, and other services, without necessarily relieving the parent of responsibility.

The recently passed federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) replaced the Aid to Dependent Children (ADC) program with the Temporary Assistance to Needy Families (TANF) program nationwide. Under provisions of TANF, teen parents receiving assistance must now live under the supervision of a guardian. While these welfare reforms have been politically popular, they may serve to make it even more difficult for homeless youth who have children to receive welfare benefits. Youth without children, even those who are legally emancipated minors, have virtually no access to public assistance in most localities. It is our view that, if the goal is to serve homeless youth better, expanding eligibility for benefits, rather than further restricting them, may be the better policy course.

Youth Leaving State Institutions. Not all homeless youth have received services from state youth-care agencies such as foster care, group homes, or juvenile detention. However, these represent an important subgroup of the larger homeless youth population (Mangano, 1999). Mangano suggests three key components for any youth-care agency that seeks to reduce and end homelessness among those it serves: discharge planning, aftercare tracking, and expanding “next-step” residential options. Early in the case-management process, agency caseworkers could develop service plans for clients that help youth establish and maintain contacts with community resources (such as health care, job training, and recreation) that would ideally continue after discharge. He also suggests that aftercare tracking (which is rarely done currently) will allow state agencies to review their effectiveness in preparing the youth for a return to their families or independent living. Finally, an increase in the number of “next-step” residential and housing resources is needed since youth who have been in state care or institutions often have less skills or resources needed to maintain their own housing. Such residential options could include a variety of supports such as substance abuse and mental health services, life-skills training, and peer counseling.

Evidence is mounting that the lack of discharge planning and aftercare at state agencies can leave youth and young adults ill-prepared for a return to their families or for independent living. Providers suggest that increased aftercare tracking by state agencies would help inform discharge planning and other efforts to prevent homelessness among at-risk youth.

Recommendations for Future Research
Needs Assessment: Methodological Issues

Sampling and Measurement. Many studies on homeless youth provide only very sketchy information on the sampling methods used. Researchers studying homeless adults have recently found important differences depending on the sources of their samples (e.g., Hannappel, Calsyn, & Morse, 1989; Link et al., 1994; Robertson, Zlotnick, and Westerfelt, 1998; Toro et al., 1999b; Toro & Wall, 1991). Studies of homeless youth (Greene et al., 1997) reviewed in this paper suggest that sampling effects may be even greater for homeless youth.

We recommend that future research on homeless youth carefully document the sampling methods used. A growing number of large-scale studies of homeless adults have refined probability sampling procedures for selecting representative groups from a variety of settings across large geographical areas (e.g., Dennis, 1991; Koegel, Burnam, & Morton, 1996; Robertson, Zlotnick, and Westerfelt, 1997; Toro et al., 1999b). We recommend that future research consider adapting such methods for homeless youth (we are aware of only one ongoing study that has done this; see Toro et al., 1998).

Another common flaw in the existing research literature involves the use of standardized instruments without documented reliability and validity for use with homeless youth. In addition, very few common measures have been used across studies, making comparison of findings difficult. We recommend that researchers give more attention to documenting the psychometric properties of standardized measures they use and, where appropriate, use measures that have been used in previous studies to enhance comparability across studies.

Comparison Groups. The existing literature tends to paint a rather disturbing picture of the homeless youth population. Homeless youth seem to have multiple, often overlapping problems, including serious medical and emotional health problems, substance abuse, sexual and social risk taking, and poor educational attainment. However, without appropriate comparison groups, it is impossible to determine the degree to which these problems are unique to homeless youth. While recent studies on homeless adults and families have benefited from appropriate comparison groups (e.g., Shinn, Knickman, & Weitzman, 1991; Sosin, 1992; Toro et al., 1995; Wood, Valdez, & Hayashi, 1990), few studies on homeless youth have included appropriate comparisons (see McCaskill et al., 1998; Wolfe et al., 1999). Comparison groups are essential to get a clearer picture of the unique features that distinguish homeless youth from other youth.

Also, carefully analyzed qualitative interview data has proven useful in understanding the needs of homeless adults and families (Banyard, 1995; Koegel, 1992; Underwood, 1993) and a few such studies have been done on homeless youth (e.g., Lagloire, 1990). Similar approaches to needs assessment may be useful in studies of homeless youth. When assessing the needs of homeless youth, we believe that it is important to include the opinions of the youth themselves.
**Longitudinal Research.** Though there is a growing number of longitudinal studies on homeless adults and families (e.g., Shinn et al., 1998; Toro, Goldstein, Rowland, Bellavia, Wolfe, Thomas et al., 1999a; Toro et al., 1997; Zlotnick, Robertson, and Lahiff, 1999), there have been only a few such studies on homeless youth. The intervention research of Cauce et al. (1993, 1994a) represents another recent example of longitudinal research on homeless youth and there are at least three ongoing longitudinal studies (Albornoz et al., 1998; Cauce et al., 1994b; Toro et al., 1998). Much more work of this type is needed to help us understand what happens to homeless youth over time and what services and other resources seem to help them achieve positive long-term outcomes as they approach adulthood.

**Strengths Versus Deficits.** The existing research and professional literature has focused intently on the problems and deficits of homeless youth. Virtually no attention has been paid to the strengths and competencies these youth may possess.

**Geographic Coverage.** Further research is also needed to document needs of homeless youth in rural areas, smaller urban centers and in the central US.

**Program Evaluation**

There is a paucity of research evidence about best practices for meeting the needs of homeless youth. We need research around the effectiveness of case management, primary care, mental health and substance abuse services much in the same way that we have research for the adult systems. We would be interested in knowing not only what works, but under what conditions, for which groups, and at what cost.

Most shelters and other services for homeless youth have not been systematically evaluated. One exception comes from work by Cauce and her colleagues who have used an experimental design to evaluate an intensive case management program for street youth in Seattle (Cauce et al., 1993, 1994a). More such rigorous designs, including control groups, are needed to determine which approaches to assisting homeless youth are most effective. Another is a recent national evaluation of the Transitional Living Program (TLP) for Homeless Youth (based on a quasi-experimental design implemented in 10 sites with 175 homeless youth, most ages 18 to 21), which found some positive program effects over a 6-month follow-up period (MacAllum, Kerttula, & Quinn, 1997).

We recommend that the organization and financing of services for homeless youth be informed by reliable information about the population and its needs. Input from service providers, policy makers, and other community leaders can also inform research on this population (Acosta & Toro, 1999).

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**References**


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