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FAMILY AND YOUTH SERVICES BUREAU
STREET OUTREACH PROGRAM

DATA COLLECTION STUDY FINAL REPORT APRIL 2016

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EXECUTIVE SUMMARY

INTRODUCTION

The Street Outreach Program (SOP), administered by the Family and Youth Services Bureau (FYSB), Administration on Children, Youth and Families, provides outreach to runaway and homeless youth on the streets or in areas that increase the risk of sexual exploitation with the goal to help young people get off the streets. To that end, the program promotes efforts by its funded grantees to build relationships between street outreach workers and homeless street youth. Grantees also provide support services that aim to move youth into shelter or stable housing and prepare them for independence. Homeless youth also use SOP drop-in centers to shower, eat a hot meal or obtain food coupons, receive hygiene kits, and/or obtain referrals for medical, dental, mental health, or social services.

The aim of the SOP Data Collection Study was to obtain information on service utilization and needs from a subset of homeless street youth being served by a cohort of SOP grantees funded in fiscal year 2010 (data collection occurred in 2013). The goal was to learn about the needs of street youth from their perspective, to better understand which services youth found helpful or not helpful, and to identify alternative services they felt could be useful to them. The SOP Data Collection Study included standardized collection of data from youth served by 11 grantees. Data were collected from youth via computer-assisted personal interviews and focus groups. The participants included street youth served by FYSB's SOP grantees and street youth who were not currently using services from SOP grantees. The 11 grantee sites were: Austin, TX; Boston, MA; Chicago, IL; Minneapolis, MN; New York City, NY; Omaha, NE; Port St. Lucie, FL; San Diego, CA; Seattle, WA; Tucson, AZ; and Washington, DC.

This report provides a portrait of the young people, ages 14–21, who were experiencing homelessness in areas served by the 11 SOP grantees. The sample is not nationally representative; however the data provide detailed information about the experiences and service needs of the 873 street youth from around the country who participated in the study. The intent is that data from the study will be used to inform service design and policy to better meet the needs of street youth who obtain and access services through street outreach programs.

METHODS

Data for this study were collected from youth through both interviews and focus groups. From March 2013 through September 2013, 656 young people ages 14–21 who were experiencing homelessness participated in interviews for the study. Data were collected via computer-assisted personal interviews. The participants included street youth served by FYSB's SOP grantees and street youth who were not currently using services from SOP grantees. The interview participants were initially recruited using Respondent-Driven Sampling (RDS), a methodology used to recruit statistically representative samples of hard-to-reach groups by taking advantage of intragroup social connections. A variant of chain-referral sampling, RDS uses a dual system of

structured incentives that has been shown to reduce the biases generally associated with chain-referral methods (Heckathorn, 2002; Heckathorn, Semaan, Broadhead, & Hughes, 2002). In most of the data collection sites, RDS was only moderately effective and did not yield as many participants as originally designed. Therefore, 212 interviews were conducted with youth who were identified using RDS and 444 interviews were conducted with youth who were identified using convenience sampling. In addition to the 656 participant interviews, focus groups were conducted to obtain qualitative information about homeless history, personal characteristics, future goals, and service utilization of participants. An additional 217 young people were recruited through convenience sampling to participate in focus groups. Demographic information for focus group participants was not collected.

KEY FINDINGS

Participant Characteristics

Compared with samples from other studies of street youth, the majority of the SOP Data Collection Study sample (69.7%) is slightly older, between 19 and 21 years of age. Two-fifths of the sample (41.1%) identified as Black or African American, and one-third (33.3%) identified as White only. Just over 3 percent identified as American Indian or Alaska Native, 0.5 percent as Asian, and 0.2 percent as Native Hawaiian or Pacific Islander. Just over one-fifth of participants (21.7%) identified as being two or more races. Approximately one-quarter of the participants (25.7%) identified as being Hispanic or Latino/Latina. The SOP sample was 54.4 percent male, 45.6 percent female, with 6.8 percent of participants identifying as transgender, which is 3 times the percentage of transgender youth found in a recent national study of runaway and homeless youth served by street outreach programs (Durso & Gates, 2012). Consistent with other studies, two-thirds of the sample identified as heterosexual, 20 percent identified as bisexual, 9.9 percent identified as gay or lesbian, and 4.1 percent identified as “something else.” More than half of the SOP sample (50.6%) reported having stayed in a foster home or group home. At the time of the interview, 14.2 percent of the participants reported caring for children, and 9.0 percent reported being currently pregnant.

Homeless History

The most commonly reported reason for becoming homeless the first time was being asked to leave by a parent or caregiver (51.2%), followed by being unable to find a job (24.7%), being physically abused or beaten (23.8%), or problems in the home due to a caretaker’s drug or alcohol abuse (22.6%). Only 29.5 percent of participants reported they had the option of returning home. On average, participants had been homeless for a total lifetime rate of 23.4 months and reported first becoming homeless at age 15. While

homeless, 78.6 percent of participants had slept in an emergency shelter or transitional living program. More than half of participants had slept or rested outside on a street, in a park, or on a bench (51.8%). A little less than half of the participants had slept or rested in a hotel or motel paid by someone else (45.8%) or that they paid for themselves (40.9%). Less than half (40.3%) had slept or rested in a car, and 33.1 percent had slept or rested in a bus station, airport, subway station, or train station. Some of the other locations where participants had spent the night included a homeless camp or tent city (18.7%) or a public restroom (14.9%).

Sex, Sexual Health, and Pregnancy

Almost one-quarter of participants (24.1%) said that they had "agreed to be sexual" with someone in exchange for money, and 27.5 percent had "agreed to be sexual" with someone in exchange for a place to spend the night. One-fifth (20.3%) of the participants reported having a sexually transmitted infection at some point in their lives. Of those who were sexually active, 29.8 percent reported using a condom "all of the time" during the past year when they had vaginal sex, and 39.3 percent reported using a condom "all of the time" during the past year when they had anal sex. Lifetime pregnancy rates were 46.5 percent for females and 25.8 percent for males (impregnating a female). The lifetime pregnancy rate of the SOP sample is slightly higher than that found in other samples of homeless girls, which range from 27 percent to 44 percent (Greene & Ringwalt, 1998; Solorio, Milburn, Weiss, & Batterham, 2006). Slightly more than 14 percent of males were unsure if someone had been pregnant with their child.

Victimization

Victimization while homeless was a common occurrence—14.5 percent of participants had been sexually assaulted or raped, 32.3 percent had been beaten up, 18.3 percent had been assaulted with a weapon, 40.5 percent had been threatened with a weapon, and 40.8 percent had been robbed. Almost two-thirds (60.8%) had experienced at least one of these types of victimization. For every additional month spent homeless, the likelihood of being victimized while homeless increased by 3 percent. Lesbian, gay, bisexual, and transgender (LGBT) youth and youth who had formerly been in foster care reported higher levels of victimization both prior to and after becoming homeless, compared with the rest of the sample.

Mental Health and Substance Abuse

Almost two-thirds of participants (61.8%) reported symptoms associated with depression and were at risk for experiencing clinical depression. Consistent with their victimization histories, 71.7 percent of participants reported having experienced major trauma, such as physical or sexual abuse or witnessing or being a victim of violence, at some point in their lives. In addition, 79.5 percent reported they had experienced symptoms of post-traumatic stress for more than 1 month. Rates of substance use for the previous 12 months by the study participants were consistent with those found in other homeless youth studies. Almost three-quarters of participants (73.2%) reported use of alcohol, 64.6 percent reported use of marijuana, and 37.5 percent reported use of hard drugs (intravenous drugs, inhalants, cocaine, and methamphetamine) in the previous 12 months. Rates were lower for past month use at 59.1 percent for alcohol, 55.1 percent for marijuana, and 13.2 percent for hard drugs.

Social Support and Relationships

Street youth also reported having strengths and resources. Eighty-three percent of the sample reported having healthy self-esteem. Additionally, study participants said that there are a number of people in their lives they can turn to for support (e.g., money, food, or a place to stay). Those individuals most likely to give the youth aid without asking for

anything in return were a parent, other relatives, and friends. Just under half the youth (45.4%) indicated they currently had a romantic partner.

Services

The types of service needs youth identified focused on meeting basic needs—access and challenges related to safe shelter (55.3%), education (54.6%), and employment (71.3%)—and basic supports like transportation (66.6%), clothing (60.4%), and laundry facilities (54.0%). When asked about things that had prevented them from accessing shelter, 52.6 percent of participants said that they were unable to access a shelter because it was full, 51.8 percent didn't know where to go, and 42.6 percent didn't have transportation to shelter. Focus group participants discussed the need for more flexible shelter policies related to age restrictions, better training for shelter and drop-in center staff around being more welcoming and engaging to youth, characteristics of desirable and helpful staff, and help navigating bureaucracy to obtain personal records and proof of identity.

RECOMMENDATIONS

The SOP Data Collection Study furthers our understanding that homeless youth are a very diverse group and, as such, require an array of services and supports that can be tailored to their individual needs. A number of key findings from the SOP study have practice and research implications.

Unlike other social services in the United States (e.g., child welfare, mental health, substance abuse), efforts focused on serving homeless youth do not have a coordinated system of care. Instead, individual providers around the country procure federal, state, local, and nonprofit funds to operate. Better coordination among homeless youth and other social service providers can strengthen efforts to better serve the homeless youth population. Interagency cooperation could be augmented by linkages between

community nonprofit and local government agencies that serve the same youth (e.g., child welfare, mental health, and juvenile justice). Bringing together stakeholders from all parts of the youth-serving community can help build the needed continuum of care—prevention, early intervention, longer-term services, and aftercare—for homeless youth. Consolidating resources and forging service alliances among these stakeholders can further develop a homeless youth continuum of care that includes coordinated screening, assessment, intake, referral, and data systems.

PRACTICE IMPLICATIONS

Street outreach programs serve a vital role in a coordinated system of services for all homeless youth. Recommendations specific to SOPs are discussed below.

Need for More Shelter

Study results suggest too few emergency shelter programs are available to meet the existing need.

A larger investment is required to prevent youth from sleeping on the streets. More flexibility in shelter response would allow access for youth who have been turned away because they've reached the maximum stay or exceeded age restrictions. Communities may also want to consider innovative alternatives to emergency shelter, such as host homes. A larger investment is also needed to reunify youth with their families when possible. Family reunification with family support services can not only help to end a current episode of homelessness but also prevent future homelessness by addressing the reasons why a youth left home. Because emotionally connecting youth to their families has been found to positively impact youth outcomes, efforts should be made to emotionally connect youth to their families, when deemed appropriate, even if physical reunification isn't possible.

Intensive Case Management

Street outreach programs serve a vital role in a coordinated system of services for all homeless youth. SOP services are limited and focused on getting youth off the streets and providing some basic living essentials and service referrals. In addition to SOPs, street youth may also use drop-in centers and emergency shelters. All of these programs provide opportunities to further engage street youth in needed services as well as a gateway to intensive case management. Intensive case management includes 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, and open-ended service provision. A focus on screening and assessment should include careful matching to services and tracking the progress of youth served. All youth experiencing homelessness are not the same. The finding that a large percentage of the youth in the SOP study sample is LGBT and that they experience barriers to services suggests more efforts are needed to better serve these youth. Screening, assessment, and monitoring of risk and protective factors are crucial to understanding their needs, matching those needs to culturally appropriate interventions, and monitoring progress over time.

Targeted Supportive Services and Interventions

The elevated rates of substance abuse, mental health problems, and exposure to trauma experienced by the participants in the SOP Data Collection Study prior to becoming homeless suggest more intensive interventions and supports are needed to help prevent youth from becoming homeless. Most homeless youth have significant experience with trauma. As seen with the SOP study sample, and with LGBT youth in particular, traumatic experiences can include multiple types of abuse, neglect, and exposure to violence prior to and after becoming homeless.

It is essential that intervention strategies are trauma-informed in all aspects of how they approach and support young people to facilitate healing and recovery, including engagement or reunification with families when it is appropriate. Youth also need interventions that can help them to reach positive developmental milestones and become healthy, productive adults, such as interventions that enhance youth skills, competencies, and existing strengths. Barriers to use of services and interventions identified by LGBT study youth included lack of LGBT-friendly policies and staff. Services and programs will need to be especially sensitive to LGBT and other special populations, like youth who have been in foster care and pregnant and parenting youth, who are overrepresented in the homeless youth population and are at even higher risk of experiencing health and mental and behavioral health issues.

Core Outcomes and Pathways

Appropriate interventions should target and help further develop the protective factors a youth has as

well as identify factors a youth is lacking, for future research. Practitioners working with homeless youth may find it especially helpful to use a "strengths perspective" to empower the young people they work with to become masters of their own lives. The majority (83%) of the study youth reported having good self-esteem, as well as having friends, parents, or relatives they could rely on for help. Focusing on protective factors has considerable advantage in working with homeless youth because it is their strengths in overcoming difficulties that can mitigate negative outcomes. Improvements in risk and protective factors can serve as pathways to get to better outcomes, such as stable housing, permanent connections, well-being, and education or employment. Achieving sustainable gains in these four outcomes can help put youth on a path toward a healthy adolescence and positive transition to adulthood.

RESEARCH IMPLICATIONS

The limited amount of high-quality empirical research on homeless youth leaves many gaps and questions for future research. Three main areas that require additional research are: (1) the causes, scope, and demographics of youth homelessness; (2) the efficacy of interventions; and (3) system planning and infrastructure.

Causes, Scope, and Demographics

The ability to accurately describe the causes, scope, and characteristics of youth experiencing homelessness is important for the planning and funding of interventions and recruitment strategies that address the diversity of the homeless youth population. Comprehensive multi-method approaches that include point-in-time counts, shelter and street outreach, and household surveys are needed to reach youth where they are in order to obtain accurate prevalence and incidence estimates of the homeless youth currently in the United States. In addition, more information is required about the particular needs of youth who are overrepresented in the homeless youth population—such as LGBT, foster care, minority, pregnant and parenting—to better serve these youth. Future studies will need large samples of these youth to determine geographical differences, as well as identify possible pathways that may be specific to these populations moving into and out of homelessness.

Efficacy of Interventions

Few intervention studies have been conducted with homeless youth, and particularly street youth. Although the effectiveness of certain interventions has been demonstrated, very few studies have employed rigorous methodologies. Much of the research literature is limited by small convenience samples, lack of long-term follow-up, lack of control or comparison groups, and high sample attrition. More research is needed to identify which interventions work best, with whom, and under what conditions. Intervention development will need to consider the cognitive and emotional developmental stages of

youth and to recognize that the specific content or targets of interventions may need to vary based upon the reasons youth became homeless and the length of homelessness. More quantitative and qualitative studies are needed to explore the outcomes of homeless youth and the pathways through which they exit, or fail to exit, homelessness. Also, more longitudinal studies are needed to understand how various factors at the individual, peer, family, and community levels influence both short-term and long-term outcomes.

System Planning and Infrastructure

More research is needed to identify best practices in coordinated engagement strategies that include use of youth-friendly screening and assessment tools and processes for identifying and referring youth for needed services. There is also a need to identify and study best practices around coordinated data systems that can monitor and measure progress toward decreasing homelessness as well as support providers in coordinating services, measuring outcomes, making adjustments, and improving service delivery at the individual youth and systems levels. Information about the characteristics of the various populations using homeless youth services and programs can allow planners to better design and target program interventions and to advocate for appropriate policy revisions at the local, state, and federal levels. Development of instruments that can identify homeless youth based on typologies that categorize their levels of risk, protection, and time spent on the streets can help providers better anticipate and match the needs of the youth to existing services and inform any needed changes to the service array.

CHAPTER 1: INTRODUCTION

The Street Outreach Program (SOP), administered by the Family and Youth Services Bureau (FYSB), Administration on Children, Youth and Families (ACYF), provides outreach to runaway and homeless youth on the streets or in areas that increase the risk of sexual exploitation, with the goal to help young people get off the streets. To that end, the program promotes efforts by its funded grantees to build relationships between street outreach workers and homeless street youth. Grantees also provide support services that aim to move youth into shelter or stable housing and prepare them for independence. Homeless youth also use SOP drop-in centers to shower, eat a hot meal or obtain food coupons, receive hygiene kits, and/or obtain referrals for medical, dental, mental health, or social services.

The aim of the SOP Data Collection Study was to obtain information on service utilization and needs from a subset of homeless street youth being served by a cohort of SOP grantees funded in fiscal year 2010. At that time, ACYF leadership recognized that the SOP provided an opportunity to gather more comprehensive information on SOP participants and other street youth than is feasible to collect within the requirements and resources of typical SOP grants, but that is needed to inform policy and practice. The SOP Data Collection Study included standardized collection of data at the 11 grantee sites. The participants included street youth served by FYSB's SOP grantees and street youth who were not currently using SOP services but were recruited through the grantee agencies. The 11 grantee sites were: Austin, TX; Boston, MA; Chicago, IL; Minneapolis, MN; New York City, NY; Omaha, NE; Port St. Lucie, FL; San Diego, CA; Seattle, WA; Tucson, AZ; and Washington, DC.

BACKGROUND

It is difficult to know how many runaway and homeless youth live in the United States because various sources provide a wide range of estimates. Specifically, government and nonprofit prevalence estimates and counts of the number of homeless youth vary based on use of different age ranges and definitions of homelessness (Pergamit, Cunningham, Lee, Howell, & Bertumen, 2013a & 2013b). Also, methods often used for counting homeless youth do not accurately capture their survival strategies, such as being mobile and transient, "couch surfing," or trying to hide in plain sight. For example, approximately 45,000 unaccompanied youth were living on the streets, in shelter, or in transitional housing without a parent or guardian on a given night in 2014, according to the Department of Housing and Urban Development's Point-in-Time (HUD PIT) count. The majority of young people counted in the HUD PIT were over 18. Furthermore, more than 90,000 unaccompanied youth enrolled in public school districts were identified as homeless at some point over the course of the 2013–2014 school year, according to Department of Education (ED) data. However, the majority of youth captured in the ED data was under 18 and included, among others, youth who were doubled-up or "couch surfing."

Youth report leaving home, or being asked to leave home, because of family conflict, physical or sexual abuse, and/or parental unwillingness or inability to care for them (MacLean, Embry, & Cauce, 1999; Mallett, Rosenthal, & Keys, 2005). Historically, many stakeholders have equated youth homelessness with delinquency, but more recent definitions focus on family, behavioral, and systemic issues (Riley, Greif,

Caplan, & MacAulay, 2004). The Stewart B. McKinney Homeless Assistance Act of 1987 defined a homeless youth as any youth who lacks parental, foster, or institutional care. This includes youth who have left home voluntarily, were thrown out of the home, or were removed from the home by the state (system-involved youth). The McKinney-Vento Homeless Education Assistance Improvements Act of 2001 further defined homeless individuals as those who lack a fixed, regular, and adequate nighttime residence and those whose primary nighttime residence is (1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter, and transitional housing for the mentally ill); (2) an institution that provides a temporary residence for individuals intended to be institutionalized; or (3) a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings. The Runaway and Homeless Youth Act (RHYA) of 2008 defined the term "homeless youth" as an individual, not more than 21 years of age and not less than 16 years of age, for whom it is not possible to live in a safe environment with a relative and who has no other safe alternative living arrangement. Furthermore, RHYA uses the term "street youth" to refer to both homeless youth and runaway youth, which includes youth who, without permission, leave home and stay away from home overnight or choose not to come home when expected.

Housing options for runaway and homeless youth are limited to residing at runaway and homeless youth shelters, living in host homes, living directly on the streets, squatting in abandoned buildings, or couch surfing in friends' homes. Most street youth, however, do not reach the shelter system, and for some, reuniting with their families is not possible or is not deemed appropriate (Robertson, 1991). For the purposes of this report, the term "homeless youth" refers to youth who have run away from or

been asked to leave their home and do not have a permanent place to stay. The terms "homeless street youth" and "street youth" refer to a subpopulation of homeless youth who reside primarily on the streets and are less likely to engage with shelters and access shelter services.

Youth who access emergency shelters tend to be younger than street youth and often have never spent a night on the streets (Robertson & Toro, 1999). One study showed that only 8 percent of shelter-recruited youth had ever slept overnight on the streets, and 34 percent of street-recruited youth had ever stayed overnight at a runaway shelter (Kang, Slesnick, & Glassman, 2009). Between 72 percent and 87 percent of youth who seek services from a runaway shelter return home, a finding which supports the need for family-based intervention in shelters that serve younger, recently homeless youth (Peled, Spiro, & Dekel, 2005; Thompson, Pollio, & Bitner, 2000; Thompson, Safyer, & Pollio, 2001).

Some evidence suggests that street youth fare worse than shelter youth. Street youth can be exposed to street crime and violence that shelter youth may never experience (Patel & Greydanus, 2002), and they report higher levels of drug use and risky behaviors (Clements, Gleghorn, Garcia, Katz, & Marx, 1997; Van Leeuwen, Hopfer, Hooks, White, Petersen, & Pirkopf, 2004). Clements and colleagues (1997) note the importance of assessing street youth separately from sheltered runaway youth, given the higher levels of risk behaviors reported by street youth. Many researchers stress the need for outreach, drop-in centers, and reintegration services for street youth (Robertson, 1991; Slesnick, Kang, Bonomi, & Prestopnik, 2008; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). Integration into the mainstream is especially important, as health risks and poor health outcomes increase the longer youth experience homelessness (Bailey, Camlin, & Ennett, 1998; Greenblatt & Robertson, 1993). Several researchers note that when the needs and goals of youth do not match those of service providers, the likelihood of youth rejecting services increases (Hyde, 2005; Marshall & Bhugra, 1996). In addition, fears of violations of confidentiality and of being returned to the home or the foster care placement from which they ran prevent many youth from seeking services (Ensign & Bell, 2004). Street outreach programs act as a crucial point of contact between street youth and a service system that can help them get their lives back on track.

Youth who have run away or are experiencing homelessness have often been affected by previous experiences of emotional and physical trauma. Research suggests the trauma of physical and/or sexual abuse is primary reason for leaving home, with neglect as somewhat less significant (MacLean et al., 1999; Mallett et al., 2005; Sullivan & Knutson, 2000). Several studies (Daddis, Braddock, Cuers, Elliot, & Kelly, 1993; Schweitzer, Hier, & Terry, 1994; Votta & Manion, 2003) and reviews of runaway child reports (Whitbeck, Hoyt, & Ackley, 1997) have identified problems in the caretaker–child relationship, including bonding, attachment, parental care, and violence. Numerous studies based on adolescent self-reports indicate high levels of physical and sexual abuse among runaway and homeless youth perpetrated by caretakers (Farber, Kinast, McCoard, & Falkner, 1984; Janus, Archambault, Brown, & Welsh, 1995; Janus, Burgess, & McCormack, 1987; Kaufman & Widom, 1999; Kennedy, 1991; Kufeldt & Nimmo, 1987; Kurtz, Kurtz, & Jarvis, 1991; Molnar, Shade, Kral, Booth, & Watters, 1998; Mounier & Andujo, 2003; Noell, Rohde, Seeley, & Ochs, 2001; Pennbridge, Yates, David, & MacKenzie, 1990; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Tyler, Hoyt, Whitbeck, & Cauce, 2001; Tyler, Whitbeck, Hoyt, & Cauce, 2004; Whitbeck & Hoyt, 1999; Whitbeck & Simons, 1993).

Family conflict and lack of acceptance are most often identified as the reason lesbian, gay, bisexual, and transgender (LGBT) youth leave home. The percentage of youth experiencing homelessness who self-identify as LGBT is reported on average as between 20 and 40 percent, a proportion that is quite high compared to the 3 to 5 percent of the nation's general population who self-identify as LGBT (Ray, 2006). When LGBT youth come out, they often experience significant, negative reactions from their families. In one study, more than half (57%) of runaway and homeless youth who identified as LGBT reported being rejected and put out of their homes as a result of disclosing their sexual orientation or gender identity (Remafedi, 1987). In a more recent study, 46 percent of runaway and homeless youth who identified as LGBT reported that they ran away, and 43 percent reported being forced out of their homes by parents due to disclosing their sexual orientation or gender identity (Durso & Gates, 2012). Coming out at a young age is associated with increased risk for

longer time spent homeless (Rosario, Schrimshaw, & Hunter, 2012).

LGBT young people often encounter intolerance, stigma, bullying, and humiliation at school, which results in skipping school and being almost twice as likely to not finish high school or pursue college, compared with the national average (Kosciw, Diaz, & Greytak, 2008). The emotional and physical trauma LGBT youth experience appears to make them more vulnerable when they leave home. Once on the street, LGBT youth are more likely to engage in survival sex and other risky behaviors like substance abuse (Greene, Ennett, & Ringwalt, 1997), to be victimized, and to meet criteria for mental disorders than their homeless heterosexual peers (Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). When LGBT youth become homeless, they also face higher rates of violence, discrimination, and poor health (Quintana, Rosenthal, & Krehely, 2010). Gay and transgender youth who seek help in homeless youth shelters can face just as much abuse and mistreatment in those settings as they do on the streets. They report being discriminated against, sexually and physically assaulted by staff, and physically harassed by peers at higher rates than heterosexual youth and youth who are not transgender in the same shelters (Dunn & Krehely, 2012). These conditions lead many LGBT youth to turn to the streets instead of seeking the services they need.

Homeless youth may be arrested or taken into police custody for acts committed while on the street, including violation of probation, burglary, drug use, or drug dealing. Researchers emphasize that criminal offenses or illegal acts committed by runaways and youth experiencing homelessness are frequently motivated by basic survival needs, such as food and shelter; the presence of adverse situations, such as hunger and unemployment; self-medication through use of alcohol and drugs; and a lack of opportunities for legitimate self-support (Kaufman & Widom, 1999; McCarthy & Hagan, 2001; Whitbeck & Hoyt, 1999). Moreover, although running away can increase the odds of youth engaging in delinquent or criminal behavior, it can also increase the odds of youth being exposed to or becoming the victim of criminal or delinquent acts (Hammer, Finkelhor, & Sedlak, 2002; Hoyt, Ryan, & Cauce, 1999). For example, Hoyt and colleagues (1999) found that the amount of time homeless adolescents spent living on the streets was associated with increased risk of criminal victimization, as was prior experience of personal assault.

Finally, homeless young people living on the street tend to be very involved in street networks and culture. Their primary communities comprise other street-involved young people who get most, if not all, of their needs met through engaging in the street economy, such as eating at soup kitchens, sleeping outdoors, and panhandling (Thompson, McManus, Lantry, Windsor, & Flynn, 2006). It has been shown that acculturation to the streets and street economy progresses with the length of exposure to homelessness and homeless peers (Auerswald & Eyre, 2002; Gaetz, 2004; Kidd, 2003; Kipke, Unger, O'Connor, Palmer, & LaFrance, 1997). One study reported the longer a person is homeless and living on the streets, the more likely it may become a way of life (Reid & Klee, 1999).

A growing body of research demonstrates the need for services among members of this highly vulnerable population of youth who are experiencing homelessness. Without social service intervention, there is an increased likelihood of street youth having repeated exposure to trauma and victimization (Gaetz, 2004; Kipke et al., 1997; Thompson et al., 2006; Tyler et al., 2001; Whitbeck & Hoyt, 1999). Thus, agencies providing services to homeless youth must identify the extent of their needs and adopt a proactive approach by connecting and offering assistance early in their

homeless experience, before they become entrenched in street culture (Reid & Klee, 1999).

METHODS

Data Collection Sites

The sites selected for data collection were from a subset of SOP grantees funded by FYSB in fiscal year 2010 through a competitive grant process. The 11 participating agencies are nonprofit organizations that offer homeless, runaway, and at-risk youth a variety of services beyond street outreach, which may include short- and long-term shelters, health care, mental health counseling, educational and employment services, and basic subsistence items. Each agency hired staff dedicated to participant recruitment and data collection for the study. The 11 street outreach program grantee agencies that participated in the study were:

- Bridge Over Troubled Waters, Boston, MA
- Children's Home Society of Florida, Port St. Lucie, FL
- The Door, New York, NY
- LifeWorks, Austin, TX
- The Night Ministry, Chicago, IL
- Our Family Services, Tucson, AZ
- San Diego Youth Services, San Diego, CA
- Sasha Bruce Youth Work, Washington, DC
- YouthCare, Seattle, WA
- Youth Emergency Services, Omaha, NE
- Youthlink, Minneapolis, MN

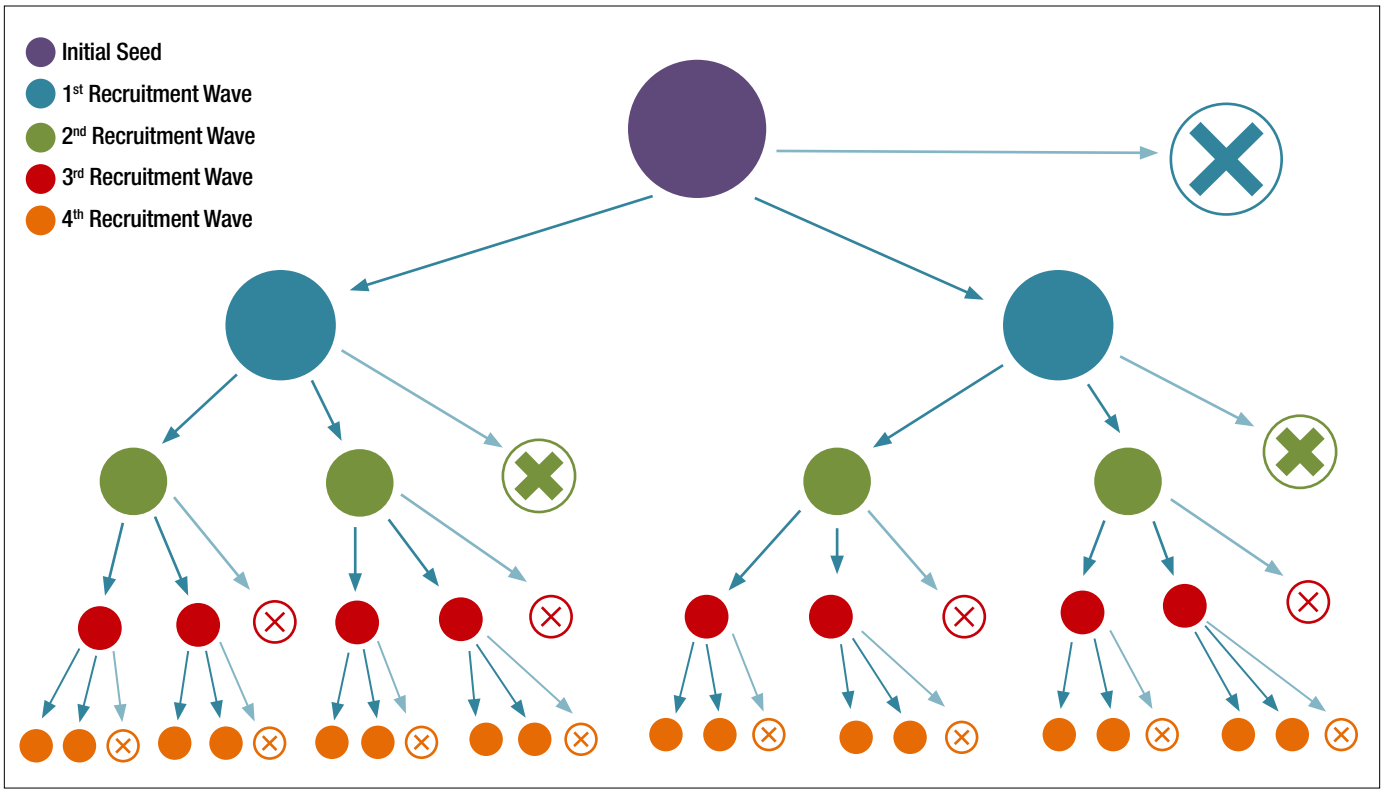
Participant Recruitment

Participants were recruited between March and September of 2013. To participate in the study, youth had to meet three inclusion criteria: (1) be 14–21 years old, (2) not have a permanent place to stay, and (3) provide written, informed consent. Youth were excluded if they were incapable of comprehending the consent form because of cognitive limitations (psychotic symptoms or developmental delays) or if they were noticeably intoxicated at the time

of the interview (interviews and focus group participation were rescheduled for another time). Study participants were recruited within the selected sites or in public spaces through street outreach during regular agency hours of operation. Agency staff facilitated an introduction between the youth and the interviewers or focus group moderators, who then explained the study procedures and obtained written consent. Recruitment procedures were nearly identical across all sites. To obtain a diverse respondent group, youth could participate in either an interview or focus group, not both.

The study used Respondent-Driven Sampling (RDS) to recruit and select interview participants. Based on the limitations associated with popular methods to count homeless populations (Dennis, 1991; Rossi, U.S. Census Bureau, U.S. Department of Housing and Urban Development, & U.S. Interagency Council on the Homeless,1990; Wright, Fisher, & Willis, 1987; Wright & Devine, 1992) and the desire to access a subpopulation of homeless individuals, RDS (Heckathorn, 2002; Heckathorn et al., 2002) was chosen based on its use in other studies to sample

Figure 1.1: Interview Seeds with Reimbursements



and analyze hidden populations, including homeless populations (Coryn, Gugiu, Davidson, & Schroter, 2007; Gwadz et al., 2010; Salganik & Heckathorn, 2004). RDS is a variant of chain-referral sampling that employs a dual system of structured incentives that has been shown to reduce the biases generally associated with chain-referral methods.

The research teams in each site recruited four street youth to serve as initial "seeds" (initial participants who referred other youth) who met the inclusion criteria. Initial "seeds" were recruited by word of mouth and through posted fliers in each city. "Seeds" were reimbursed with a $20 gift card for their interview and were offered further financial incentives to recruit peers for the same interview they completed. "Seeds" were given three recruitment coupons and were told that if they passed them on to peers who could complete the interview, they would receive a $10 gift card for each recruited peer. All new recruits were offered the same dual incentives as the "seeds"—completing the interview and recruiting peers into the study. Coupons had unique identifiers that linked to the "seed" and had to be used within 14 days.

Figure 1.1 is a visual representation of the RDS design. Solid-colored circles represent homeless individuals who completed a personal interview. Arrows indicate the recruitment coupons given to peers. Bold arrows signify that an individual was successfully recruited and completed a personal interview. Thin arrows that lead to circles marked with an "X" indicate that the coupon was not returned and the seed was unsuccessful.

To meet the target sample total for each site, a convenience sampling approach was employed to supplement the RDS approach. Participants recruited through convenience sampling were found at the grantee site or in areas where SOP program staff conducted street outreach. Participants who completed the interview through convenience

sampling were reimbursed with a $20 gift card. Therefore, 212 interviews were conducted using RDS and 444 through convenience sampling, for a total of 656 interviews across all 11 SOP sites.

In addition to participant interviews, focus groups were conducted to obtain qualitative information about homeless history, personal characteristics, future goals, and service utilization of participants. Participants for the focus groups were recruited through convenience sampling methods through each SOP site, and each focus group consisted of 4 to 8 homeless youth who met the same inclusion criteria used for interview participants. At each site, two local study interviewers served as moderators for each of four focus groups, which lasted approximately 1 hour and followed a standard protocol. Focus group participants received a $20 gift card for their participation. Focus group discussions were recorded on a digital audio recorder, and the recordings were sent to University of Nebraska–Lincoln (UNL) for transcription. A total of 217 youth participated in the focus groups.

Measures

Five interview measures were used: the Rosenberg Self-Esteem Scale, the Center for Epidemiologic Studies Depression Scale (CES-D), and screens for symptoms of anger, mania, and post-traumatic stress.

Self-Esteem—The Rosenberg Self-Esteem Scale (Rosenberg, 1965) is a 10-item unidimensional scale designed to measure the self-esteem of adolescents. It measures personal worth, self-confidence, self-satisfaction, self-respect, and self-deprecation. All items are answered using a 4-point Likert scale ranging from "strongly agree" to "strongly disagree." Negatively worded items are reverse-coded.

Depression—The CES-D is a 20-item measure that asks respondents to rate how often over the past week they experienced symptoms associated with depression, such as restless sleep, poor appetite, and feeling lonely. Response options range from 0 to 3 for each item (0 = rarely or none of the time, 1 = some or little of the time, 2 = moderately or much of the time, 3 = most or almost all the time). Scores range from 0 to 60, with high scores indicating greater depressive symptoms. The CES-D provides cutoff scores (e.g., 16 or greater) that help identify individuals at risk for clinical depression (Radloff, 1977).

Anger—The Tri-Ethnic Center Anger Scale (Oetting, Beauvais, & Edwards, 1998) consists of six questions that assess respondents' feelings of anger. All items are answered using a 4-point Likert scale ranging from "most of the time" to "none of the time."

Mania—The six mania screening items are taken from the Achenbach Child Behavior Checklist (Achenbach, 1991). This screen defines mania as elevated, expansive, or irritable mood. Respondents were read six statements and asked whether the statement was "never true," "sometimes true," or "always true" for them.

Post-Traumatic Stress—The post-traumatic stress screener was developed for another study (see Marshall, Olfson, Hellmann, Blanco, Guardino, & Streuning, 2001) to examine the prevalence of subthreshold (symptoms that fall short of meeting full diagnostic criteria) post-traumatic stress disorder (PTSD) and associated impairment. Respondents were asked if they had experienced any extremely frightening, traumatic, or horrible events in their past. Responses are reported as the percentage of respondents who have experienced the event.

The interviews also included questions about demographics, service needs, service access, service utilization, life history, thoughts and feelings, and drug use. The majority of questions were noninvasive. The interviews were conducted in private rooms.

Interviewers read most questions aloud to the participant and recorded his or her responses in Voxco survey software. However, some questions, especially those related to sexual behavior, substance use, and physical and sexual abuse, were considered sensitive. The short series of sensitive questions was not read aloud by the interviewer. Rather, for these self-administered questions, the interviewer gave the computer to the participant to read the questions silently (or to listen to the question read aloud via headphones) and click to record his or her responses.

Interview questions were programmed using Voxco survey software and uploaded onto computer tablets. Pilot testing of the interview instrument and data collection procedures took place in Omaha, Nebraska, from July through September of 2012. Computer tablets were provided to each site for data collection. After each interview, local SOP staff, using Voxco survey software, uploaded the completed interview via the Internet to a secure password-protected UNL accessible only to project staff. Data stored on the computers were identifiable with random number IDs, which were encrypted to protect participants' identities. Participants were only identified on the computer-assisted personal interviewing program by random number IDs.

Data Collection Training

Each SOP site was responsible for choosing one person from their agency to serve as a study supervisor and three to four staff members to conduct interviews and focus groups. All of the supervisors were full-time employees of the agency and spent 5 to 10 hours of their work week on SOP data collection study tasks. Interviewers were paid hourly and were sometimes case managers or outreach workers at the agency, agency interns, or other personnel. The SOP supervisors and data collection staff members from each of the 11 sites came to Omaha, Nebraska, in January 2013 to attend an intensive 5-day training

on the interview protocol and interviewing techniques, the focus group protocol and focus group facilitation, the RDS protocol, and data storage and transfer. SOP staff in Omaha received similar training from UNL in July 2012 to pilot-test the RDS protocol and the interview instrument and protocol. After training, project staff returned to their agencies to complete practice interviews and institutional review board Collaborative Institutional Training Initiative human subjects training certification. Data collection staff also completed a short training refresher course before data collection began in March 2013.

Informed Consent and Confidentiality

An informed consent statement was read to each youth before he or she agreed to participate in the study. The youth were given the opportunity to ask any questions about the study and have those questions answered before agreeing to participate in either an interview or focus group. Participants were informed their information would be kept private to

the extent permitted by law and their participation was voluntary. They were also informed they could choose to not answer a question and move on to the next one. Each youth who agreed to participate was given a copy of the consent form to keep and was asked to sign a consent form that the research team then kept in a locked cabinet. The consent forms were sent via Federal Express to project staff at UNL, who then stored the consent forms in a secure location.

Data Collection

Data were collected from youth via computer-assisted personal interviews and focus groups. All data collection instruments were selected by UNL for this study to include previously validated measures. The participants included street youth served by FYSB's SOP grantees and street youth who were not currently using services from SOP grantees.

Across the 11 sites, data were obtained during 656 computer-assisted personal interviews. The interview questions were developed to collect data across four broad areas:

- Who are the youth street outreach programs are coming into contact with?
- What services and supports do these youth say they need?
- Which services and supports do youth access/use? Which do they not access and why?
- What are some of the challenges that youth encounter when accessing services?

Focus group discussions were conducted to capture information from 217 youth on homeless history, personal characteristics, future goals, and service utilization. Four focus groups were conducted, and each lasted approximately 1 hour. Each discussion was recorded using a digital audio recorder and later transcribed.

Data Analysis

Two forms of data were collected in the study: statistical, coded data from a survey interview and narrative, qualitative data from open-ended questions asked during focus groups. This report primarily discusses the results of the analysis of interview-based quantitative data analyzed using the Statistical Package for the Social Sciences (SPSS) software. All analyses for the study were conducted by UNL. Analysis of Variance (ANOVA) was used to detect differences between groups (for example, males versus females), with statistically significant results reported using "p" values at the .05 level or less ($p<.05$). In addition, bivariate logistic regression was used to examine various predictors, resulting in odds ratios. An odds ratio is a measure of association between a predictor (e.g., past year drug use, number of months homeless) and an outcome (e.g., being victimized while homeless). Significance of predictors is indicated by $p<.05$.

The results of the SOP Data Collection Study are summarized in the following chapters, which cover participant characteristics, homeless history, social support and relationships, sexual behavior, mental health, substance use, life on the streets, and service needs. In most chapters, both quantitative (survey interview) data and qualitative (focus group) data are reported. In this report, the information from the focus groups is used to support or add further context for the quantitative findings, and it appears as direct quotes from focus group participants' responses.

CHAPTER 2: PARTICIPANT CHARACTERISTICS

This chapter provides demographic information on the 656 young people who participated in the interviews, including age, biological sex and gender identity, race and ethnicity, education, employment, and income. Information on participant characteristics of the 217 focus group participants was not collected.

INTERVIEWS BY LOCATION

Participants in the study were sampled from 11 different sites: Austin, TX; Boston, MA; Chicago, IL; Minneapolis, MN; New York City, NY; Omaha, NE; Port St. Lucie, FL; San Diego, CA; Seattle, WA; Tucson, AZ; and Washington, DC. The study aimed to conduct 62 interviews in each city. In total, 656 interviews were conducted. Each site conducted between 60 and 62 interviews, with the exception of the Boston site, which conducted 48 (see Table 2.1).

Table 2.1: Number and Percentage of Interviews by Location (*N*=656)

City	*n*	% of total sample
Austin	61	9.3%
Boston	48	7.4%
Chicago	62	9.5%
Minneapolis	60	9.1%
New York	60	9.1%
Omaha	60	9.1%
Port St. Lucie	61	9.3%
San Diego	60	9.1%
Seattle	62	9.5%
Tucson	62	9.5%
Washington, DC	60	9.1%
TOTAL	656	100%

AGE

On average, participants were 19.14 years old (see Table 2.2). Participant ages ranged from 14 years to 21 years, with most participants (69.7%) between 19 and 21 years old.

Table 2.2: Age Distribution (*N*=656)		
Age	*n*	**%**
14 years	16	2.4%
15 years	13	2.0%
16 years	26	4.0%
17 years	52	7.9%
18 years	92	14.0%
19 years	131	20.0%
20 years	156	23.8%
21 years	170	25.9%
TOTAL	656	100%

BIOLOGICAL SEX AND GENDER IDENTITY

More than half of the participants reported their biological sex was male (54.4%), and 45.6 percent reported their biological sex was female (see Figure 2.1). When asked about gender identity, 93.2 percent of participants reported "I am not transgender." The remaining 6.8 percent of the participants identified as transgender. Eleven participants (1.7%) reported being "transgender and identify as a boy or man." Nineteen participants (2.9%) reported being "transgender and identify as a girl or woman." An additional 14 participants (2.2%) reported being "transgender, but identify in some other way." (See Figure 2.2)

Figure 2.1: Percentage of Participants by Biological Sex (*n* = 651)

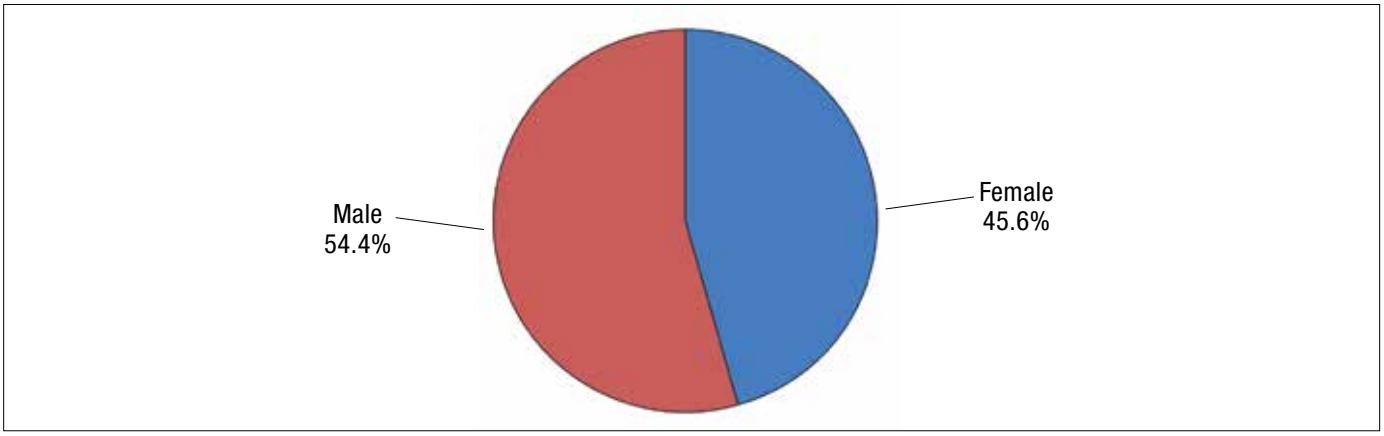
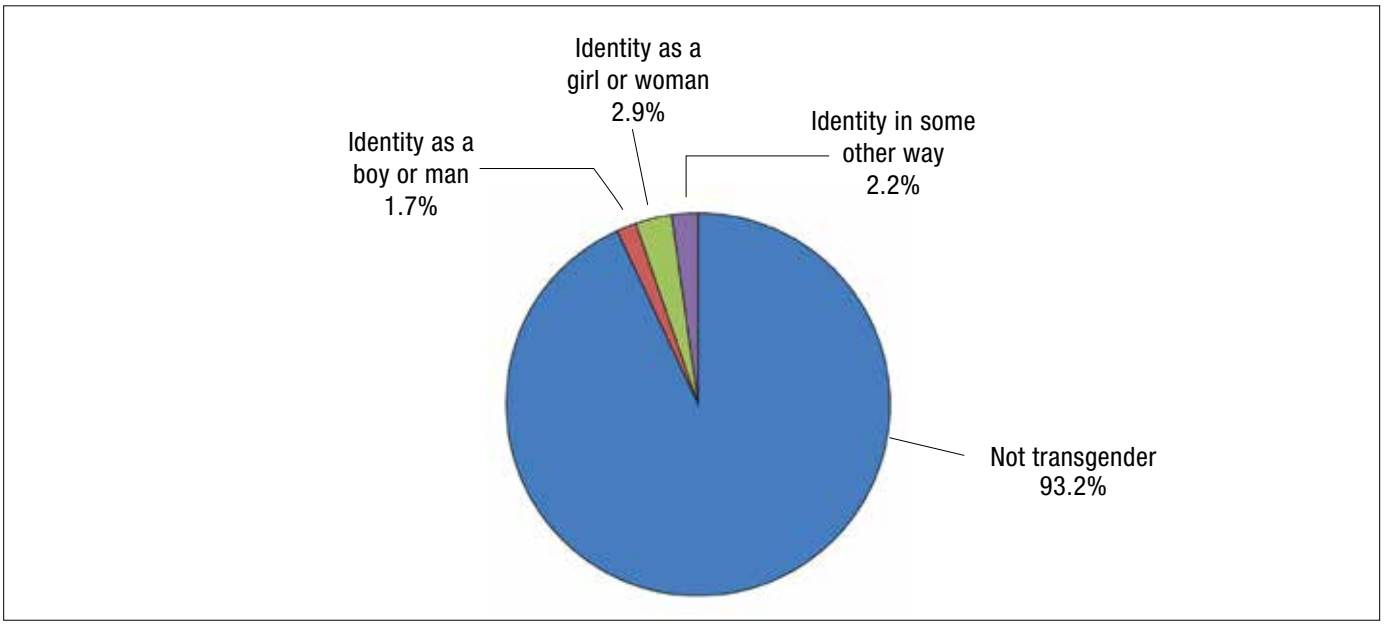


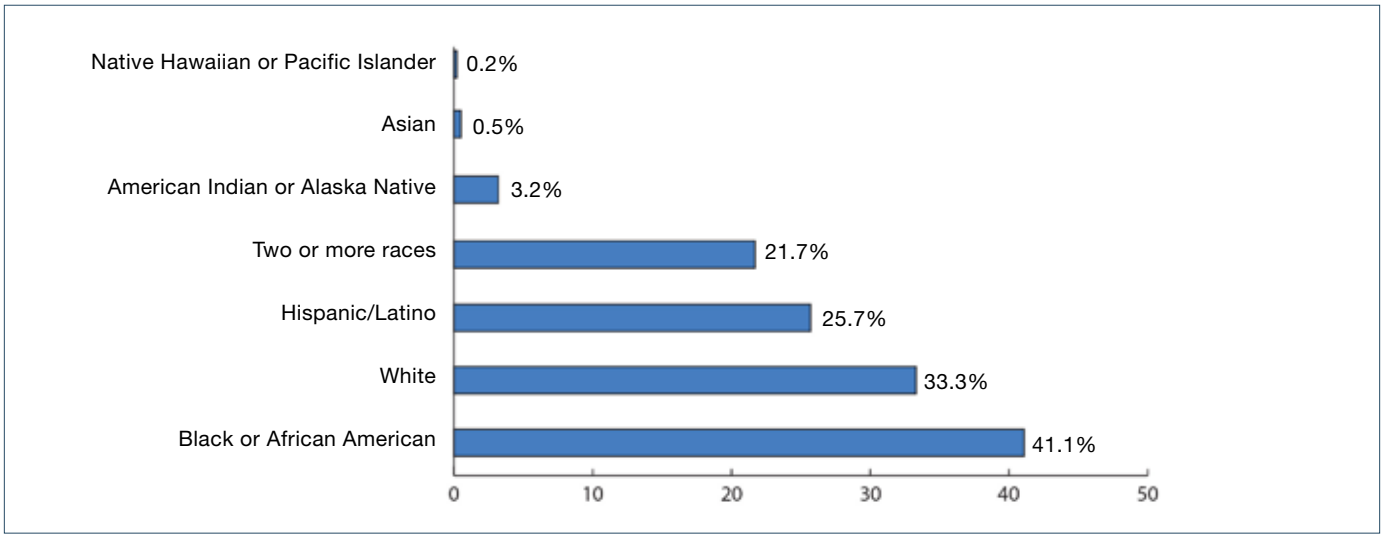
Figure 2.2: Percentage of Participants by Gender Identity (*n* = 656)



RACE AND ETHNICITY

Figure 2.3 displays the racial composition of the interview participants. Forty-one percent of the participants identified as Black or African American and one-third (33.3%) identified as White only. Just over 3 percent identified as American Indian or Alaska Native, 0.5 percent as Asian, and 0.2 percent as Native Hawaiian or Pacific Islander. About one-fifth of participants (21.7%) identified as being two or more races. One-quarter of the participants (25.7%) identified as being Hispanic or Latino/Latina.

Figure 2.3: Race (*n* = 567)



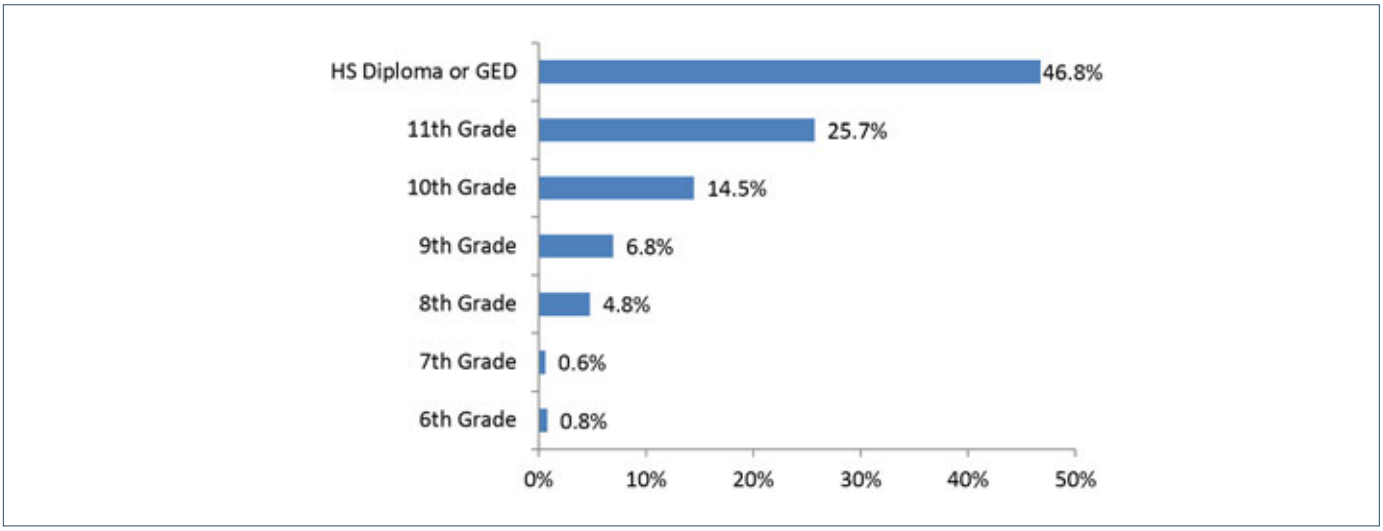
ANOVA was conducted to explore differences by race for shelter use, victimization, and substance use. Both White and non-White participants were equally likely to have "ever used" an emergency shelter, a temporary shelter, or a transitional living program. White participants were significantly more likely to have experienced any

victimization while homeless (68.3%) compared with non-White participants (55.6%; p=.003). White participants were also significantly more likely to have used drugs in the past 30 days than were non-White participants. In the past month, more White than non-White participants had smoked cigarettes (74.3% vs. 59.3%; p=.000), drunk alcohol (65.6% vs. 54.6%; p=.011), smoked marijuana (61.8% vs. 51.1%; p=.015), used methamphetamine (15.6% vs. 2.1%; p=.000), used prescription drugs nonmedically (18.3% vs. 6.4%; p=.000), used cocaine (10.3% vs. 4.0%; p=.011), used injection drugs (7.0% vs. 1.3%; p=.004), and used other illegal drugs such as LSD, PCP, ecstasy, mushrooms, or heroin (23.4% vs. 8.6%; p=.000).

EDUCATION

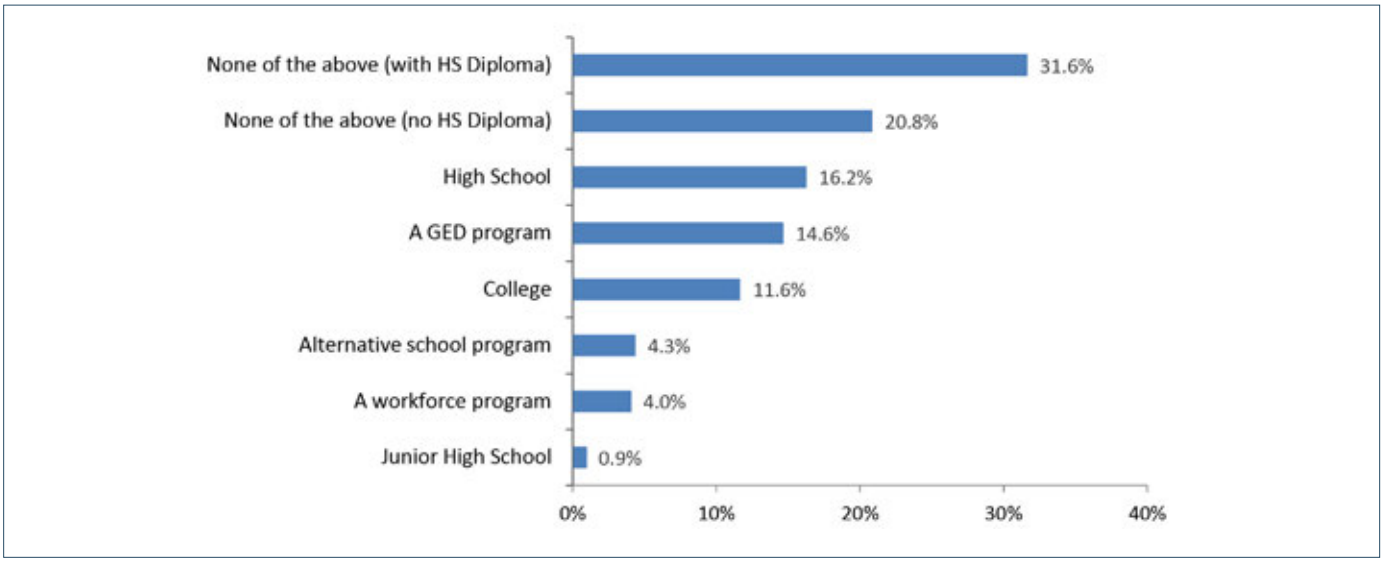
A little less than half (46.8%) of the participants had a high school diploma or General Educational Development (GED) certificate. Just over one-quarter (25.7%) had completed 11th grade, 14.5 percent had completed 10th grade, 6.8 percent had completed 9th grade, 4.8 percent had completed 8th grade, less than 1 percent had completed 7th grade, and less than 1 percent had completed 6th grade (see Figure 2.4).

Figure 2.4: Educational Completion (*n* = 650)



Participants were also asked whether they were ever told by a teacher, counselor, doctor, or some other professional that they had a learning disability. Almost 41 percent (40.6%) of the participants reported being told they had a learning disability at some point in their lives. Participants were also asked whether or not they were currently enrolled in school or other educational programs (see Figure 2.5). Almost one-fifth (16.2%) were currently enrolled in high school, 14.6 percent were enrolled in a GED program, and 11.6 percent were enrolled in college. About 4 percent were enrolled in an alternative school program, like night school, 4 percent were enrolled in a workforce program, and 0.9 percent were enrolled in junior high school. Just over half (52.4%) were not currently enrolled in school or an education program.

Figure 2.5: Current Educational Enrollment (could choose more than one); *n* = 656



During the focus groups, participants who weren't enrolled in school were asked about services or supports they needed to return to school. The kinds of help participants most often mentioned were transportation, school supplies, and school clothes. Others said they needed help filling out forms to obtain financial aid. One focus group participant talked about her disappointment with the lack of support and encouragement she received from her family concerning her education:

> I was gonna say like the family thing because well again, my family is kind of the reason why I'm homeless in the first place so I feel like it won't make sense to try and reach out to them if they're the reason I'm in this situation. And again, they always, they turn their backs on me more than once, more than twice, more than three times. Like one situation that I will never forgive was the first time I was supposed to go off to [university], which was like last year, and I had everything together, I was accepted, I had my scholarships, I had my housing together and I was ready to leave. The only thing I needed help with was I needed someone to drive me down there or at least accompany me on [Amtrak] to help me get my things and stuff. Would nobody help me? They just said, "I don't think you should go." Not as opposed to I don't think you should go because you're not ready, but I don't think you should go as in don't go, don't succeed, because we haven't. Because I was the first person out of my whole family to graduate from high school and to be accepted into a university, and I guess they're not immune to things like that, it just felt like they wanted me to be a part of that. So they pretty much sabotaged me. —Focus group participant (Chicago, IL)

Focus group participants were also asked where they see themselves in 5 years. Participants spoke about completing high school or entering college so they could be employed and have professional careers.

> I just hope I have my education by then… It would be easier for me to get a job and support everything. —Focus group participant (Austin, TX)

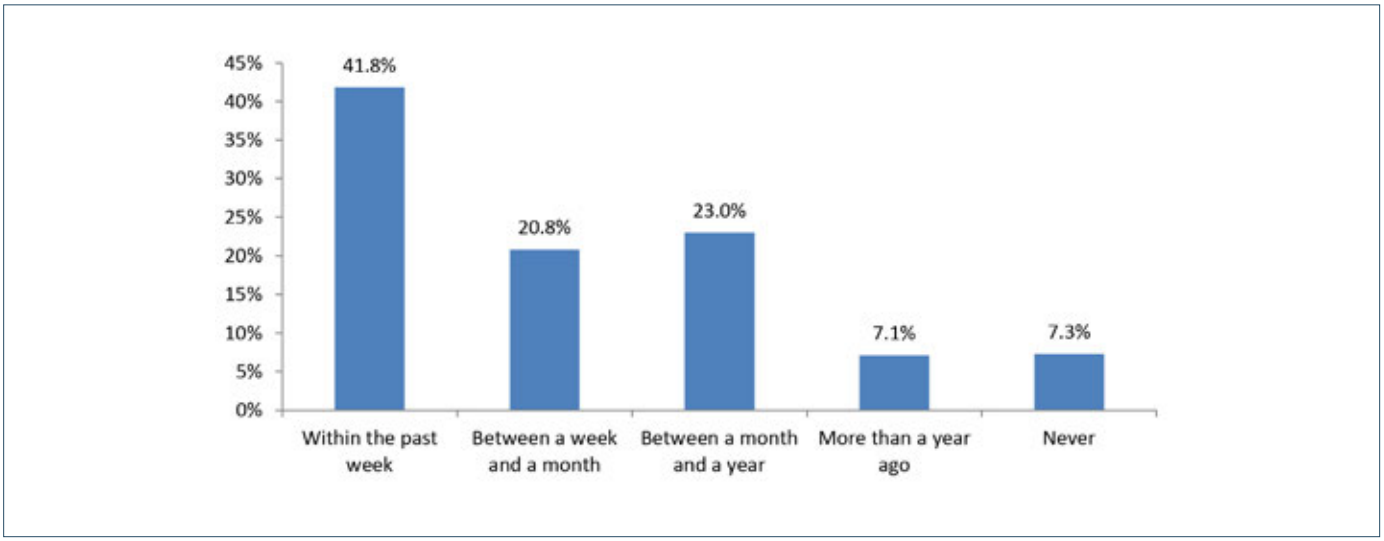
I pretty much see myself in 5 years being done with high school, college, I want to be a police officer. I wanna do that and if that doesn't work I'll just go with plan B and probably join the army pretty much it. —Focus group participant (Boston, MA)

In 5 years… I will definitely be in school—a 4-year college. I definitely aspire to be in college. I feel like that's the biggest goal of all. —Focus group participant (Chicago, IL)

EMPLOYMENT AND INCOME

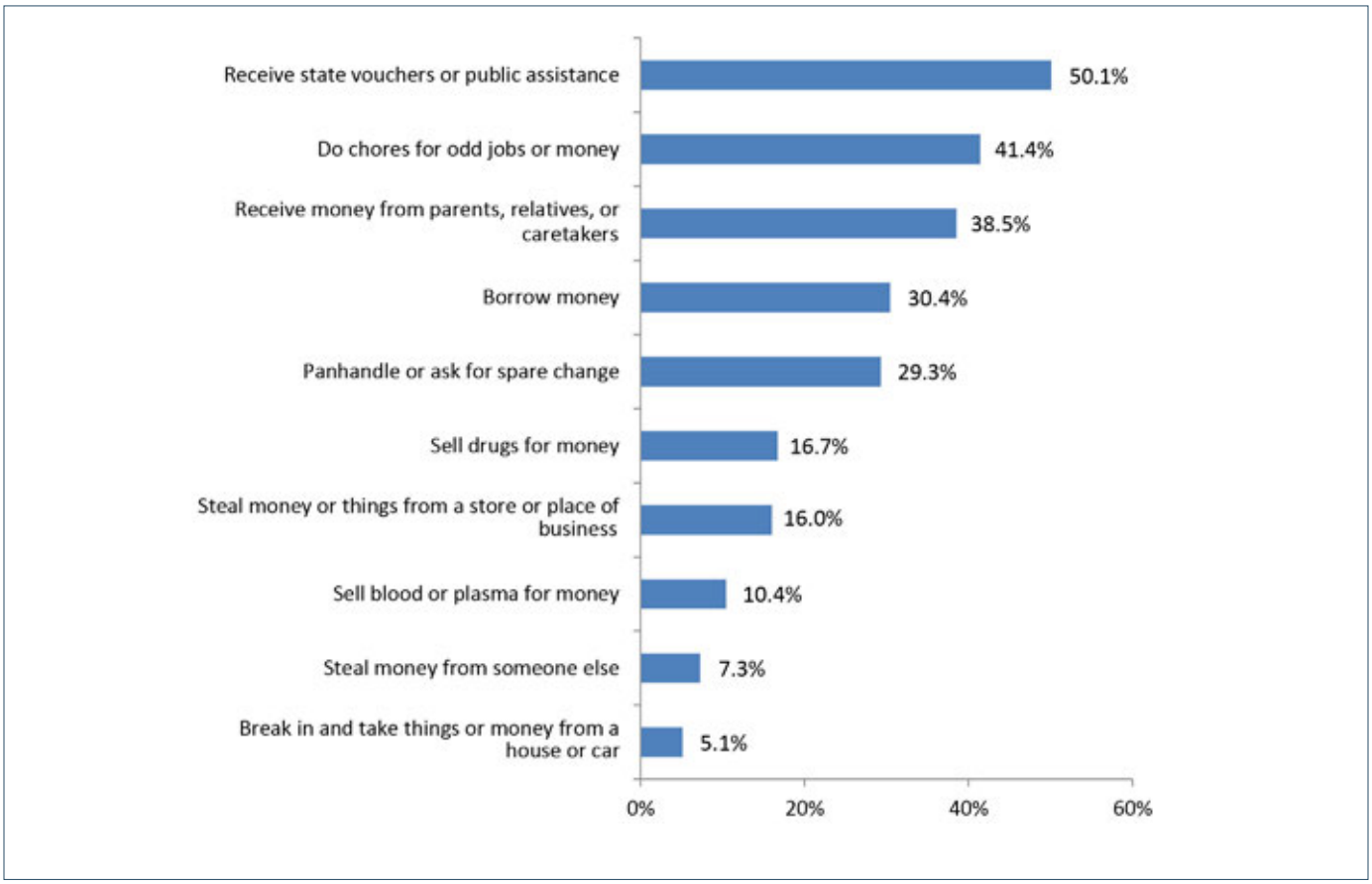
A total of 6.3 percent of participants had a full-time job and 16.7 percent had a part-time job at the time of their interview. Five percent of the sample had enlisted in the military. During the interview, participants were asked about the last time they applied for a job. More than 40 percent (41.8%) reported that they had applied for a job within the past week. About one-fifth (20.8%) applied for a job more than a week ago but within the last month, and 23.0 percent applied for a job more than 1 month ago but within the last year. Fewer participants reported the last time they applied for a job was more than a year ago (7.1%), and another 7.3 percent of participants had never applied for a job (see Figure 2.6).

Figure 2.6: Last Applied for a Job; (*n*=648)



Participants were also asked about their means of obtaining money in the past month (see Figure 2.7). The response most selected was receiving state vouchers or public assistance (50.1%), followed by doing chores or odd jobs for money (41.4%); receiving money from parents, relatives, or caretakers (38.5%); and borrowing money (30.4%).

Figure 2.7: Past 30-day Income (n = 648)



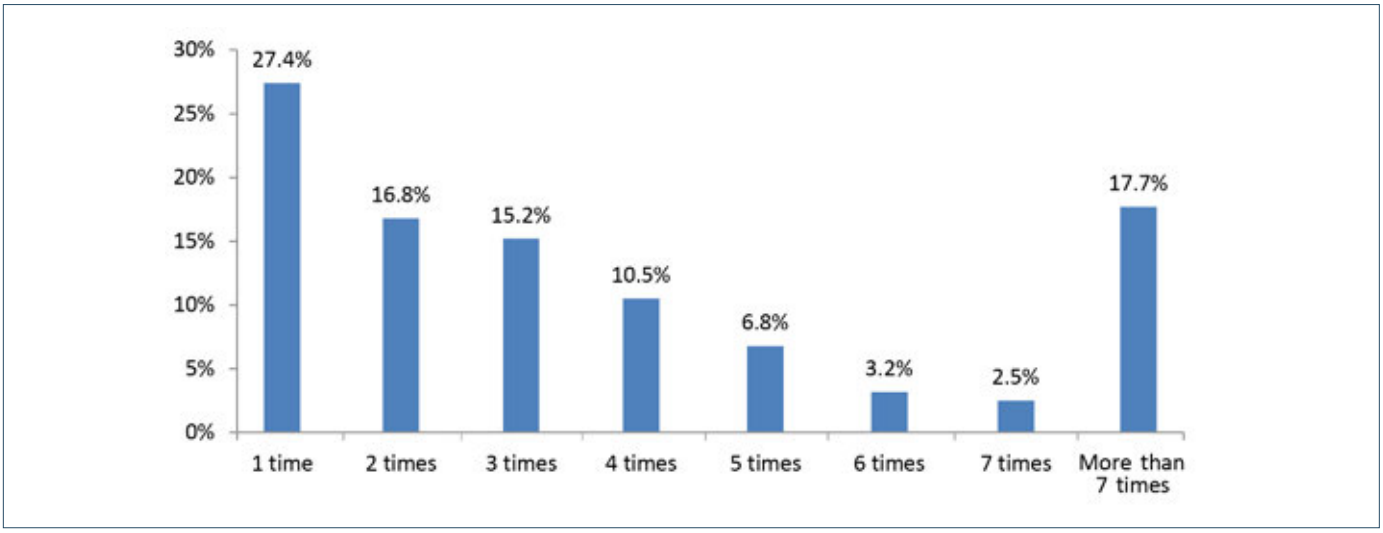
CHAPTER 3: HOMELESS HISTORY

This chapter presents information youth provided on their experiences of homelessness, including the number of homeless episodes, length of time homeless, living situation prior to becoming homeless, reasons for becoming homeless, victimization while homeless, locations used to sleep or rest, foster care involvement, and attitudes toward homelessness. Such information can provide a better understanding of the origins of homelessness and the experience of youth while homeless, and it may help inform prevention and outreach strategies.

HOMELESS EPISODES

Participants were asked how many times they had been homeless throughout their entire lives, with possible responses ranging from one time to more than seven times (see Figure 3.1). More than one-quarter (27.4%) of participants had been homeless only one time. Approximately one in six had been homeless two times (16.8%) and about another one in six, three times (15.2%). Fewer had been homeless between four and seven times, but 17.7 percent had been homeless more than seven times throughout their lives.

Figure 3.1: Number of Homeless Episodes (*n* = 650)



During the focus groups, participants were asked whether they had gone back and forth between being homeless and having a place to live. Many shared their experiences:

> Ah, I've been through like a family and then I, actually at one point, stayed with a girlfriend, then a teacher and then another girlfriend, my mom, and then my best friend, and then back here. —Focus group participant (Port St. Lucie, FL)

I've been bouncing from being on the street to my mom's for like 2 months, and then I went to my dad's for like a month. And then, he was telling me that I—that I was tying him down. And then, basically back on the street again in that sense. —Focus group participant (Tucson, AZ)

I've, um, been in—in different foster homes and group homes. And I got to live with my aunt. And I was adopted at one point. And then I went back to foster care. So it's just been all around. —Focus group participant (Port St. Lucie, FL)

When I was in 4th grade, I lived in a campground, three homeless shelters, my mom's ex- boyfriend's, and I went back with my dad, and then left again, and then went back with my dad, and then now I came here. —Focus group participant (San Diego, CA)

I'm kind of been off and on homeless for a couple years. I got kicked out of the house when I first got pregnant my freshman year in high school. I was just kind of hopping couches, and then I moved in with my boyfriend which is also my daughter's father. That didn't work out so I got kicked out, didn't have anywhere to go so my daughter stayed with him and it's just kind of like a cycle. —Focus group participant (Omaha, NE)

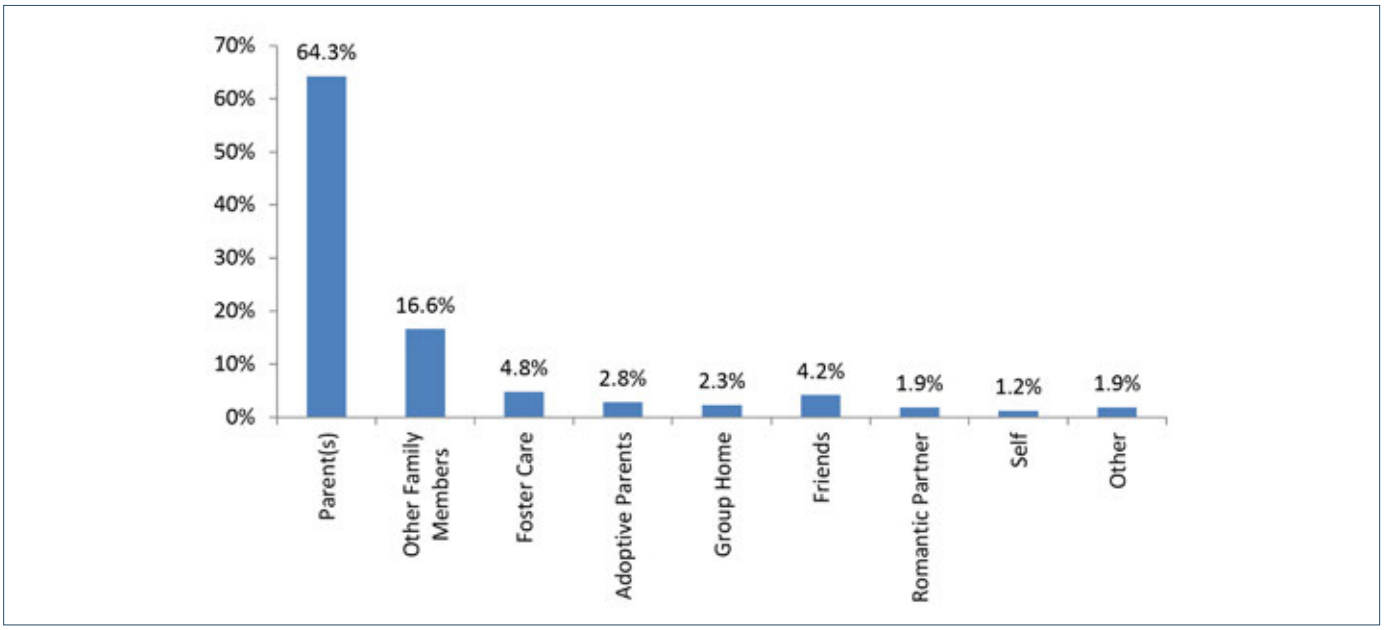
For me, I was going from friends' houses to under some bridges to going to some shelters and find a safe place. —Focus group participant (Omaha, NE)

TIME SPENT HOMELESS

Participants reported having been homeless from 1 week to 21 years. On average, participants had been homeless for 23.4 months of their lives (n = 647). The age at which they first experienced homelessness ranged from ages 1 to 21, with an average age of 15 years old. If participants experienced homelessness more than once, they were asked about the duration of their first homeless episode. On average, participants who experienced more than one episode of homelessness were homeless for 6 months during their first homeless episode.

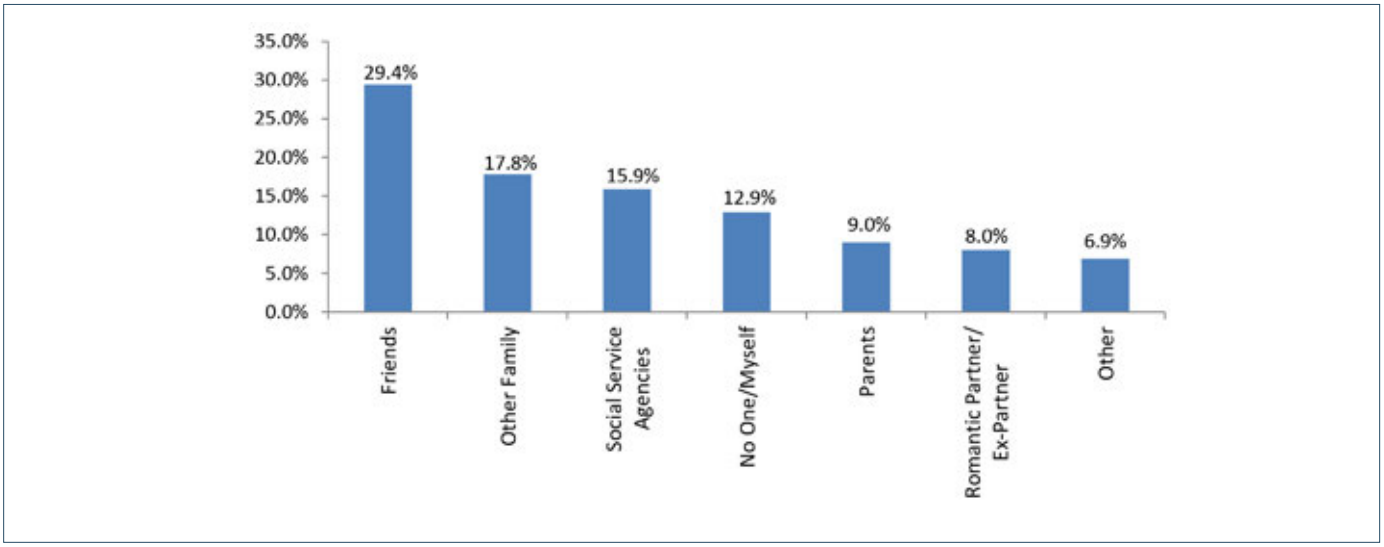
The majority of youth interviewed (64.3%) were living with their parent or parents right before they first became homeless (see Figure 3.2). About one-sixth (16.6%) were living with other family members, like grandparents, aunts, or siblings, before their first homeless episode. Some youth were living in foster care (4.8%), with adoptive parents (2.8%), in a group home (2.3%), or with friends (4.2%) before their first homeless episode.

Figure 3.2: Living Situation Prior to First Homeless Episode (*n* = 644)



When seeking assistance during their first homeless episode, youth had turned to many different sources for help (see Figure 3.3), including friends (29.4%), other family members (17.8%), social service agencies (15.9%), parents (9.0%), and romantic partners or ex-partners (8.0%). A little less than 13 percent of the young people surveyed turned to "no one" or "myself" when they became homeless.

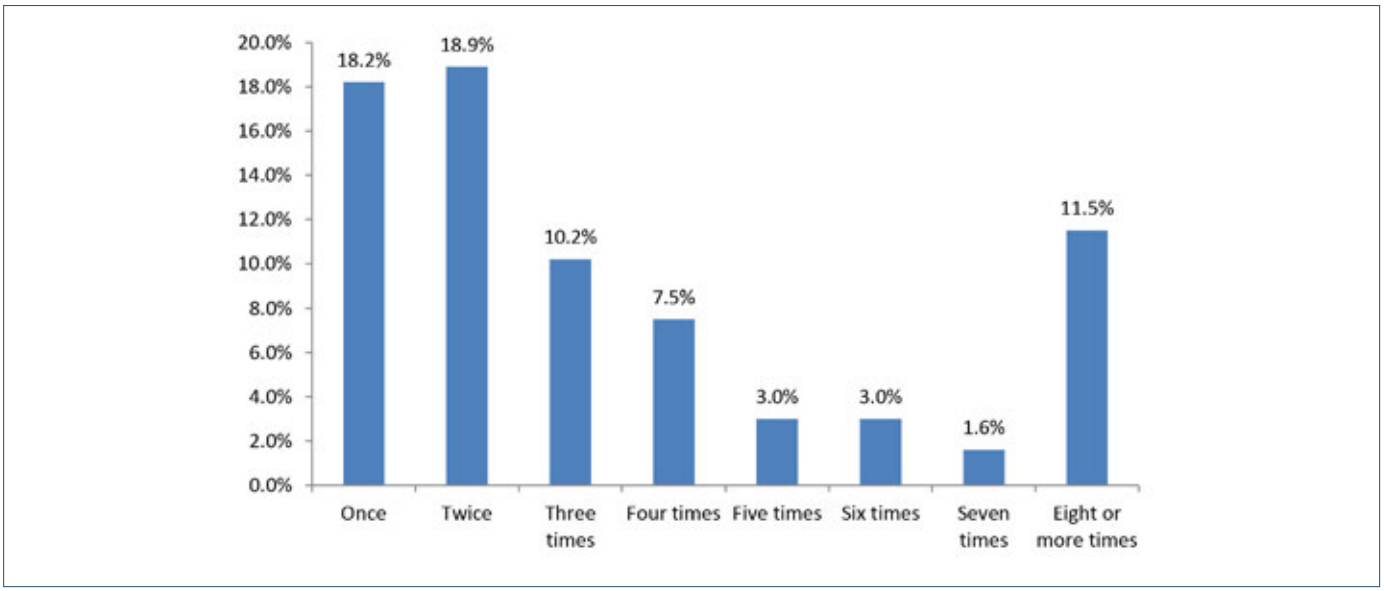
Figure 3.3: Persons Who Were Asked to Help (*n* = 622)



KICKED OUT

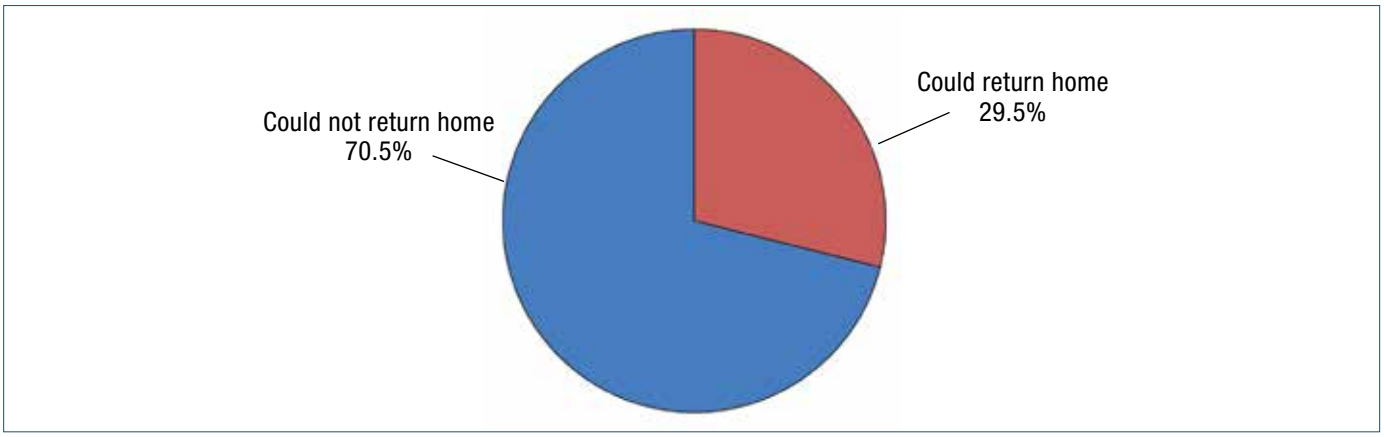
About three-quarters of participants (74.0%) had been kicked out of their homes by a parent or other adult caretaker. Approximately one-fifth of participants had been kicked out once (18.2%) or twice (18.9%). About one-tenth of the participants had been kicked out three (10.2%) and 7.5 percent, four times. Fewer participants had been kicked out of their homes five times (3.0%), six times (3.0%), or seven times (1.6%). About one-tenth (11.5%) of participants had been kicked out eight or more times (see Figure 3.4).

Figure 3.4: Number of Times Kicked Out of Family Home



Participants were also asked if they could return home to live if they wished to do that. About 7 out of 10 participants (70.5%) reported that they could not go home. Only 29.5 percent had the option of going home if they wanted to (see Figure 3.5). Participants were asked for the reason they were unable to return home. Most youth (67.8%) cited parents' unwillingness to have them return to the home or the existence of family conflict. Six participants (1.3%) cited overcrowding or family homelessness as reasons why they couldn't return home. Seven participants (1.5%) reported not having a home to return to, due to either a death in the family or the involvement of Child Protective Services. Three participants (0.2%) said that it wasn't safe at home or that their family had a problem with their sexual orientation that prohibited them from returning home.

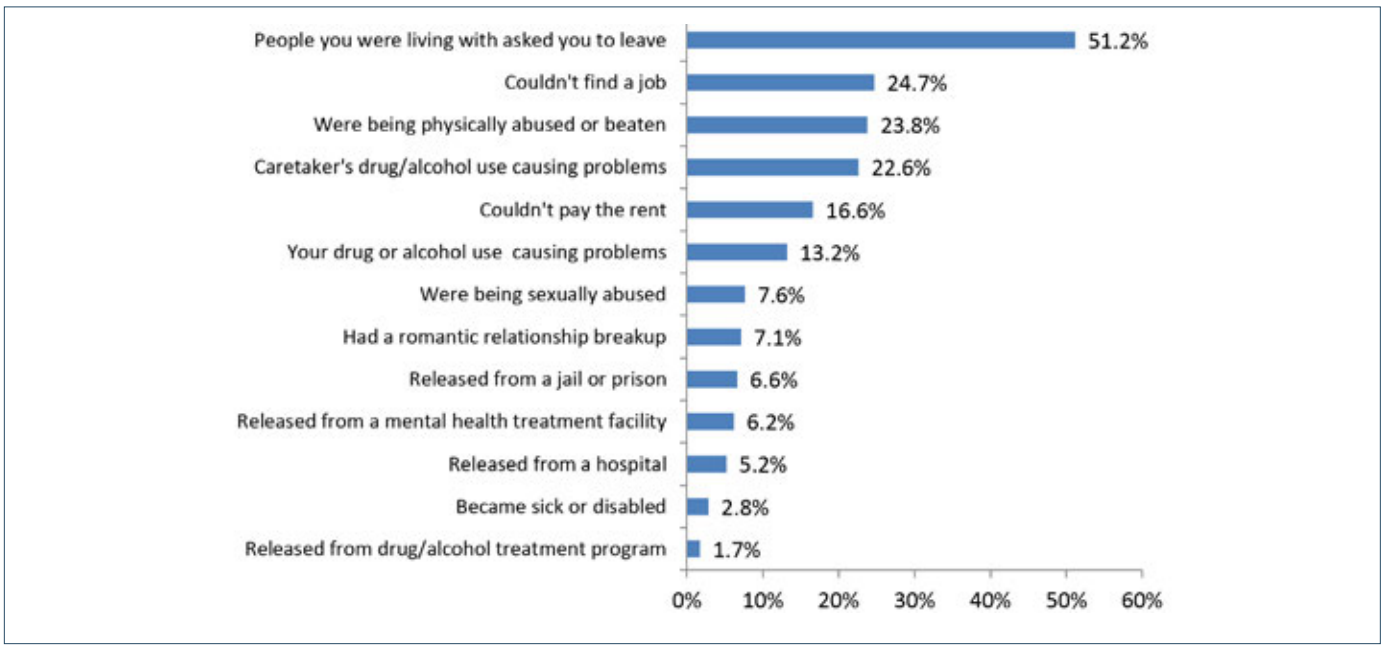
Figure 3.5: Percentage of Participants Able to Return Home



REASONS FOR HOMELESSNESS

During the interview, participants were asked about their reasons for becoming homeless the first time (see Figure 3.6). The reason most selected was being asked to leave (51.2%), followed by being unable to find a job (24.7%) and being physically abused or beaten (23.8%).

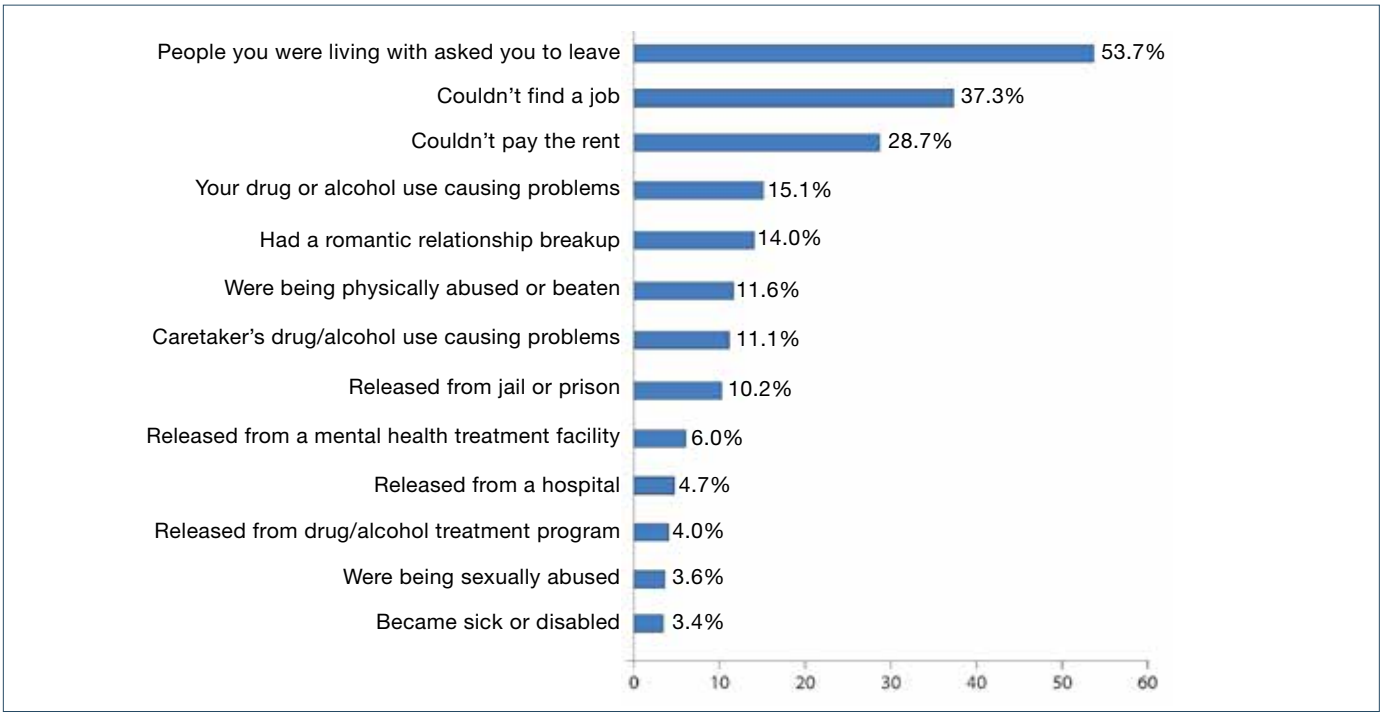
Figure 3.6: Reasons for First Homeless Episode (% Yes)



Youth who had experienced multiple episodes of homelessness and youth who had experienced only one episode of homelessness reported similar reasons for becoming homeless during their most recent episode, with 53.7 percent being asked to leave and 37.3 percent being unable to find a job (see Figure 3.7). In general, reasons for the most recent homeless episode tended to relate to more adult responsibilities, such as inability

to pay the rent (28.7%), going through a breakup of a romantic relationship (14.0%), and the respondent's substance abuse (15.1%). Fewer youth who had experienced multiple episodes of homelessness listed physical or sexual abuse as a reason for their most recent homeless episode, compared with peers who had experienced only one homeless episode.

Figure 3.7: Reasons for Most Recent Homeless Episode (% Yes)



Focus group participants were also asked about why they became homeless during their most recent episode. Many reported family discord, abuse, involvement in the foster care system, and inability to find steady employment:

> My mother would hit me, she would put me down, tell me that I'm emotional, unable to work, tell me I have learning disability. She would personally hit me with a leather belt, throw me on the floor, trip me, anything to put me on the floor while she holds me down with her knee on the back. Hits me on the back, she bruised me here, she bruised my back with cuts and she tried to get disability out of me. —Focus group participant (Port St. Lucie, FL)

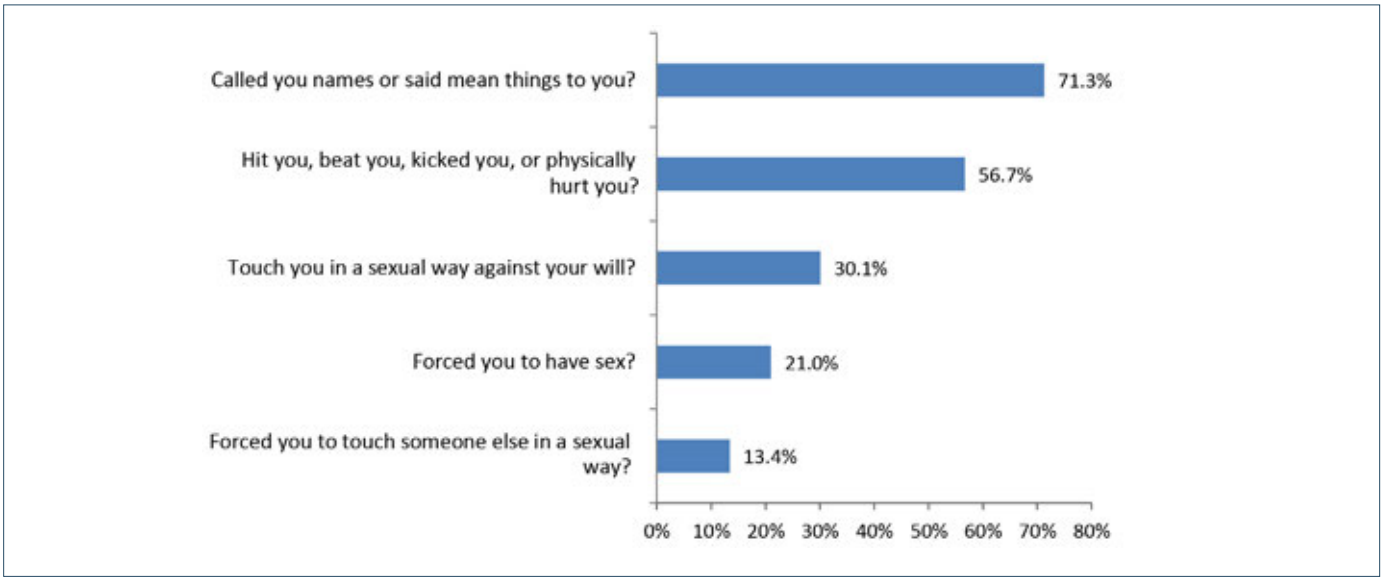
> My mother kicked me out my senior year of high school. My aunt took me in for that year, and then once I graduated high school, she said that she couldn't afford to keep taking me into town to job search, so I went and stayed with my friend for a month, and then they went out of town for a vacation they planned before I ended up in the situation, and they were unable to take me with them. So I stayed with my ex-boyfriend, who I was dating at the time, for a week, and then I managed to get into the program. —Focus group participant (Tucson, AZ)

Um, I had a job in Fort Lauderdale and I was paying, you know, I didn't have a name on a lease or anything, like you said, but I was paying a little bit of rent to a friend I was staying with and I got laid off of that job and I couldn't find another one so…homeless! —Focus group participant (Port St. Lucie, FL)

CHILDHOOD ABUSE

Participants were asked about whether or not they had experienced various forms of emotional, physical, or sexual abuse by an adult (see Figure 3.8). Nearly three-quarters (71.3%) of participants reported that an adult had called them names or said mean things to them before they were 18 years old. More than one-half (56.7%) had experienced physical abuse by an adult during their childhood. Just under one-third of participants (30.1%) were touched in a sexual way by an adult, and approximately one-fifth of participants (21%) were forced to have sex. Finally, 13.4 percent had been forced by an adult to touch someone else in a sexual way.

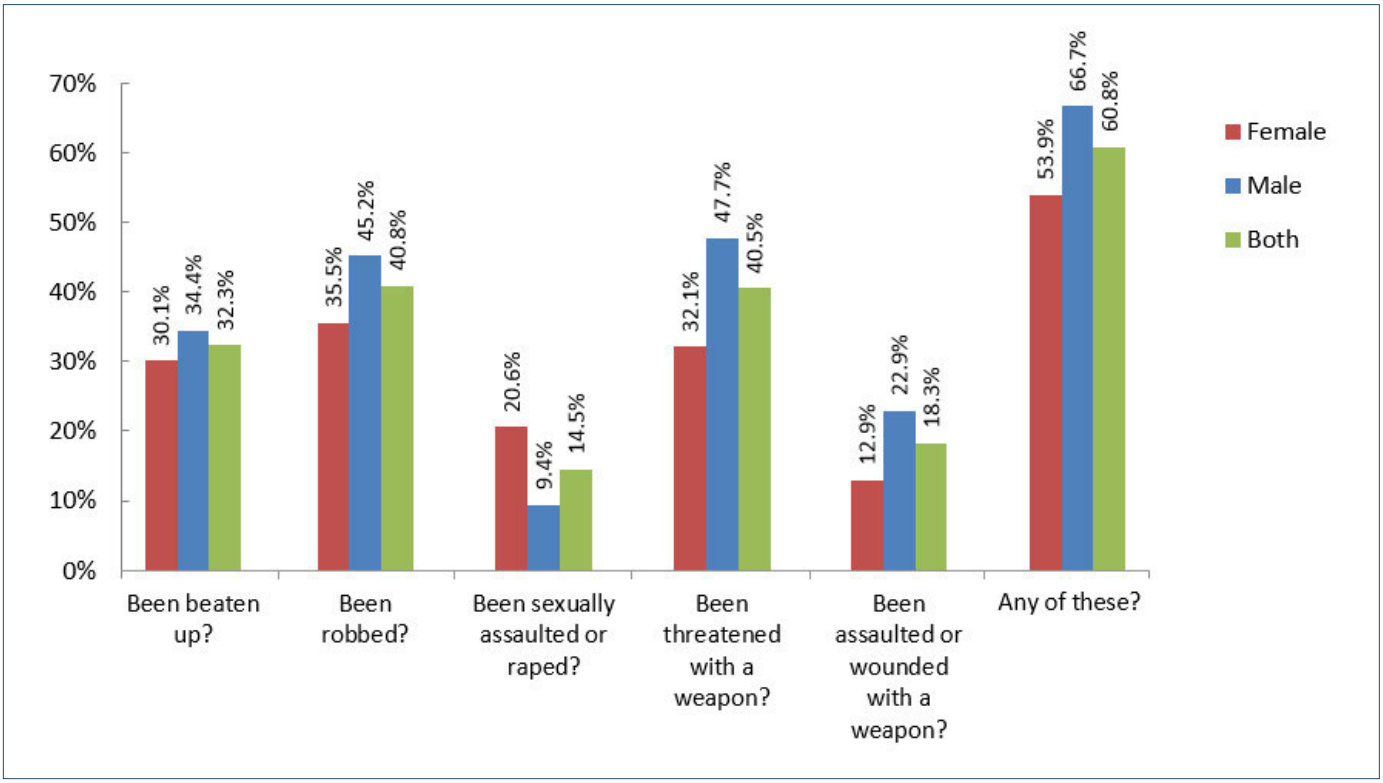
Figure 3.8: Childhood Abuse (% Yes; could choose multiple items, *n* = 610)



HOMELESS VICTIMIZATION

Participants were asked whether they had ever experienced various types of victimization while they were homeless. Figure 3.9 presents victimization experience for participants who responded and by gender, as type of victimization can vary for males and females. Experiences with victimization were quite common among participants. Almost 61 percent (60.8%) of participants had experienced at least one kind of victimization while they were homeless. About 40 percent (40.5%) of the participants had been threatened with a weapon, 40.8 percent had been robbed, and 32.3 percent had been beaten up. About one out of seven (14.5%) had been sexually assaulted or raped, and 18.3 percent had been assaulted or wounded with a weapon. More males than females had been beaten up, robbed, threatened with a weapon, or assaulted or wounded with a weapon. More females than males had been sexually assaulted or raped. Participants who reported identifying as transgender (n=44) were more likely to report experiencing any type of victimization while homeless (74.4%) compared with participants who reported they were not transgender (59.7%; p=.042).

Figure 3.9: Victimization While Homeless (% Yes; *n* = 648)



LGBT participants were significantly more likely to have experienced victimization on the street (including being beaten up, robbed, sexually assaulted/raped, threatened with a weapon, or assaulted with a weapon) than their heterosexual counterparts. Significantly more LGBT youth had experienced at least one type of victimization on the streets, compared with heterosexual youth (68.4% vs. 57.8%, p=.01).

CORRELATES OF HOMELESS VICTIMIZATION

A series of logistic regression models was developed to examine possible predictors of victimization. Standard errors were adjusted for clustering by location. Table 3.1 presents the odds ratios and the number of complete cases for each predictor variable. An odds ratio, in this case, can be interpreted as the odds of being in one category (e.g., ever victimized vs. never victimized) over the other. Odds ratios greater than one indicate a greater likelihood, while odds ratios less than one indicate a lower likelihood. Each variable analyzed was statistically significant, which indicates the probability of observing these relationships is greater than chance.

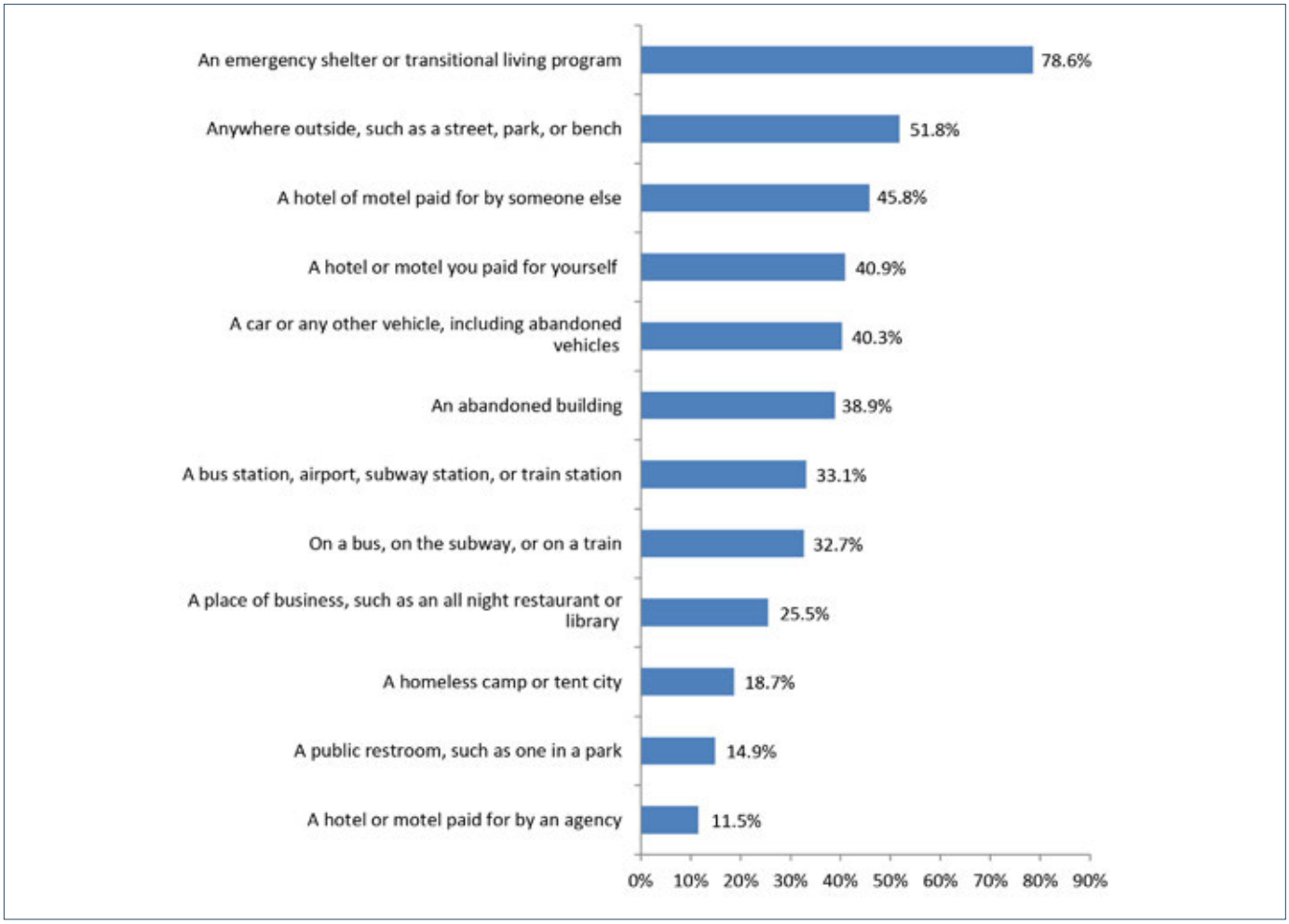
Youth experiencing homelessness were more likely to have been victimized if they were male or experienced high levels of depression and mania, trauma, childhood physical abuse by a caretaker, homelessness at an earlier age, or no one to whom they could turn for support. Participants had increased odds of being victimized if they reported using marijuana (two times as likely to be victimized) and other illicit drugs (three and a half times), and binge drinking (three times). And for every additional month participants experienced homelessness, their odds of being victimized increased by 3 percent.

Table 3.1: Unadjusted Odds Ratios Predicting Victimization While Homeless		
***p<.05; **p<.01; ***p<.001**	**Odds Ratio**	**n**
Depressive Symptoms	1.04***	641
Traumatic Event	4.64***	626
Manic Symptoms	2.63***	641
Number of Months Homeless	1.03***	642
Age at First Homeless Episode	0.95*	630
Social Support	0.60*	647
Past Year Binge Drinking	3.33***	636
Past Year Marijuana Use	2.83***	641
Past Year Illicit Drug Use	3.68***	634
Child Physical Abuse	3.19***	626
Child Sexual Abuse	2.31***	615
Male	1.71***	646

LOCATIONS USED TO SLEEP OR REST

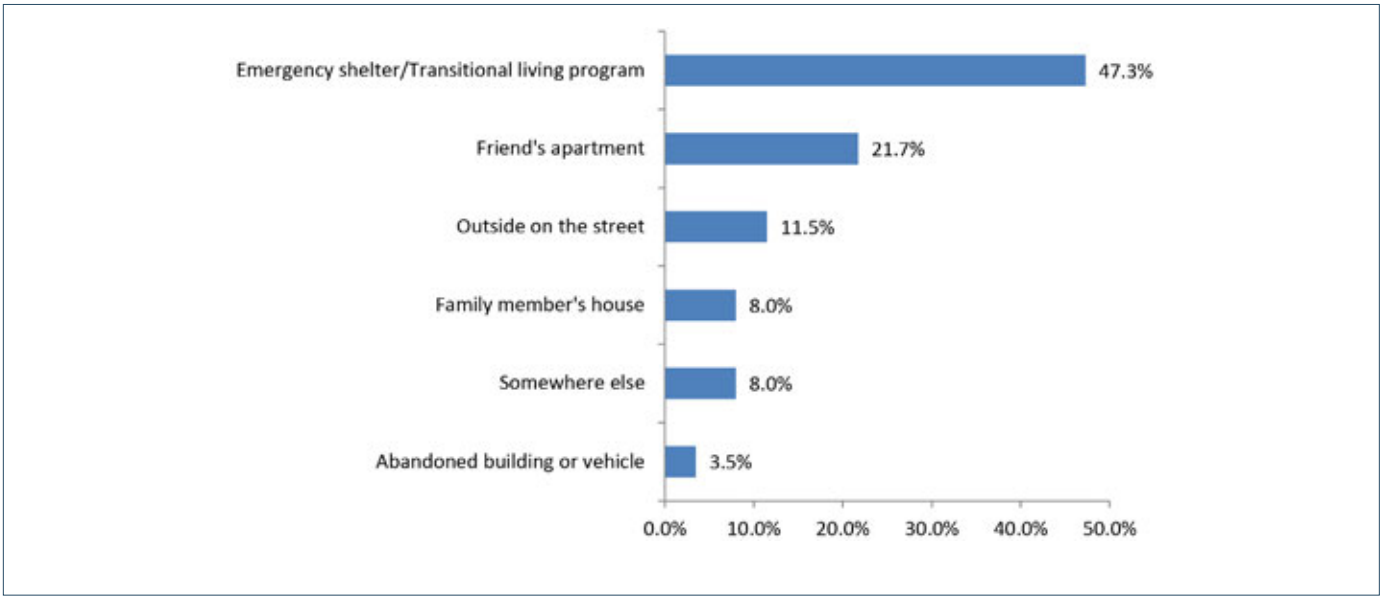
Participants were asked about the places they had slept or rested while homeless (see Figure 3.10). More than three-quarters of participants (78.6%) had slept in an emergency shelter or transitional living program. More than half of participants slept or rested outside on a street, park, or bench (51.8%). A little less than half (45.8%) had slept or rested in a hotel or motel paid for by either someone else or themselves (40.9%). Less than half (40.3%) had slept or rested in a car, and 33.1 percent had slept or rested in a bus station, airport, subway station, or train station. A small number of participants had slept in other locations, like homeless camps and businesses.

Figure 3.10: Where Youth Slept While Homeless (% Yes; n = 650)



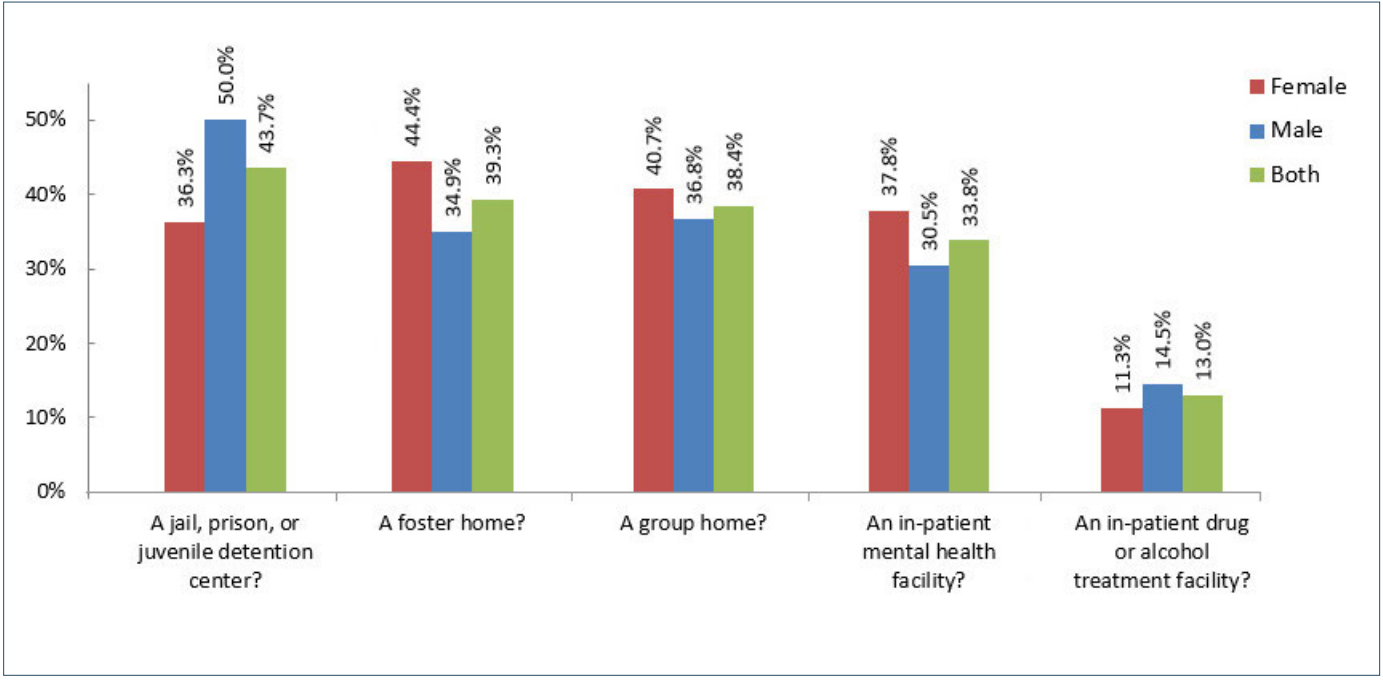
Participants were also asked about where they had slept the night before they were interviewed (see Figure 3.11). Just under half (47.3%) of the participants had slept in an emergency shelter or transitional living program, one-fifth (21.7%) had stayed at a friend's house or apartment, and a smaller proportion had slept outside on the street (11.5%), at a family member's house (8.0%), or in an abandoned building or vehicle (3.5%). Eight percent reported sleeping "somewhere else." On average, participants reported residing at their identified location for 87 days.

Figure 3.11: Where Youth Slept the Night Before the Interview



Participants were also asked about other types of places they had stayed in their lifetimes (see Figure 3.12). More than 43 percent (43.7%) reported they had stayed in a jail, prison, or juvenile detention center. More the one-third (39.3%) had been in a foster care or group home (38.4%). Some participants reported staying in an inpatient mental health facility (33.8%) and a small proportion reported staying at an inpatient drug or alcohol treatment facility (13.0%). Males were more likely to have had a stay in a jail, prison, juvenile detention center, or inpatient drug or alcohol treatment facility, and females were more likely to have had a stay in a foster home, group home, or inpatient mental health treatment facility.

Figure 3.12: Ever Stayed In… (% Yes; *n* = 650)



FOSTER CARE INVOLVEMENT

Analyses of variance were conducted to more closely examine if the experiences of homelessness differed for youth who had reported being in foster care or group home placements versus youth who had not been involved in the foster care system. The sample was evenly split between participants who had a foster care history (n=328; 50.6%) and those that did not (n=320; 49.4%).

On average, participants with a foster care history had been homeless for a significantly longer period of time than their peers with no foster care history (27.5 months vs. 19.3 months, p=.000). In addition, 66.4 percent of participants who had been in foster care scored in the range indicating need for further assessment for depression on the CES-D scale, compared to 57.1 percent of participants who had not been in foster care, a statistically significant difference (p=.016). Significantly more participants with a foster care history than their non-foster care peers experienced:

- a highly traumatic incident (like being the victim of a violent crime or being seriously injured in an accident) (76.2% vs. 66.9%, p=.010);
- a stay in an inpatient mental health treatment facility (46.9% vs. 20.7%, p=.000); and
- a stay in an inpatient drug or alcohol treatment facility (16.6% vs. 9.4%; p=.007).

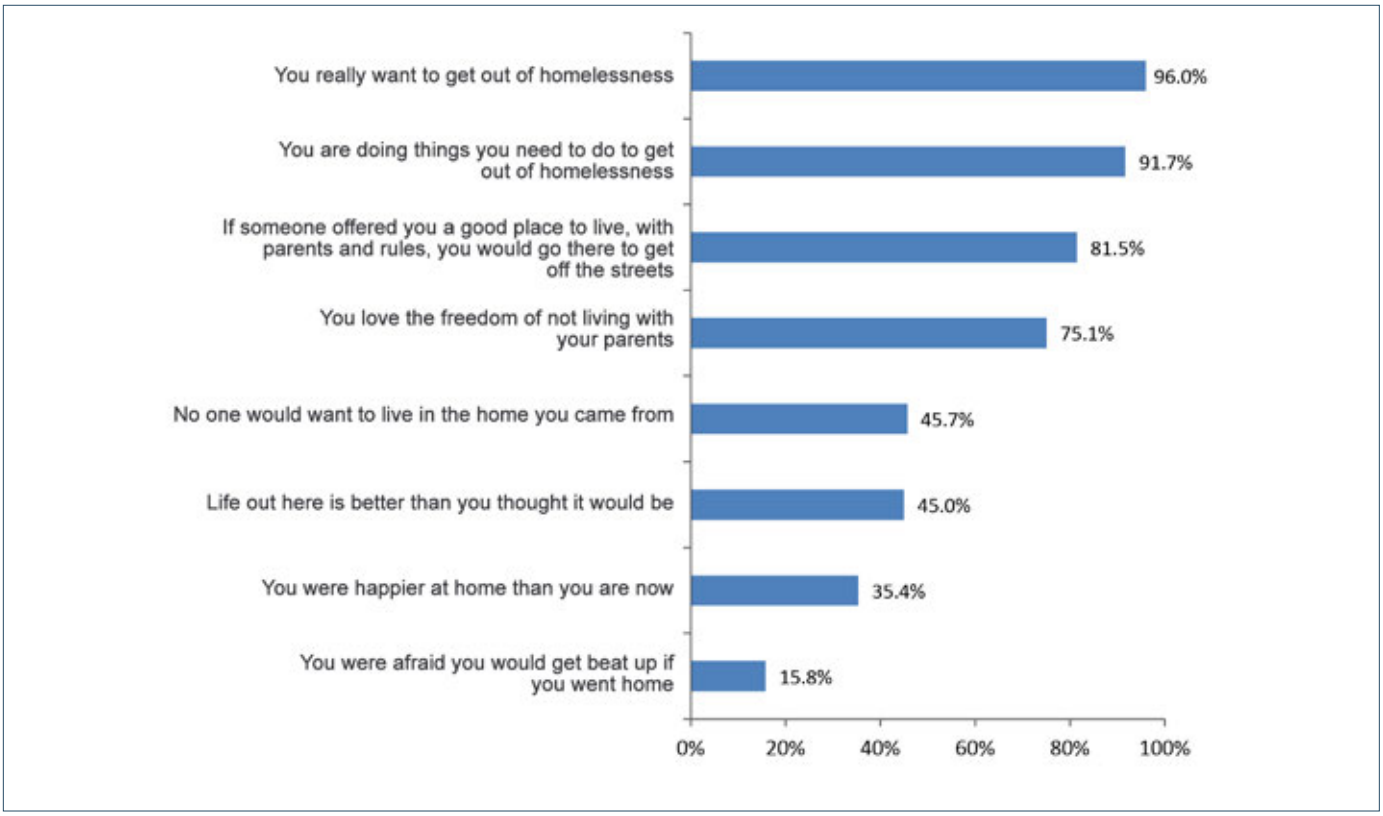
Significantly more participants with a history of foster care had been arrested, compared with participants who had never stayed in foster care (67.7% vs. 55.9%, p=.002). There were no significant differences between participants with a history of foster care and those with no foster care history for trading sex for food, money, protection, drugs, or shelter.

No significant differences were found for past 30-day use of alcohol, marijuana, methamphetamine, cocaine, injection drugs, and other illegal drugs, or for nonmedical use of prescription drugs, between the two groups. The only significant difference was that more participants with a foster care history had smoked cigarettes in the past month, compared with participants without a foster care history (68.8% vs. 61.0%; p=.04).

ATTITUDES TOWARD HOMELESSNESS

Participants were read a series of statements about homelessness and living situations and were asked to choose among four response options—"strongly agree," "agree," "disagree," or "strongly disagree" (see Figure 3.13). As would be expected, almost everyone interviewed (96.0%) either "strongly agreed" or "agreed" with the statement, "You really want to get out of homelessness." Nine out of ten participants (91.7%) "agreed" or "strongly agreed" that they were doing the things they needed to do to get out of homelessness. Eighty-one percent of participants "agreed" or "strongly agreed" with the statement, "If someone offered you a good place to live, with parents and rules, you would go there to get off the streets." Almost half of participants (45.7%) "strongly agreed" or "agreed" with the statement, "No one would want to live in the home you came from," and 15.8 percent of participants strongly agreed or agreed with the statement, "You are afraid you would get beat up if you went home."

Figure 3.13: Attitudes About Homelessness (% reporting "Strongly Agree" or "Agree"; *n* = 650)



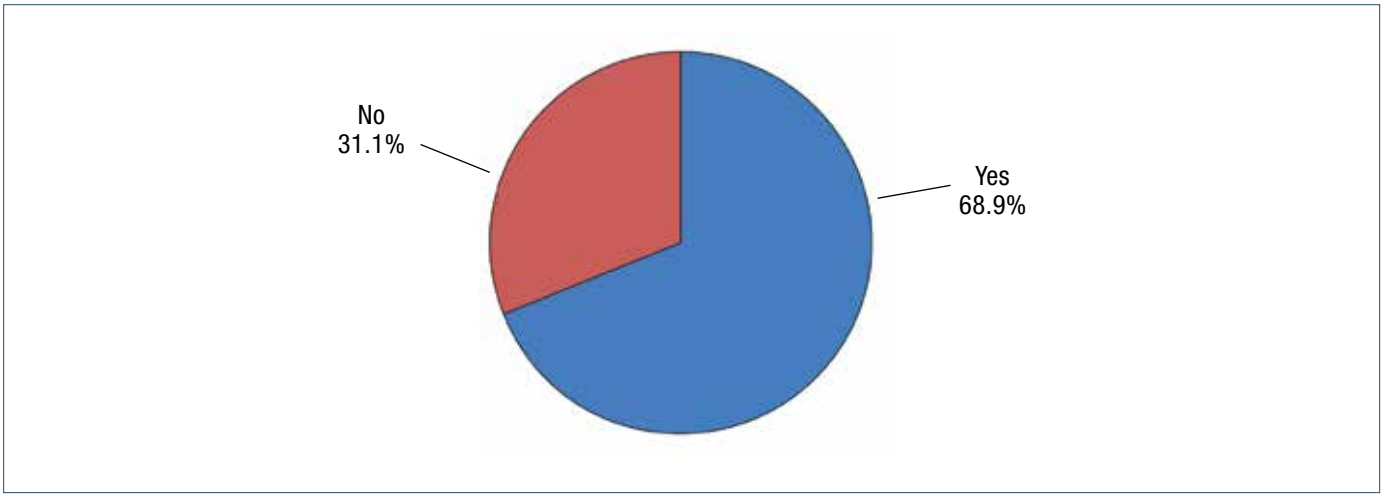
CHAPTER 4: SOCIAL SUPPORT AND RELATIONSHIPS

This chapter provides information on the people and relationships in the lives of the youths interviewed, including their experiences with social support, family, friendships, and romantic partnerships. These relationships can be important sources of support for youth while homeless and for the longer term.

FAMILY, FRIENDS, AND SOCIAL SUPPORT

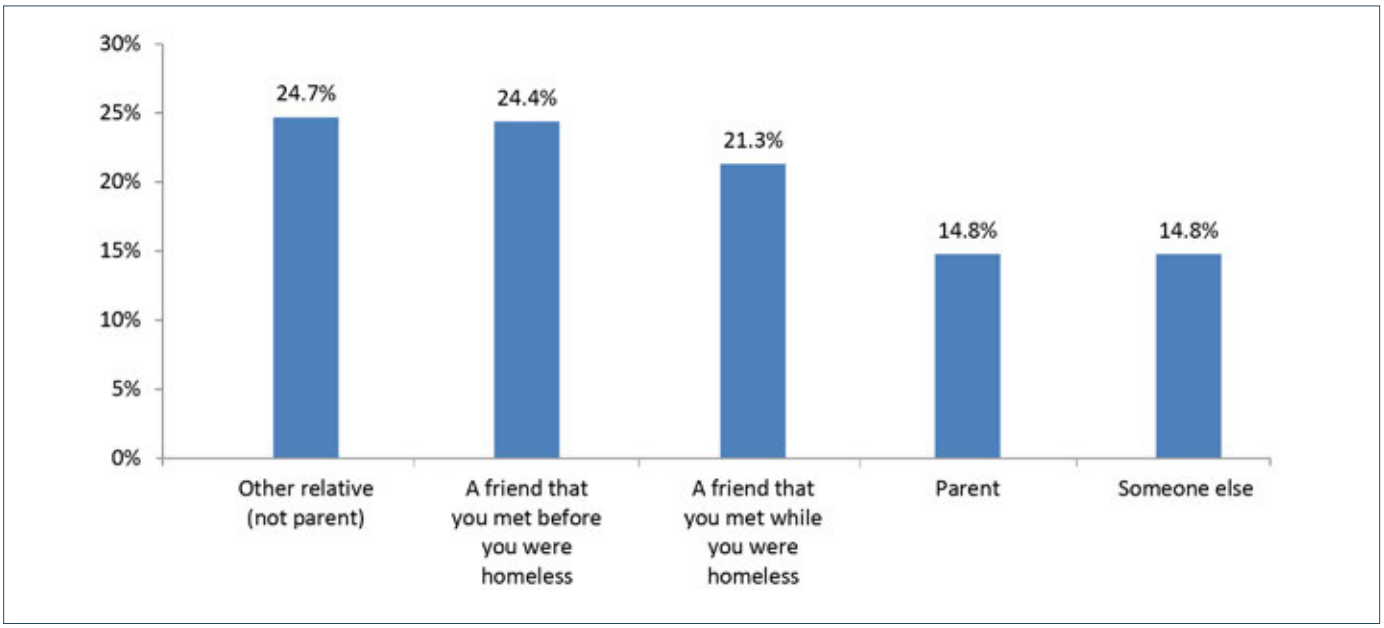
Participants were asked whether or not they had people in their lives they could count on to give them help and aid, such as people who might lend them money, give them food, or give them a place to stay without asking for anything in return. Approximately two-thirds of participants (68.9%) reported there were people in their lives they could count on to provide help and aid (see Figure 4.1).

Figure 4.1: Youth Have Someone They Can Count on to Provide Help and Aid



The individuals reported most likely to give help and aid (see Figure 4.2) were a relative other than a parent (24.7%), a friend they had met prior to becoming homeless (24.4%), a friend they had met while experiencing homelessness (21.3%), a parent (14.8%), and someone else (14.8%).

Figure 4.2: Who Is the Most Likely to Provide You With Help and Aid? (*n* = 446)



Participants were also asked to provide information about their closest friends. Specifically, participants reported how many close friends they had before they became homeless and how many of those individuals remained friends when they (the participants) became homeless. On average, participants reported losing four close friends after they became homeless.

Focus group participants also talked about friends and family who supported them either financially or, as seen in the excerpts below, emotionally:

> My dad constantly, like I said he constantly calls me, he's always telling me I'm here for you, I'm supporting you. Other family likes to Facebook me and just let them [sic] know that they're thinking about me and I actually have friends down here now and they're all like trying to help me find a place and always wanting me to hang out with them to me [sic] like moral support and you know just something to keep my mind busy, just constantly there. —Focus group participant (Omaha, NE)

> My best friend understands what I'm going through because she was right there with me as I was being homeless like she had a place to stay that I couldn't stay so I was living in my car and she was just couch surfing so like she understands like she tells me every day how proud she is of me like for being in the program and getting this far in my life that like she went back to live with her family cuz that was an option and I decided I didn't want to live with her family because I didn't want to move to California. I was ready to leave Nebraska so um my I mean my best friend understands everything I go through and is one of my biggest support systems. —Focus group participant (Omaha, NE)

My best friend, he's always there when I needed something. He will come and help me and he'll like, he'll appreciate me and stuff like that and he'll tell me all the good things that I need to hear. —Focus group participant (Minneapolis, MN)

Others, though, reported they could rely on no one but themselves:

I think you need… to believe in yourself. Nobody else can help you believe anything but that's where it starts, that's where it is um if you believe in everything's gonna be fine and you can tell yourself that and you can coach yourself that I think you'll ultimately end up being the biggest support system you have because people can walk out on you and people can leave you hanging and they can disappoint you. —Focus group participant (Omaha, NE)

Ever since I became homeless I tried to make it a point where I rely mostly on myself. A lot of people rely on me for a lot of things as a friend. So, I try to be less of a victim, and I try not to put victim mentalities in my head. —Focus group participant (Seattle, WA)

Really, I can't rely on anybody for anything, for any support or nothing. I really want some, but the reason I don't rely on people is because I've never had anybody like, every time I rely on somebody, something bad always happens or it turns out to be bad, you can't rely on them at all. —Focus group participant (New York, NY)

ROMANTIC RELATIONSHIPS

Participants were asked whether or not they were currently in a romantic relationship with another person. A little less than half (45.4%) were in a relationship at the time of their interview.

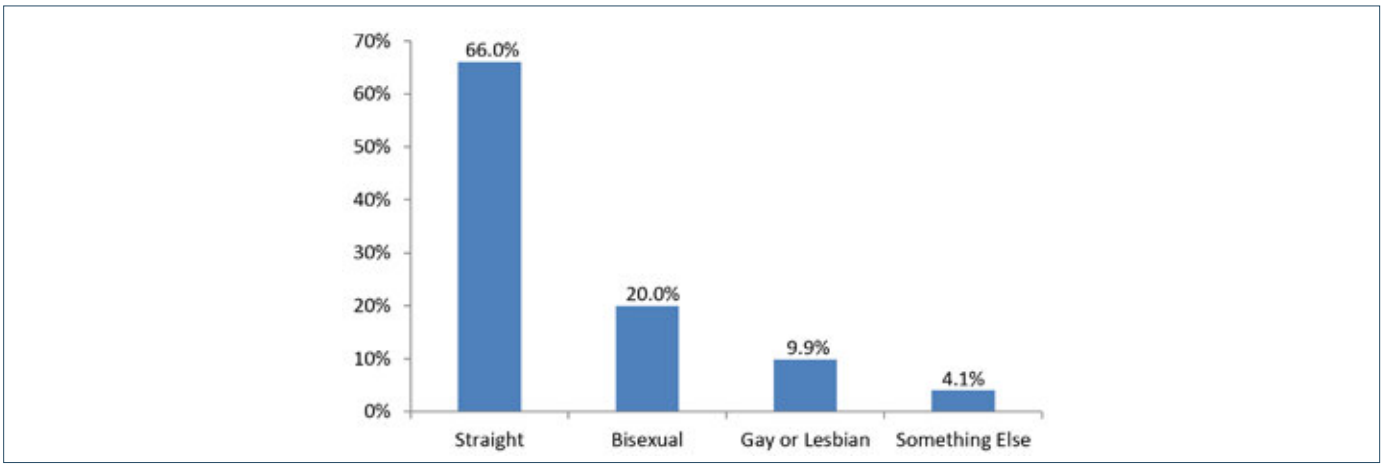
CHAPTER 5: SEX, SEXUAL HEALTH, AND PREGNANCY

This chapter covers information about sexual orientation, sexual partners, trading sex, sexual behaviors and condom use, sexually transmitted infections, pregnancies, and abortions. Sexual matters are often powerful forces shaping the lives of runaway and homeless youth. Runaway and homeless youth are at increased risk for engaging in survival sex (i.e., sex for food, shelter, money) and may engage in unsafe sexual practices. Furthermore, LGBT youth are at higher risk for running away and becoming homeless. Because of the sensitive nature of the information, participants self-administered this part of the interview. The interviewers did not read the sensitive questions aloud or see the computer screen while the questions were presented. The participant either read the questions silently or pressed a "play" button on the computer to have the prerecorded questions read to them via headphones.

SEXUAL ORIENTATION

Two-thirds (66.0%) of participants reported being "straight" or heterosexual, 20.0 percent identified as bisexual, 9.9 percent as gay or lesbian, and 4.1 percent as "something else" (see Figure 5.1). ANOVA was also conducted to more closely examine whether experiences of homelessness differed for youth who identified as LGBT versus youth who identified as heterosexual. Approximately one-third of the sample was LGBT (n=216; 32.9%), and two-thirds of the sample were heterosexual (n=419; 66.0%). Both groups reported similar patterns of past year condom use during vaginal sex and past year condom use during anal sex. Lesbian, gay, and bisexual participants were more likely to report using a condom during the past year during oral sex "all of the time" or "most of the time" than heterosexual participants (31.9% vs. 23.6%; p=.046). LGBT youth were significantly more likely to report trading sex for food, money, shelter, drugs, or protection than their heterosexual peers (50% vs. 28.8%; p=.000).

Figure 5.1: Sexual Orientation (*n* = 635)

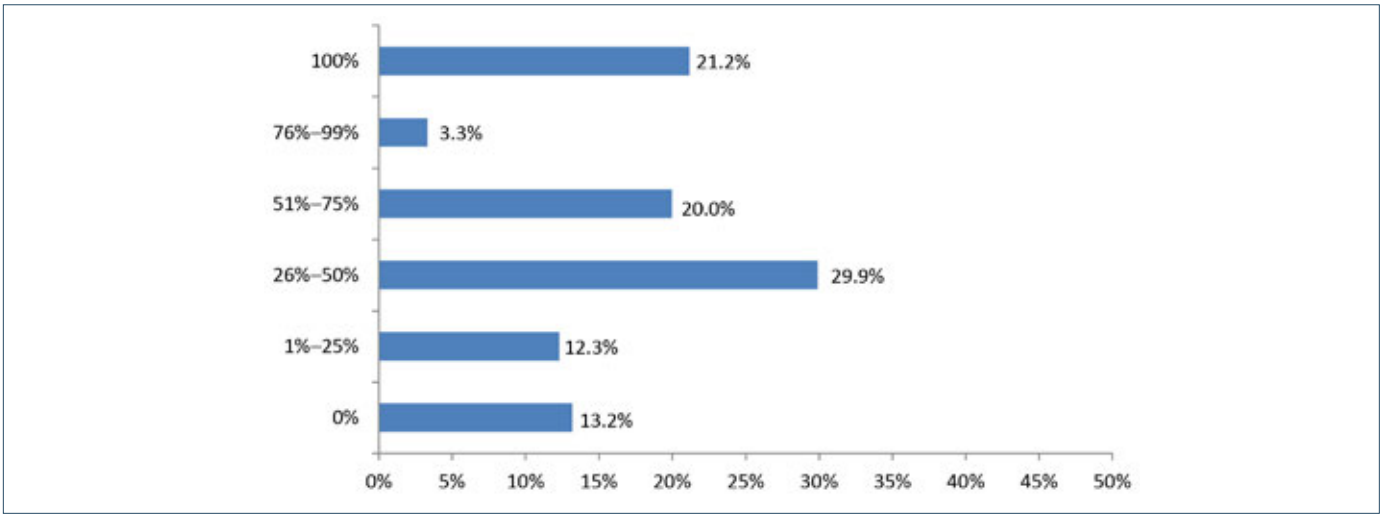


SEXUAL PARTNERS

The median number of sexual partners participants reported having in their lifetime was 6, with a range of 0 to 1,000. The median number of sexual partners in the past year was 2, with a range of 0 to 300.

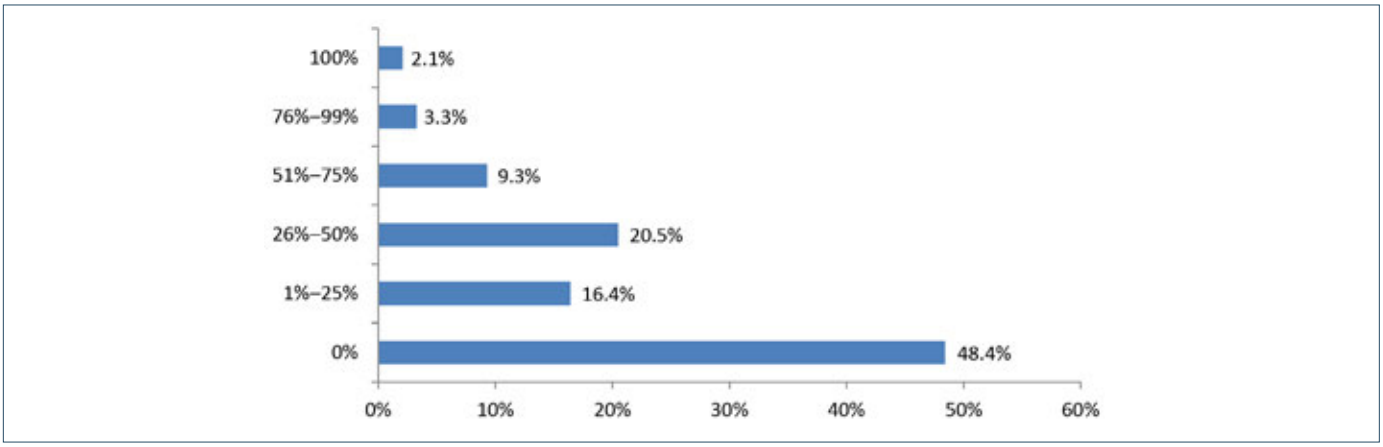
Information on participants' lifetime sexual partners can be found in Figures 5.2 and 5.3. About one-fifth of the sample (21.2%) reported that all of their sexual partners were steady boyfriends or girlfriends (see Figure 5.2). Approximately 13 percent of participants said none of their sexual partners was a steady boyfriend or girlfriend.

Figure 5.2: Percentage of Sex Partners Who Were a Steady Boyfriend/Girlfriend (*n* = 575)



Almost half of participants (48.4%) reported that none of their sexual partners had been a stranger or someone they did not know very well. One-fifth (20.5%) of participants reported that between 26 percent and 50 percent of the people they had had sex with were strangers. Only 2.1 percent of participants had sex only with strangers (see Figure 5.3).

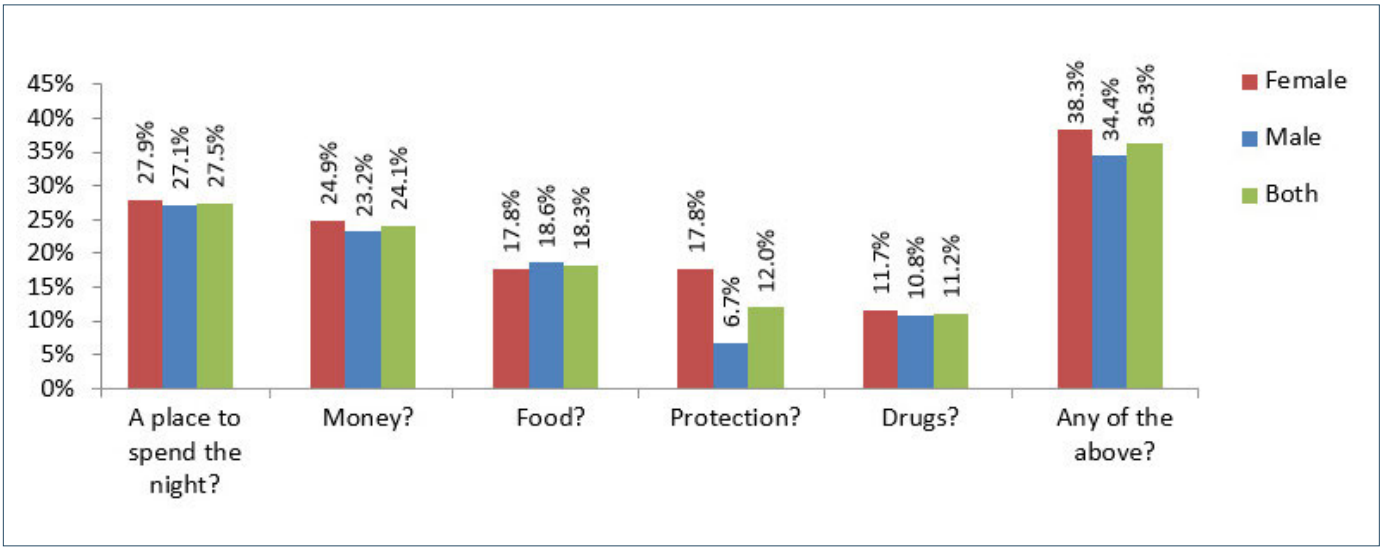
Figure 5.3: Percentage of Sex Partners Who Were Strangers (*n* = 580)



TRADING SEX

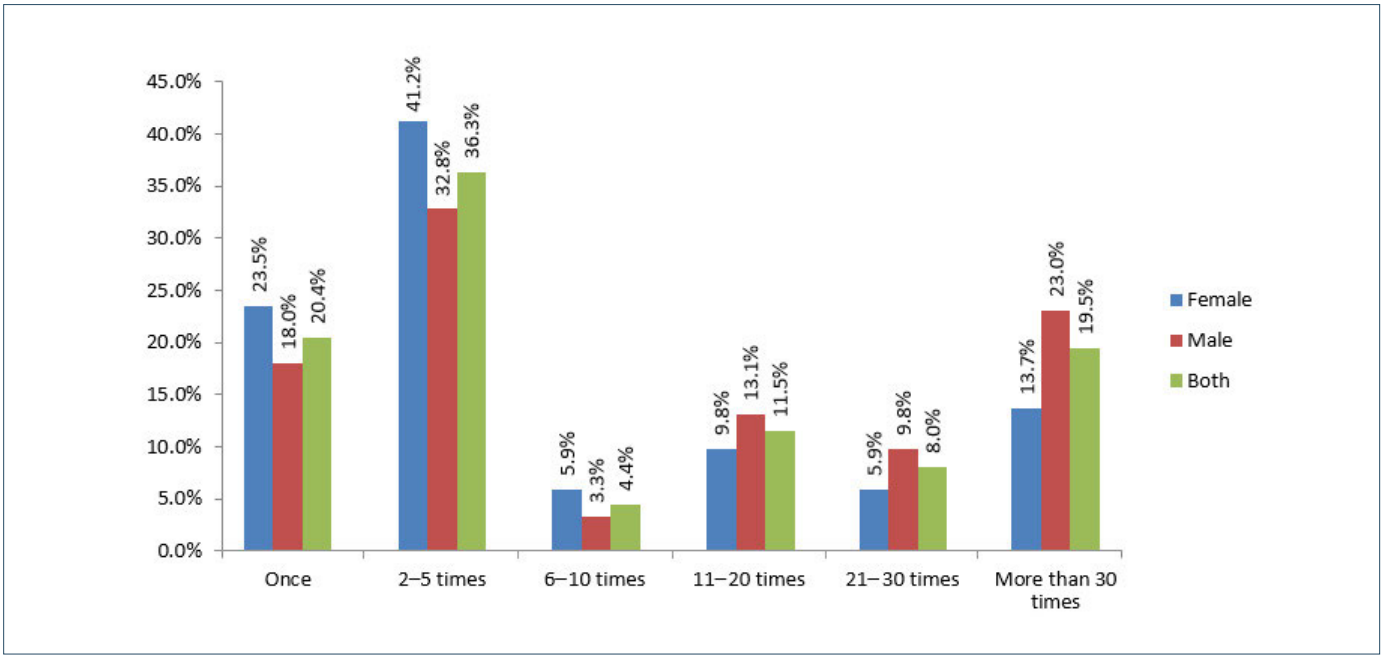
Participants were asked whether they had ever traded sex with anyone for something they needed while on the streets (see Figure 5.4). Approximately one-quarter of the participants had traded sex with at least one person for money (24.1%), a place to spend the night (27.5%), food (18.3%), protection (12.0%), or drugs (11.2%). Similar proportions of female and male participants reported trading sex for shelter (27.9% and 27.1%, respectively), food (17.8% and 18.6%), drugs (11.7% and 10.8%), and money (24.9% and 23.2%). However, significantly more female than male participants had exchanged sex for protection (17.8% and 6.7% respectively, p=.000). Additionally, 10.4 percent of the participants reported that they had been asked by a romantic partner to have sex with someone else in exchange for money (not shown in figure).

Figure 5.4: Did You Agree to Be Sexual With Any of These People Because You Needed… (% Yes; *n* = 543)



Of the 20.6 percent of the participants who reported trading sex for money (n=113), the majority (63.6%) first exchanged sex for money only after they became homeless. No significant differences were found between female and male participants in the number of times they had traded sex for money. One-fifth of participants (20.4%) had had sex in exchange for money only once (see Figure 5.5). One-third (36.3%) reported that they had traded sex for money between 2 and 5 times, 4.4 percent between 6 and 20 times, 11.5 percent between 11 and 20 times, and 8.0 percent between 21 and 30 times. Another 19.5 percent had had sex in exchange for money more than 30 times. Nearly one-quarter (23.1%) of those participants who had traded sex for money had been physically assaulted while exchanging sex for money. Eight in 10 youth (79.5%) got to keep all of the money the last time they traded sex for money.

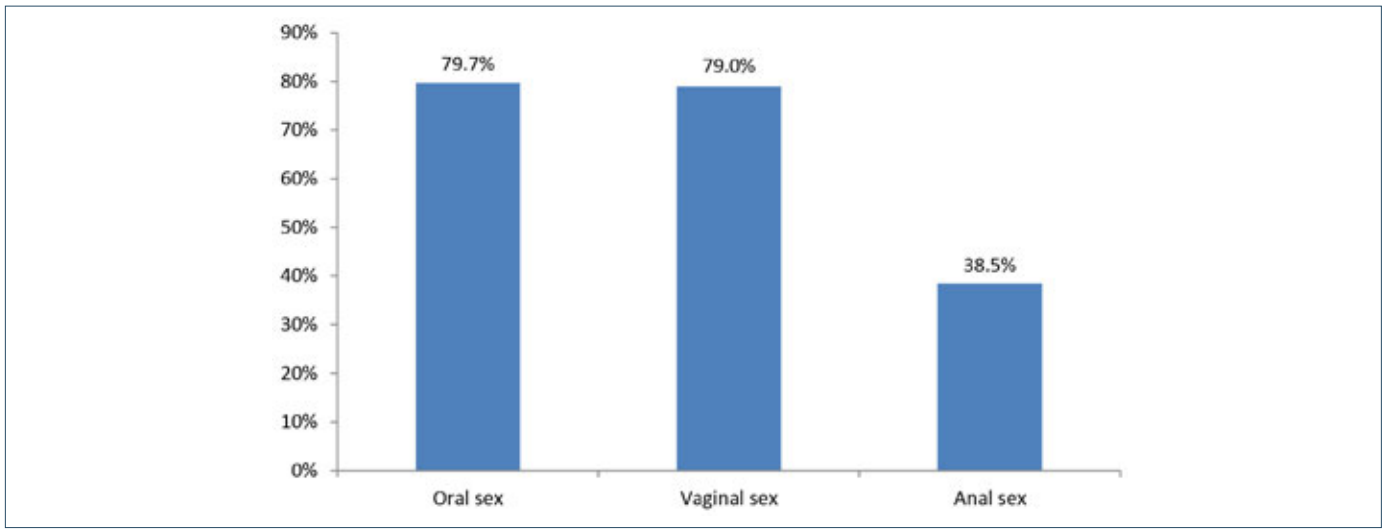
Figure 5.5: How Many Times Have You Had Sex in Exchange for Money? (*n* = 113)



SEXUAL BEHAVIORS AND CONDOM USE

Most participants in this study were sexually active. More than three-quarters of participants (79.0%) had engaged in vaginal sex, 79.7 percent in oral sex, and 38.5 percent in anal sex at some point in their lives (see Figure 5.6).

Figure 5.6: Sexual Experience: Have You Ever Had…? (% Yes; *n* = 630)



Participants who had engaged in vaginal, oral, or anal sex were asked how often in the past year they had used a condom when engaging in sex (see Figures 5.7, 5.8, and 5.9). Among sexually active participants, more than one-quarter (29.8%) reported they had used a condom "all of the time" when having vaginal sex, 16.9 percent had used a condom or dental dam "all of the time" when having oral sex, and 39.3 percent had used a condom "all of the time" when having anal sex in the past year. In the past year, 16.2 percent of participants reported they had

never used a condom when having vaginal sex, 55.2 percent had never used a condom when having oral sex, and 30.1 percent had never used a condom when having anal sex.

Figure 5.7: In the Past Year, How Often Did You Use a Condom When You Had Vaginal Sex? (*n* = 493)

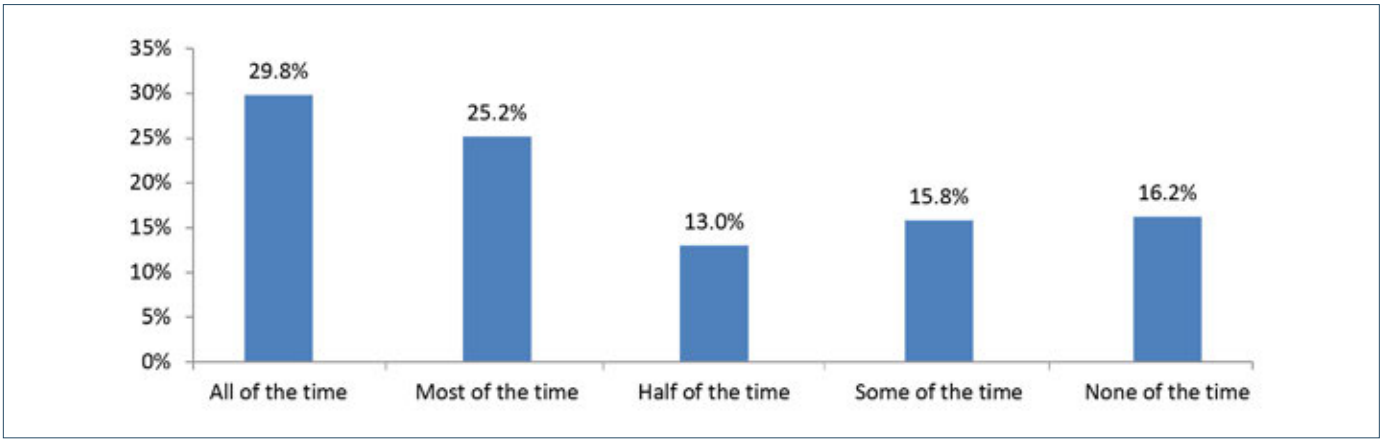


Figure 5.8: In the Past Year, How Often Did You Use a Condom When You Had Oral Sex? (*n* = 498)

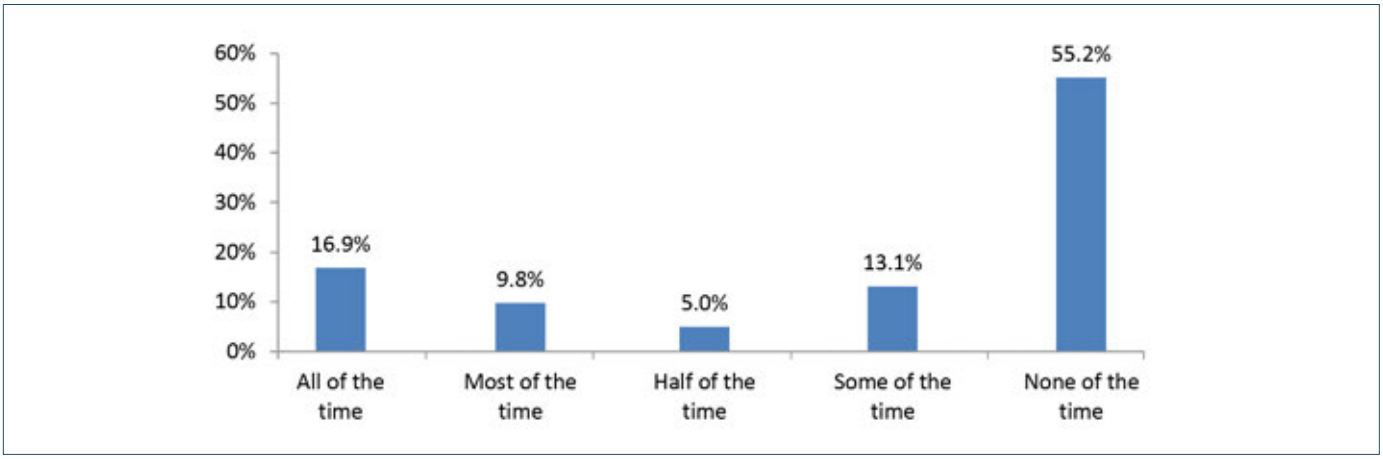
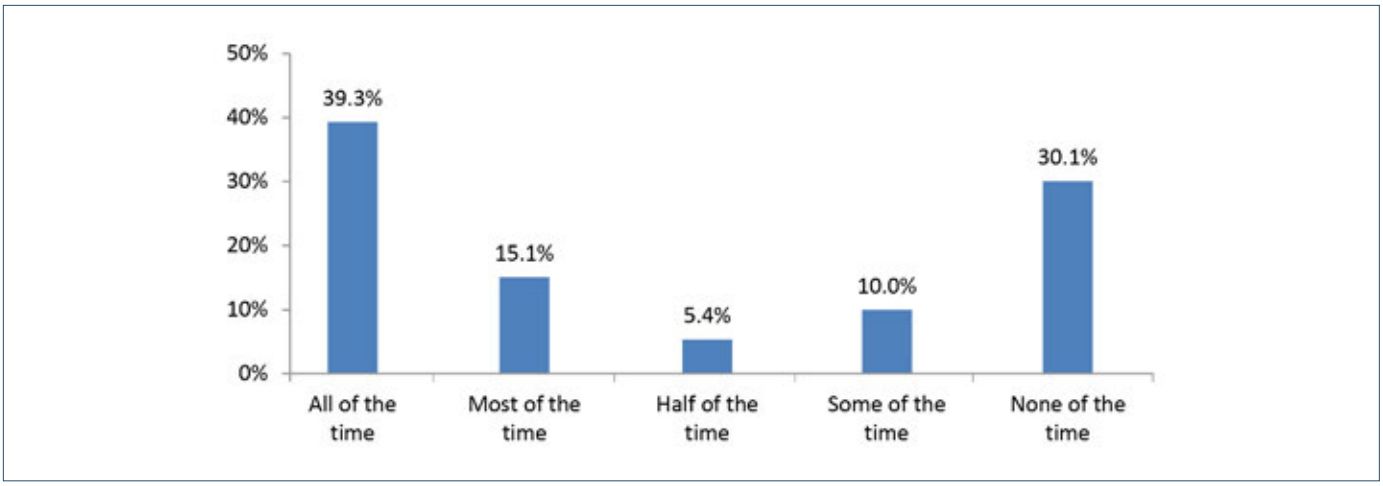


Figure 5.9: In the Past Year, How Often Did You Use a Condom When You Had Anal Sex? (*n* = 239)



CORRELATES OF PAST YEAR CONDOM USE

A series of logistic regression models were used to examine possible correlates of past year condom use for vaginal and anal sex. Table 5.1 presents the odds ratios and the number of complete cases for each predictor variable used in the regression models. Standard errors were adjusted for clustering by location. Participants were asked, "In the past year, how often did you use a condom when you had [TYPE] of sex?" All items were answered using a 5-point Likert scale format ranging from "none of the time" (lowest use category) to "all of the time" (highest use category). The odds ratio in this case can be interpreted as the odds of being in a higher condom use category (using condoms more often). An odds ratio greater than one indicates a higher likelihood of using a condom all of the time in the past year, while an odds ratio of less than one indicates a higher likelihood of using a condom none of the time in the past year.

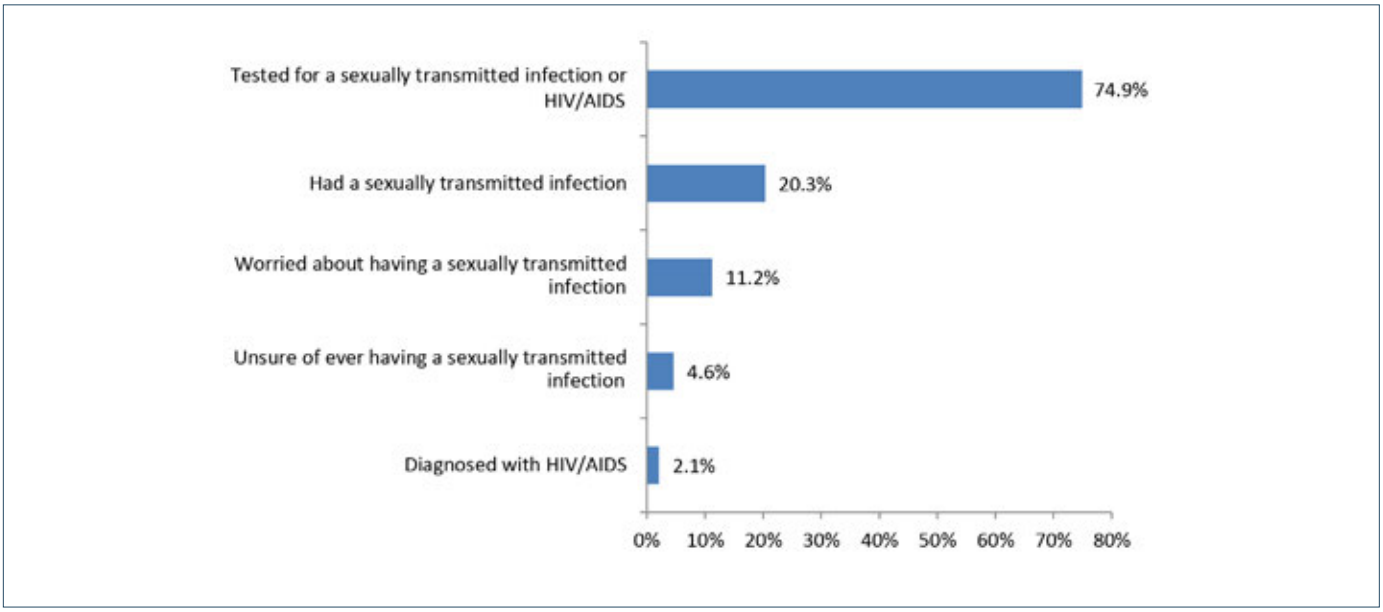
Three correlates were found to be statistically significant for decreasing the odds of condom use when engaging in vaginal sex: higher levels of depressive symptoms, past year illicit drug use, and being female. In other words, female participants with high levels of depression and past year illicit drug use were less likely to use condoms. Two correlates were found to be statistically significant for decreasing the odds of condom use when engaging in anal sex: higher levels of depressive symptoms and past year illicit drug use. Participants who reported a later age at first homeless episode had higher odds of being in a higher condom usage category.

Table 5.1: Unadjusted Odds Ratios Predicting Past Year Condom Use				
Condom Use During Vaginal			**Condom Use During Anal Sex**	
*p<.05; **p<.01; ***p<.001	Odds Ratio	n	Odds Ratio	n
Depressive Symptoms	0.99*	490	0.97**	237
Post-Traumatic Stress Disorder	0.88	481	0.62	236
Mania	0.74	490	1.37	238
Number of Months Homeless	1.00	490	1.00	236
Age of First Homeless Episode	1.04	479	1.09*	234
Support	1.21	492	1.28	238
Past Year Binge Drinking	0.74	489	0.80	236
Past Year Marijuana Use	0.97	493	0.67	239
Past Year Illicit Drug Use	0.72*	497	0.34***	236
Child Physical Abuse	0.89	489	0.91	237
Child Sexual Abuse	0.77	479	0.81	234
Male	1.43**	498	1.94	240

SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS

Nearly three-quarters (74.9%) of participants had been tested, at some point in their lives, for a sexually transmitted infection or HIV/AIDS (see Figure 5.10). About one-fifth (20.3%) reported having a sexually transmitted infection, and 4.6 percent were unsure whether they had ever had a sexually transmitted infection. Thirteen individuals (2.1%) reported they had been told by a doctor or medical professional they had HIV/AIDS. About eleven percent (11.2%) of participants worried that they may have had a sexually transmitted infection at the time of their interview.

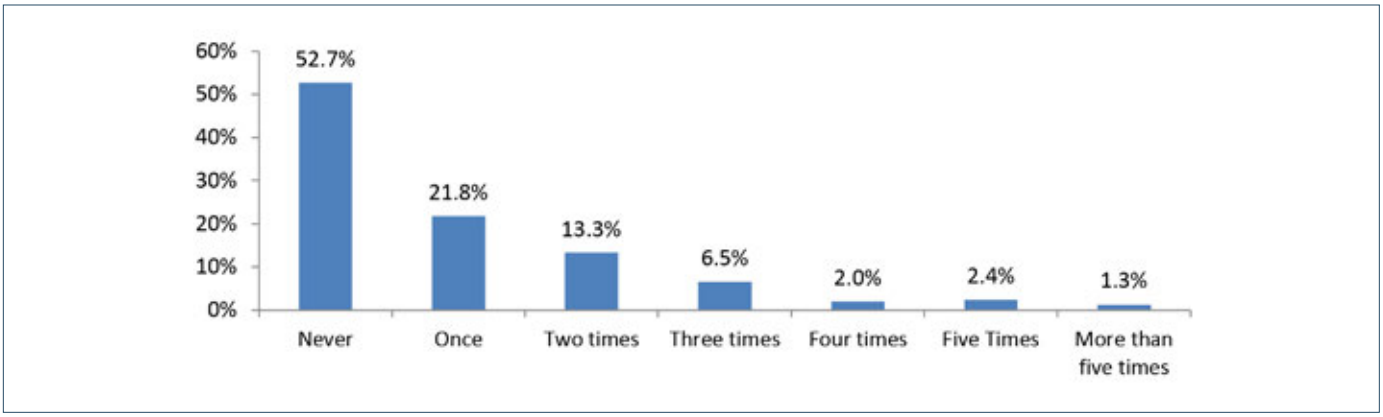
Figure 5.10 Sexually Transmitted Infections and HIV/AIDS (*n* = 561)



PREGNANCY

Male and female participants were asked questions about pregnancy. Lifetime pregnancy rates were 47.3 percent for female participants (see Figure 5.11) and 25.8 percent for male participants (impregnating a female), and with 14.1 percent of male participants unsure if someone had been pregnant with their child. Of those female participants who reported lifetime pregnancy rates, about 9 percent were pregnant at the time of their interview, and another 5 percent did not know if they were currently pregnant.

Figure 5.11: (Females) How Many Times Have You Been Pregnant? (*n* = 294)



CHILDREN

Participants were asked if they were currently caring for children. Fourteen percent (14.2%) of the participants reported caring for children at the time of their interview. Of the participants who had biological children not in their care, 9.1 percent reported giving their child up for adoption at birth and 5.7 percent at a later time. Almost half of the participants with biological children not in their care (46.0%) had their children taken from them against their wishes, and 33.0 percent had children in the custody of another family member or relative.

ABORTION

A little less than 9.0 percent of female participants reported having had an abortion during their lifetimes. Of those 26 female participants, 18 had one abortion, 5 had two abortions, 1 had three abortions, and 2 had four abortions. Of the male participants who reported having impregnated someone, 35.2 percent reported that the pregnancy had ended in abortion. Of those 29 male participants, 20 reported that one pregnancy had ended in abortion, 4 reported that two pregnancies had ended in abortion, 4 male participants reported that three pregnancies had ended in abortion, and 1 male participant reported that five pregnancies had ended in abortion.

CHAPTER 6: MENTAL HEALTH

This chapter includes information about mental and emotional health. Many runaway and homeless youth have mental health issues and histories of trauma that should be a focus of any service plan. Note that this chapter does not present any diagnostic information; mental health was evaluated using screening instruments and scales. All youth were administered the Rosenberg Self-Esteem Scale, the CES-D scale, and screeners for symptoms of anger, mania, and post-traumatic stress. (Information on the screening instruments and scales can be found in the methods section of the Introduction.)

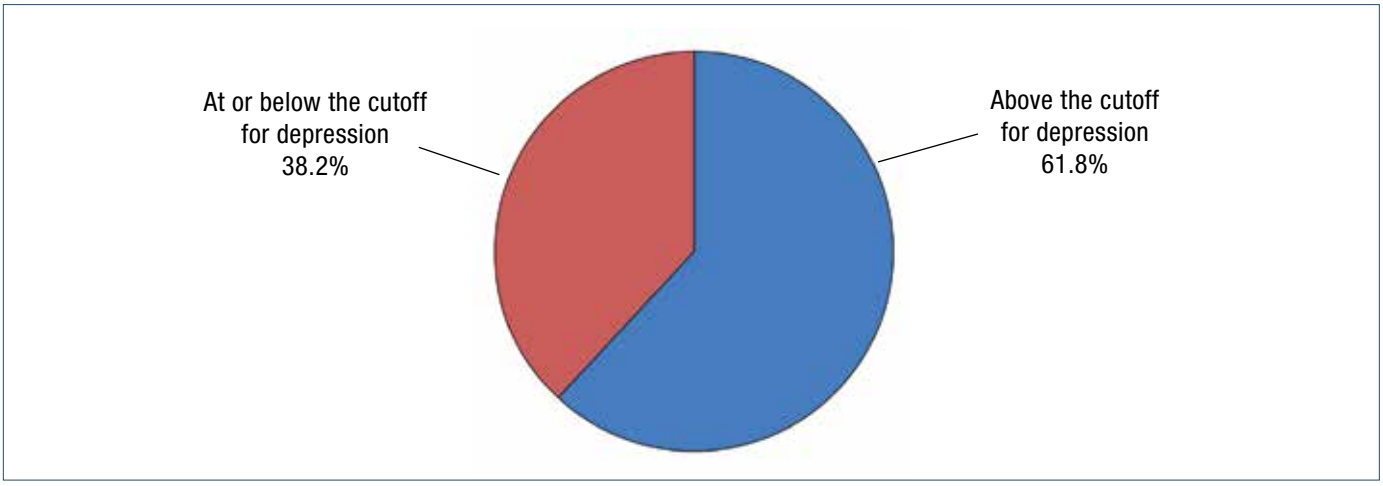
SELF-ESTEEM

The Rosenberg Self-Esteem Scale measures personal worth, self-confidence, self-satisfaction, self-respect, and self-deprecation. Based on the Rosenberg scoring criteria, 83.0 percent of the participants scored in the normal range and 17.0 percent scored in the low range of self-esteem.

DEPRESSIVE SYMPTOMS

The CES-D scale asks respondents to rate how often over the past week they experienced symptoms associated with depression, such as restless sleep, poor appetite, and feeling lonely. The CES-D has a cutoff score of 16 or greater (on a scale of 0 to 60) that helps identify individuals at risk for clinical depression (Lewinsohn, Seeley, Roberts, & Allen, 1997). On average, participants had a CES-D score of 21.71, with over half of them (61.8%) scoring above the cutoff (see Figure 6.1). LGBT participants were more likely to score in the range on the CES-D indicating need for additional assessment for depression compared with heterosexual participants (68.2% vs. 57.8%; p=.01). These results indicate that many of the youth who were interviewed struggled with depressive symptoms and may have been at risk of experiencing clinical depression.

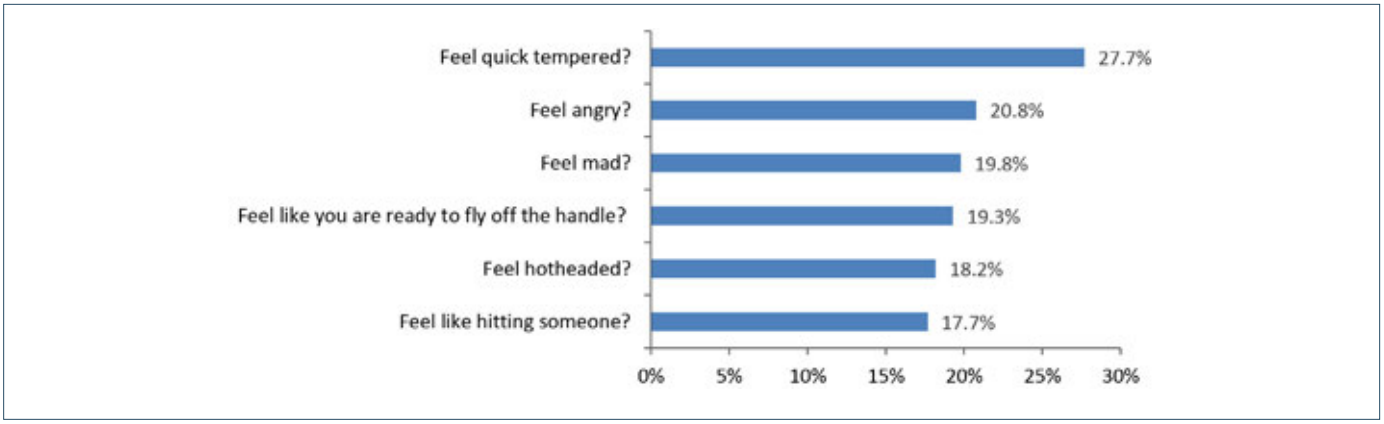
Figure 6.1: Youth Scoring Above the Cutoff for Risk of Depression (CES-D 20-item scale)



ANGER

The six items of the Tri-Ethnic Center Anger Scale were answered using a 4-point Likert scale ranging from "most of the time" to "none of the time." Figure 6.2 shows the percentage of participants who responded "most of the time" to each question. About one-fifth of participants reported feeling like they could hit someone, were ready to fly off the handle, or were mad or angry most of the time; about one-quarter reported feeling quick-tempered most of the time.

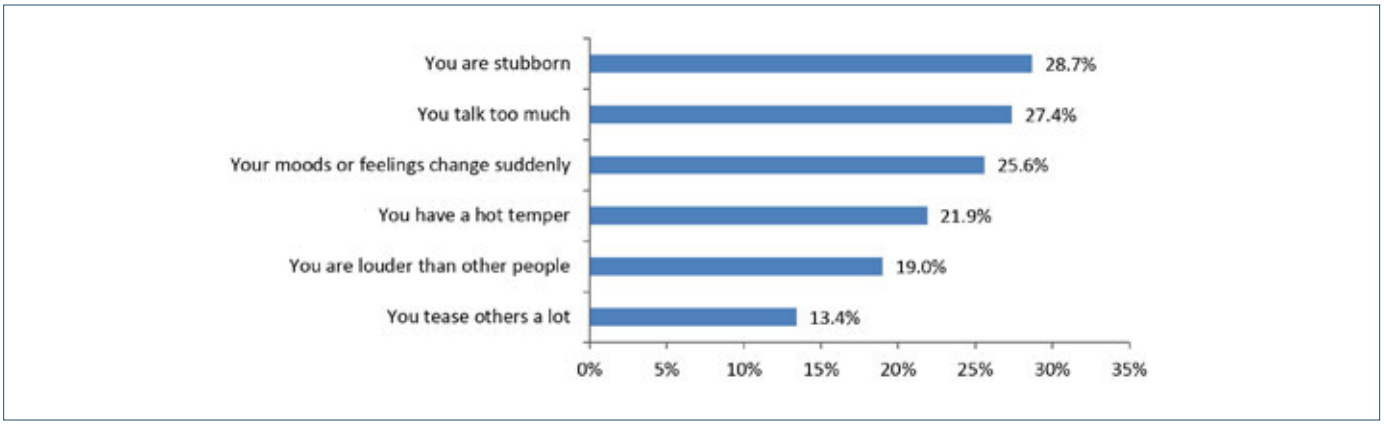
Figure 6.2: Anger Symptoms (% "Most of the time"; *n* = 643)



MANIC SYMPTOMS

Participants were read six statements and asked whether the statement was "never true," "sometimes true," or "always true" for them. Figure 6.3 depicts the percentage of participants who reported "always true" for each item. More than one-quarter of participants reported "always true" to being stubborn (28.7%), talking too much (27.4%), and having moods or feelings change suddenly (25.6%).

Figure 6.3: Manic Symptoms (% "Always true"; *n* = 643)



TRAUMATIC EVENTS AND POST-TRAUMATIC STRESS SYMPTOMS

Participants were asked if they had experienced any extremely frightening, traumatic, or horrible events in their past. Almost three-quarters of participants (71.7%) reported that they had. The youth who reported having had

a past traumatic event were then asked whether they experienced symptoms of post-traumatic stress. More than three-quarters (79.5%) reported reliving traumatic events through recurrent dreams, preoccupations, or flashbacks, and more than two-thirds (68.5%) reported having symptoms for more than 1 month. Over half (56.1%) reported being less interested in important things, not "with it," or unable to experience or express emotions, and 74.0 percent reported having had these symptoms for more than 1 month. More than three-quarters (75.1%) of participants who reported a frightening, horrible, or traumatic event in their past had problems sleeping, concentrating, or being short-tempered, and 76.2 percent reported having had these symptoms for at least 1 month. Almost three-quarters (73.6%) had avoided places or things that reminded them of the traumatic events for at least a month.

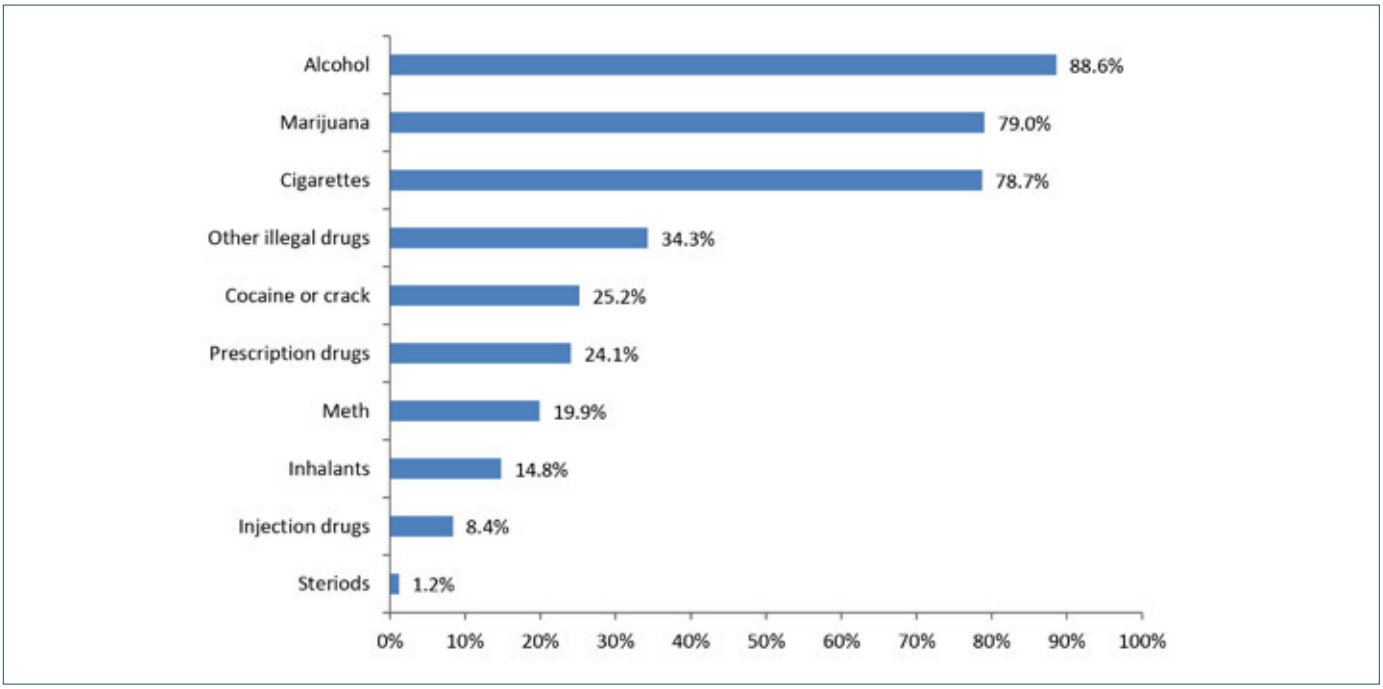
CHAPTER 7: SUBSTANCE USE

This chapter includes information about substance use. Participants were asked about lifetime, past year, and past month use of 10 different types of substances and about experiencing drug overdose. Substance use (e.g., use of marijuana, cigarettes, alcohol, cocaine, heroin) is an important health issue for all youth, and a particular concern for runaway and homeless youth.

LIFETIME SUBSTANCE USE

The majority of participants reported using alcohol (88.6%), marijuana (79.0%) or cigarettes (78.7%) at least once in their lifetimes. About one-quarter to one-fifth of participants reported using cocaine or crack (25.2%), prescription drugs not prescribed for them (24.1%), or methamphetamine (also called meth, 19.9%). Only a small percentage of participants reported ever using inhalants (14.8%), injection drugs (8.4%), or steroids (1.2%). A little over one-third of participants (34.3%) reported using other illegal drugs, such as LSD, PCP, ecstasy, mushrooms, or heroin at least once in their lifetimes (see Figure 7.1).

Figure 7.1: Lifetime Substance Use (% Yes; *n* = 642)

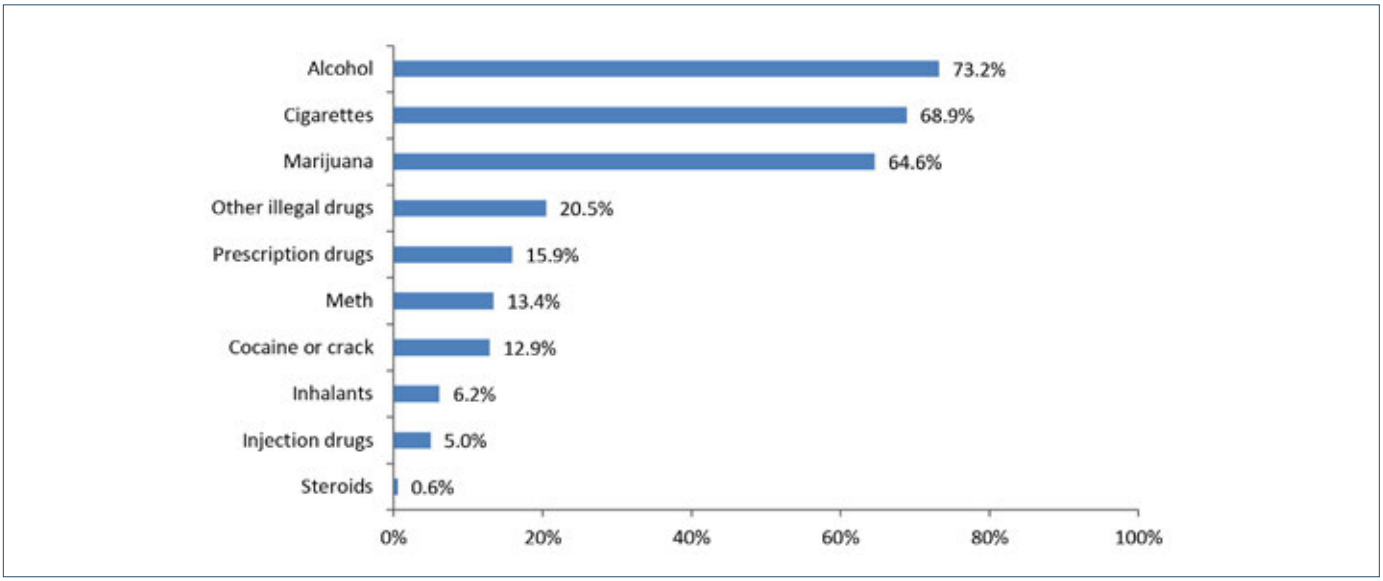


Of the participants who reported using any injection drugs during their lifetime, two-thirds reported knowing how to clean or bleach their own needles and 40.6 percent had used a needle exchange program at least once during the past year. Participants were also asked if they had ever overdosed on drugs. Of the 14.5 percent who reported an overdose, 38.0 percent reported receiving medical intervention, such as Narcan (naloxone), which is a drug used for the reversal of suspected or known opioid overdose.

PAST YEAR SUBSTANCE USE

The rates of reported past year substance use are similar to the lifetime rates (see Figure 7.2). Many participants reported using alcohol (73.2%), cigarettes (68.9%), and marijuana (64.6%) during the past year. Over one-third of participants (36.8%) reported past year binge drinking—that is, consuming four drinks (for females) or five or more drinks (for males) in a 2-hour period. About one-fifth (20.5%) reported using illegal drugs, like LSD, PCP, ecstasy, mushrooms, or heroin. Almost 16 percent of participants (15.9%) used prescription drugs nonmedically during the past year. Fewer participants reported use of methamphetamine (13.4%), cocaine or crack (12.9%), or inhalants (6.2%).

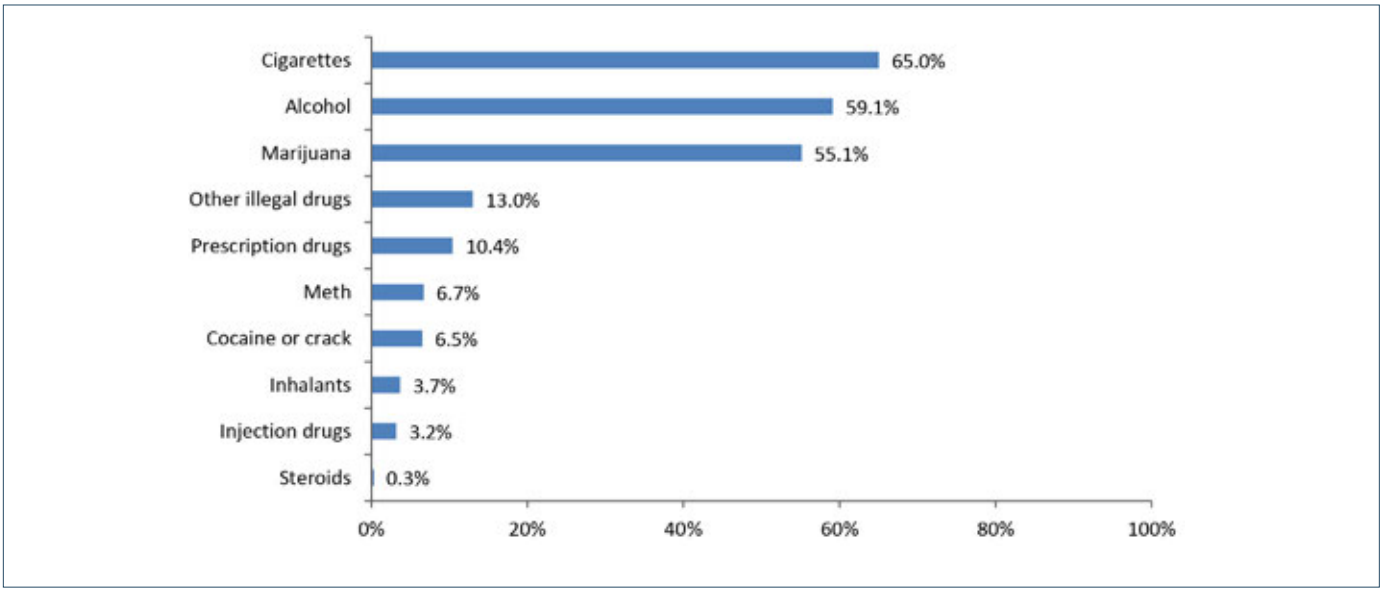
Figure 7.2: Past Year Substance Use (% Yes; *n* = 642)



PAST MONTH SUBSTANCE USE

As seen in Figure 7.3, almost two-thirds (65.0%) of participants reported using cigarettes in the past month. Of those participants, 31.0 percent reported using cigarettes every day and 14.6 percent reported smoking cigarettes nearly every day. ANOVA was conducted comparing substance use among LGBT versus non-LGBT participants. The LGBT participants were more likely to report past month cigarette use compared with their heterosexual peers (74.5% vs. 60.1%; p=.000). However, both groups were equally likely to report past month use of alcohol, marijuana, methamphetamine, cocaine, injection drugs, other illegal drugs, or nonmedical use of prescription drugs. Over half of all participants (59.1%) drank alcohol during the past month, with 13.7 percent drinking alcohol from two or three times a week to every day. Just over half of the sample (55.1%) smoked marijuana during the past month, with 15.8 percent reporting daily marijuana use. Fewer participants (13.0%) used other illegal drugs like LSD, PCP, ecstasy, mushrooms, or heroin, or nonmedically using prescription drugs (10.4%), and only small percentages of youth reported past month use of methamphetamine (6.7%), cocaine or crack (6.5%), inhalants (3.7%), injection drugs (3.2%), or steroids (0.3%).

Figure 7.3: Past Month Substance Use (% Yes; *n* = 642)



Focus group participants in Seattle, Boston, and New York City discussed substance use and addiction. Some participants talked about frequent drug use and described their day-to-day activities smoking marijuana, going to "raves" (where ecstasy is often consumed), and "doing other drugs." Other focus group participants talked about their previous struggles with drugs, including methamphetamine addiction, and the decision to become clean. Some participants talked about feeling isolated or unsafe because they preferred to do drugs alone rather than with their peers. Participants asked that more educational programs about drug addiction be available to homeless youth.

Below are examples of responses by focus group participants when asked about substance use in their daily lives:

> I smoke pot and I walk everywhere. I like to walk. —Focus group participant (Seattle, WA)

> Virtually smoking pot, doing drugs, going to raves, and drinking. —Focus group participant (Seattle, WA)

> I come back, buy a pack of cigarettes, a little alcohol, and some molly and weed and have fun, my day-to-day basis. —Focus group participant (Boston, MA)

> My day-to-day life is trying to find a frickin' program to get into so I can get sober, that's what I'm trying to do. I'm trying to find a program so I can get frickin' sober. —Focus group participant (Boston, MA)

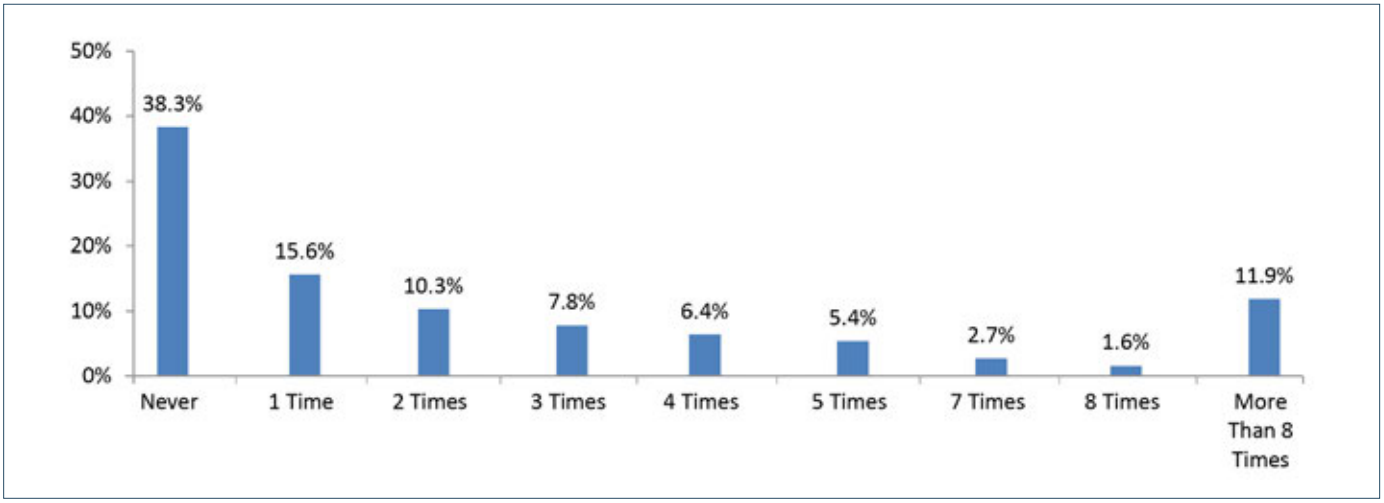
CHAPTER 8: LIFE ON THE STREET

This chapter presents information about the experiences of youth living life on the streets, including police interactions and arrest, weapons possession, gang activity, and daily activities. A day in the life of a homeless youth presents many challenges as the youth tries to navigate and survive difficult, and sometimes dangerous, situations.

POLICE AND ARREST

Over three-quarters of participants in this study (77.8%) have had an interaction with the police. Police interactions varied widely from city to city.[1] More than half (61.8%) of participants had been arrested at some point in their lives. Heterosexual and LGBT participants were equally likely to report having been arrested at some point in their lives. Fifteen percent (15.6%) of participants had been arrested once, and 10.3 percent had been arrested twice. Fewer had been arrested between three and eight times, and 11.9 percent had been arrested more than eight times (see Figure 8.1).

Figure 8.1: How Many Times Have You Been Arrested?



Focus group participants also conveyed some challenges they experienced with law enforcement while homeless:

> We slept, I don't know where it was, but it was under some kind of construction building. By this I guess it used to be a river walk kinda thing. And we were underneath there and it was, I dunno, but scared the sh-t out of me 'cause the police and all, he came and like 'wake up y'all.' It scared me to death 'cause he said

[1] Site-specific information is available through the participating SOP agencies.

y'all gotta get out of here. He banned us. If we set foot on that sidewalk, he said we can get a fine or we can go to jail for it. So we have to walk around that place when we go. —Focus group participant (Austin, TX)

I mean sleeping behind a dumpster they [police] still get mad at you. And like, there's no other place you can really sleep. I mean we don't have a tent. —Focus group participant (Austin, TX)

Yeah I have a huge scar on the side of my hip from the cops. I didn't feel safe then. —Focus group participant (Austin, TX)

And don't panhandle downtown. They don't give a f-ck wherever else you panhandle downtown, don't panhandle downtown. They will take you to jail automatically. They don't care. Yeah, cuz that's like their moneymaker. That's where all the tourists go. They don't want the tourists to see that. —Focus group participant (Austin, TX)

Yeah they don't take into consideration basic human needs. Like, if you're fighting off a cold because you spent the night out in the rain then it's much harder to do well at your job. If you're constantly worried about a place to stay and your own safety you can't really focus on being a productive member of society. And, if you wanted to do something that say didn't fit sort of the capitalist lifestyle, like if you wanted to just go live out in the woods, that's not really legal. — Focus group participant (Seattle, WA)

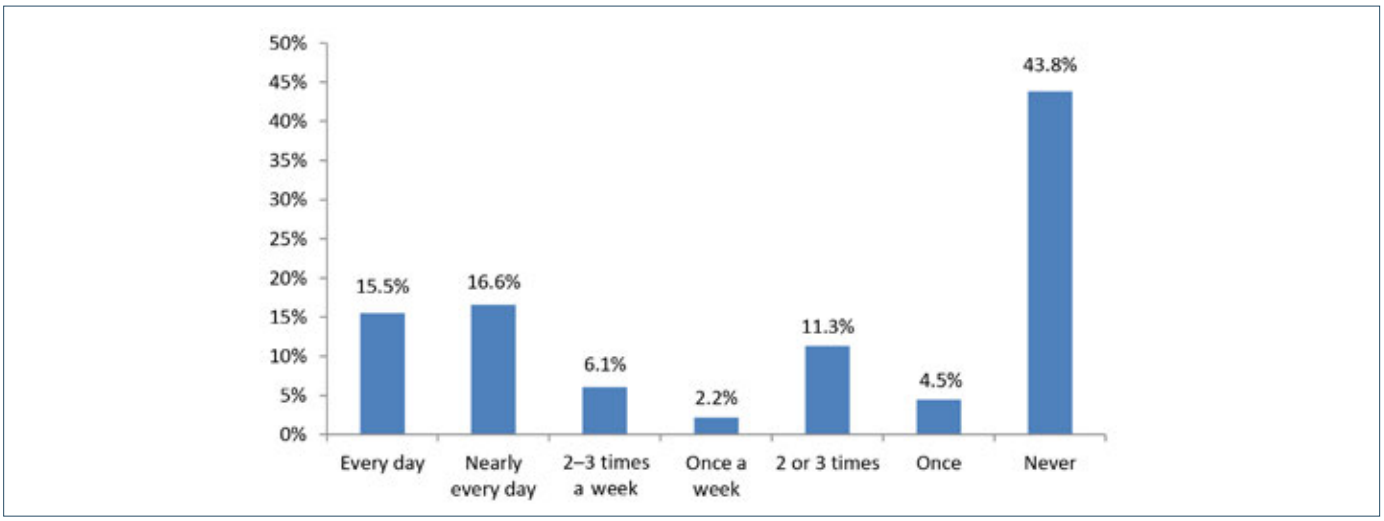
Yeah I mean you could have a friend shot in cold blood and chances are it doesn't matter because you were just like transient. Like your value as a human being is so much less. —Focus group participant (Seattle, WA)

They actually label you as transient. Like that happened to some people that were killed in a train that a friend of mine knew. They were really, like they didn't even say people, they just said three transients. —Focus group participant (Seattle, WA)

WEAPONS

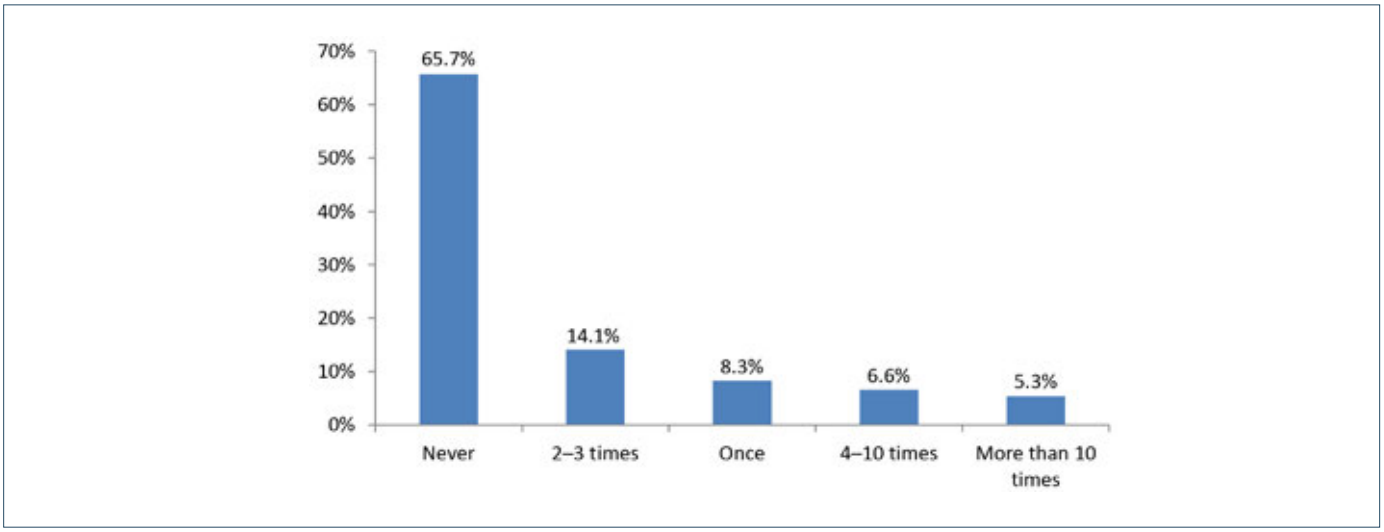
Two-thirds (61.8%) of participants had carried a weapon, such as a gun or knife, for protection at some point in their lives. Of those, 56.2 percent had carried a weapon for protection at some point during the past year, 16.6 percent had carried a weapon nearly every day during the past year, and an additional 15.5 percent had carried a weapon every day during the past year (see Figure 8.2).

Figure 8.2: How Often in the Past Year Have You Carried a Weapon for Protection? (*n* = 639)



Of those participants who reported carrying a weapon at some point in their lives, 34.3 percent had actually used a weapon for protection. About 8 percent (8.3%) had used a weapon once; 14.1 percent, two or three times; 6.6 percent, between four and 10 times; and 5.3 percent, more than 10 times (see Figure 8.3).

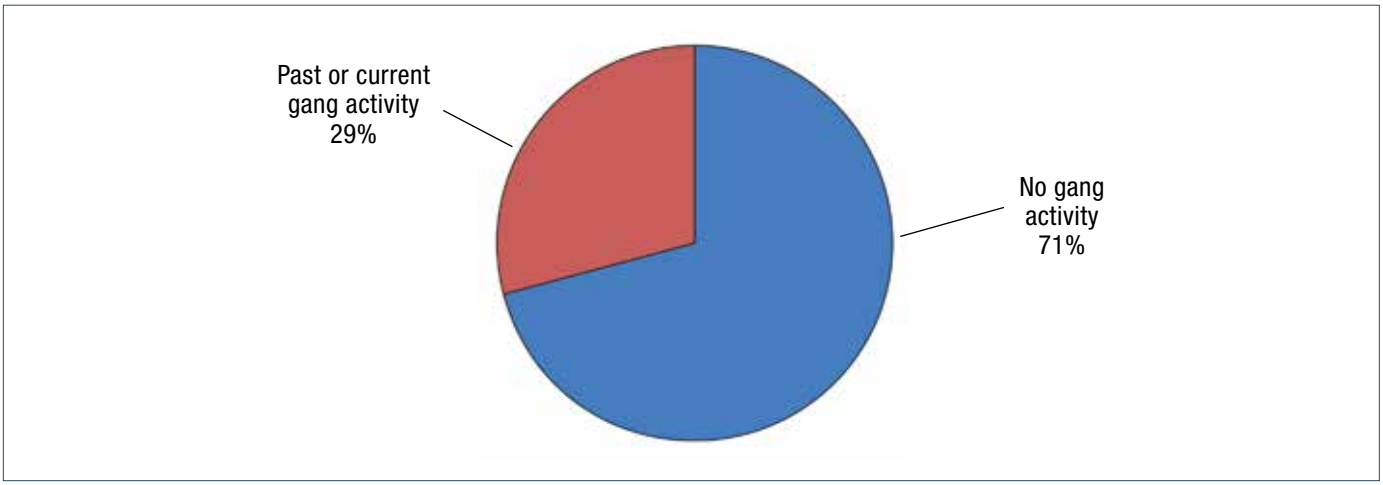
Figure 8.3: In Your Whole Life, How Often Have You Had to Use a Weapon for Protection? (*n* = 639)



GANG ACTIVITY

More than one-quarter of participants (29.0%) reported participation in gang activity at some time in their lives (see Figure 8.4), with 7.2 percent reporting that they were currently a member of a gang at the time of their participation in the study.

Figure 8.4: Gang Activity



During the focus groups, participants from Chicago and Seattle discussed how homeless young people become involved with gangs and talked about violence in general.

> But yeah, you know they just scared to be, they're scared to go to family around the house, I have no support. So they go, look at some gangs, and they look at them as, the gang provide them support to get money so you know that's one of the issues that a lot of young youth is scared, you know, go through what we, you know, what we're going through right now, you know what I'm saying? The number one thing is financial need. That's the only reason why they doing it. —Focus group participant (Chicago, IL)

> Um, well, I would like to tell y'all that… I want to talk about the violence that's been going on in Chicago. We have a lot of young youth in Chicago that is very scared of the homeless crime. —Focus group participant (Chicago, IL)

> I don't belong here. This is not my type of community. No offense, but it's like, I grew up in the suburbs, so if it's not obvious enough, this [violence] isn't my type of environment, sorry. Like the shootings and the killings, I'm not used to that…I don't feel safe. —Focus group participant (Chicago, IL)

Some participants talked about where they might be in 5 years:

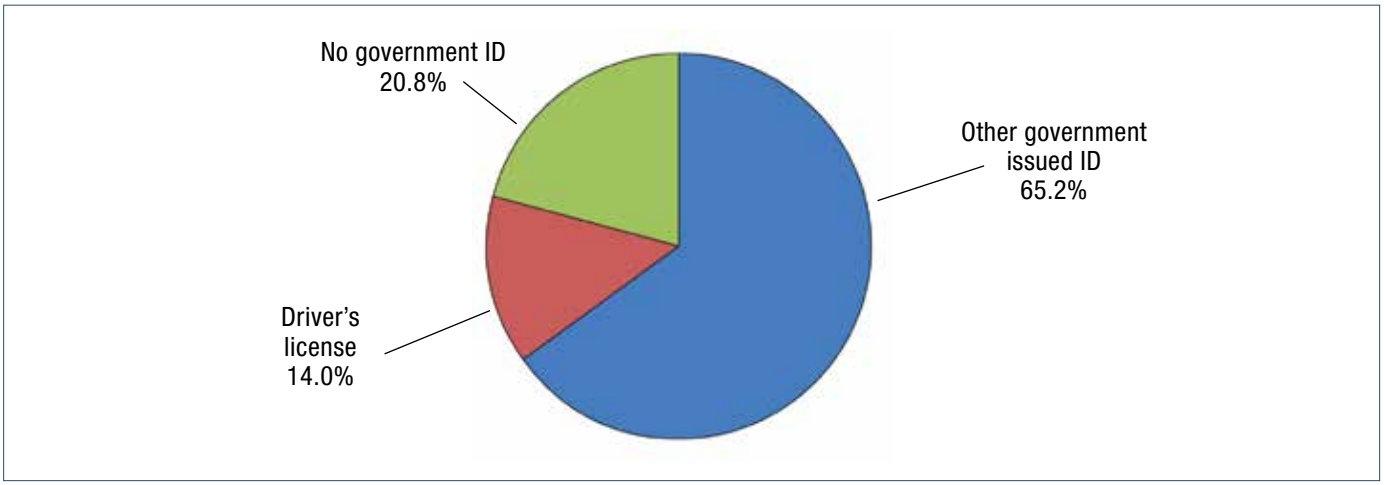
> Yeah [I would like to move away from Chicago] because of um, just how bad it is and all the gangs and you know, gangs and just what's going on. I think that over there in Indiana it's more like calmed. —Focus group participant (Chicago, IL)

> I could go back there [where respondent's father lives], but I fear that, also the place itself is just full of gang violence and just mistreatment of LGBTQ people and people who are perceived to be that. —Focus group participant (Seattle, WA)

DAILY LIFE

Across all 11 cities, 14.0 percent of participants had a driver's license and an additional 65.2 percent had a government-issued ID. In all, 79.2 percent of participants had some form of government-issued identification (see Figure 8.5). About one-half (51.9%) had a library card.

Figure 8.5: Forms of Identification



Participants were asked how recently they had used library services, had gone to a movie, and had driven a car. Nearly one-third of participants (32.8%) had used library services in the past week, and 14.8 percent had used library services within the past month. In the past week, 12.7 percent had driven a car, and 11.0 percent had gone to a movie.

During the focus groups, participants were asked what their daily life is like.

> Sittin' on the bus a lot. —Focus group participant (Austin, TX)

> I'm constantly going around places applying for jobs, going to my church, Goodwill. I'm all over the place, I don't really have time to slow down. Therapy, physical therapy, community care. —Focus group participant (Austin, TX)

> Well basically I just go to school, look for a job. —Focus group participant (Chicago, IL)

> My job, trying to get into school. —Focus group participant (Chicago, IL)

> Looking for work… trying to learn more English. —Focus group participant (Chicago, IL)

> I wake up and I get ready for school, then I go to school then right from school, then I pick up the baby from school. Then after I pick her up from school I walk to my grandma's house to go eat and stuff, and then I'll come back here and do chores and get ready for bed again and go upstairs and go to sleep. —Focus group participant (Chicago, IL)

My day-to-day life is very shuffled. Full of like, appointments and like back and forth, for like welfare and stuff like that, so to me it's very stressful. —Focus group participant (New York, NY)

For me and her [respondent's child] it's just kind of going throughout the day finding where we're going to sleep that night. —Focus group participant (Omaha, NE)

Um, just trying to find somewhere to stay, you know, trying to find a house, an apartment, whatever works. Um, trying to reconnect with my parents. —Focus group participant (Omaha, NE)

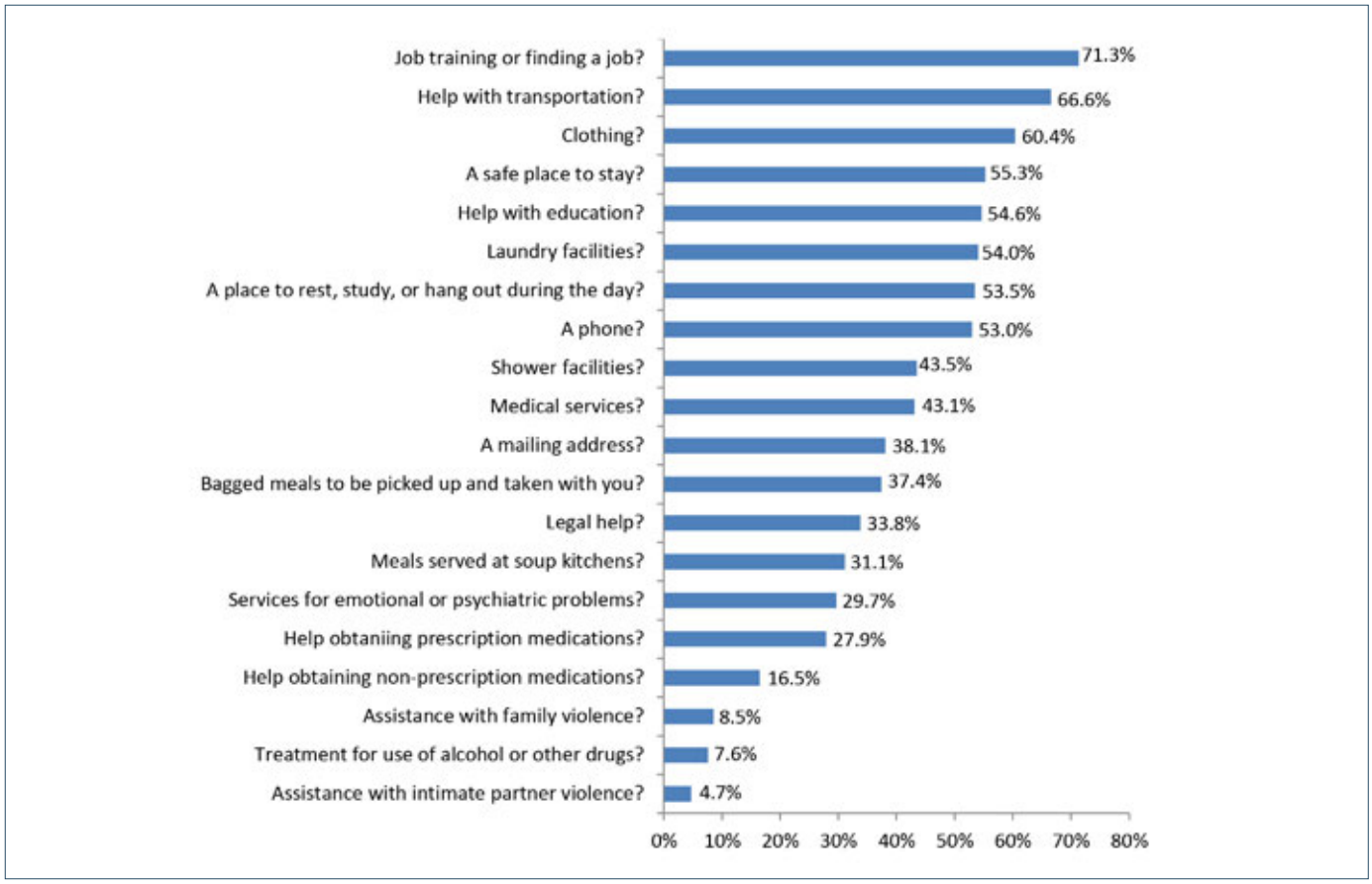
CHAPTER 9: SERVICES

This chapter provides information on the experience of youth with homeless services, including current service needs, barriers to shelter, service deficits and challenges, and services that would make the lives of street youth easier. Understanding the way youth perceive their own service needs, the barriers to having those needs met, and the adequacy of existing services can lead to the development of better and more effective services and service strategies.

CURRENT SERVICE NEEDS

Participants were asked about their current service needs (see Figure 9.1). The majority of participants needed help with job training or finding a job (71.3%), transportation (66.6%), and clothing (60.4%). A little over half the participants needed a safe place to stay (55.3%), help with education (54.6%), access to laundry facilities (54.0%), a place to study, rest, or hang out during the day (53.5%), and a phone (53.0%).

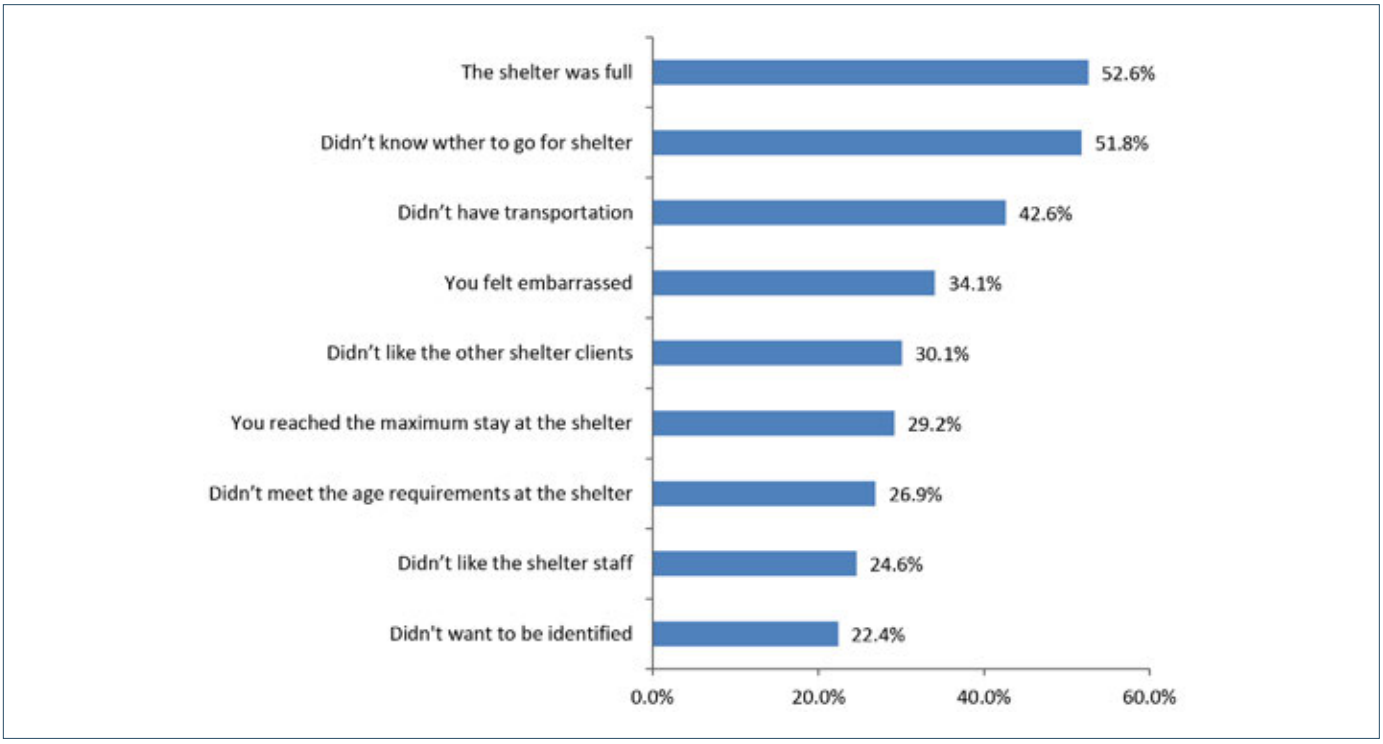
Figure 9.1: Service Needs Right Now, Do You Need… (% Yes; *n* = 654)



BARRIERS TO SHELTER

Participants were asked about a variety of things that may have prevented them from accessing shelter (see Figure 9.2). More than half (52.6%) reported that they had been unable to access shelter because the shelter was full, 51.8 percent said they didn't know where to go for shelter, 42.6 percent didn't have transportation to shelter, and 34.1 percent felt too embarrassed to access shelter. Participants also reported that they had been unable to access shelter because they didn't like the other shelter clients (30.1%), reached the maximum stay at the shelter (29.2%), didn't meet the shelter's age requirements (26.9%), didn't like the shelter staff (24.6%), or didn't want to be identified (i.e., provide personal information), (22.4%).

Figure 9.2: Has This Ever Prevented You From Accessing Shelter? (% Yes; *n* = 643)



When asked about challenges in accessing services, focus group participants spoke mainly of challenges related to transportation. They also mentioned difficulties in finding shelters that had open slots.

> Sometimes it's transportation. Just, really, just getting there. —Focus group participant (Austin, TX)

> The length of time that it takes to access that service. —Focus group participant (Austin, TX)

> Like you gotta wait in line, then it takes like 30 minutes to interview with the person. Then you gotta go. Then you've wasted your day at like one place. It's why it's… Especially if you gotta go panhandle afterwards, cuz there's only certain hours that's good for panhandling really. —Focus group participant (Austin, TX)

Like most services give us bus passes, not like a physical ride. A ride would be awesome. —Focus group participant (Austin, TX)

The openings, that was just really hard, like trying to get into just, being, a spot being available. —Focus group participant (Austin, TX)

The biggest thing, I guess, is like having an ID, like if you come out here and you don't have a type of identification, you don't have a Social, your birth certificate…that is the worst thing that they will make you do. —Focus group participant (Tucson, AZ)

They consider everyone not an American citizen unless you have your birth certificate or someone to vouch for you saying that "Oh, you're legal". —Focus group participant (Tucson, AZ)

A lot of paperwork, and a lot of having to go do this, go do that, just to get one thing done. Just one thing and you still have to a million more things to get done. —Focus group participant (Tucson, AZ)

Employment for people who have a criminal history of some sort. —Focus group participant (Minneapolis, MN)

The time, the timing. So sometimes it takes a week, 2 weeks to get some services, um, to get in some transitional homes, it might take certain qualification if you need to be at one of their shelters so they can monitor you and make sure you're, um, capable of going into a transitional home, so just timing and process. —Focus group participant (Omaha, NE)

Focus group participants also offered their input on what service agencies could do to be more effective in providing services.

Better training for their staff, like… I mean, I don't know about you guys, but I know sometimes when I go into a service place to get services that I feel that they're... like I feel that they feel like if they help me, then it's coming out of their paycheck that they're helping me when it's not like that. It's coming out of the fund that's supposed to help us. Not feel like, just some places I've been to are like, well, if they help us and help them, then that's cutting them off. Just some places I've been to is like that. —Focus group participant (Austin, TX)

And then maybe, like easier to get ahold of your medical records, and like what I said, Social Security, birth certificates, all that junk that if you leave. I don't know if you guys have trouble getting it, but when I left I didn't have anything. —Focus group participant (Omaha, NE)

Be more, like, patient with us, like we're homeless—you can't have everything set, done, did, like done for you guys when you guys need it—like, we're homeless, we're trying to build ourselves up, like, we're not like reaching all this, like half. A lot of people are, like, we're homeless, we're spit, like, we're pioneers or, we don't have nothing. They need to work with us more on being patient. Especially with people that have

mental disorders and they're out here on the streets. That's even worse, because they can get attitude just as bad as the worker, they're getting attitude back because people are getting kicked out of places and then their worker wants to be disrespectful to them, because they don't like the rules or whatever and they get, like, kicked out, but they still want to get attitude. That person get attitude right back, and they just need to be more patient. This world would be a heck of a lot better if there was patience a little bit more. —Focus group participant (Omaha, NE)

Focus group participants talked about services that they receive most often and about the benefits to being currently sheltered.

[Agency Name] is a very, like, good program, like when it comes to, like if you're determined to do things that you have to do to get ready for independence. And I know that if you work the program the right way that you'll be able to get the support and all the things that you need before you leave if you don't play around and keep your mind set. Because I know, like, in 2 months just being at the shelter I've got a lot of things done and now I'm here I'm, like, almost to the point that I have everything I need for whenever I turn 18 and I leave care, and it happened in such little time so I know that if I can do it in this little time then I'm sure everybody who works the program here, right like they're supposed, to it's possible. They do everything and it's very supportive, there's no dislikes about it. —Focus group participant (Austin, TX)

I get counseling. I guess I just get help when it need it. Like, if I'm ever in, like, a bad situation I know that I can come to anyone, anybody here and they'll find me the right help that I need. —Focus group participant (Austin, TX)

When I first started coming here I used the showers the most. —Focus group participant (Minneapolis, MN)

Tokens, bus card. —Focus group participant (Minneapolis, MN)

Like resources, computers. —Focus group participant (Minneapolis, MN)

For me it's pretty much just the shelter, the one that I'm staying at right now. It's the only thing that's ever come close to actually wanting to help. I mean my friends want to help, it's just they can't. But here they can, so it's a different story. —Focus group participant (Omaha, NE)

During the focus groups, participants were also asked about the characteristics of staff who are the most helpful. Many participants talked about the need for staff members to be patient, kind, respectful, and understanding.

Lots of patience… Being there, like when we have a problem they can tell, they can tell that you're, say, like you had a bad day they would tell the difference between a good day and a bad day for you. —Focus group participant (Austin, TX)

Just like genuinely wanting to help. —Focus group participant (Austin, TX)

Tell me out front if you're going to help me or not. Don't let me sit here and waste my time telling you and you ain't gonna do sh-t. —Focus group participant (Austin, TX)

I feel that one for me is persistence, because if they're persistent, no matter how much you push them away, they keep coming towards you just like… One of the things that my pastor said was, you know, if someone pushes you away turn the other cheek and just love them more, you know, because like they all said it's a really good thing. But for me it's persistence because that shows that they actually care. They, no matter how much they push you away, they want to keep coming toward you with everything they got. —Focus group participant (Austin, TX)

Somebody who asks a lot of questions is helpful. Somebody who actually—even if they don't actually care but pretends to care. You know? That's helpful. Like, but if they're just rude, and they just don't give a d-mn about anything that you have to say, what are—what are they really doing for you? You know? —Focus group participant (Tucson, AZ)

I would have to agree that the asking questions a lot helps, and knowing that everything we say is secure and that it's not going to be told to the whole world is pretty great. —Focus group participant (Tucson, AZ)

Friendliness. Caring. Those are helpful. —Focus group participant (Tucson, AZ)

Optimism. —Focus group participant (Omaha, NE)

Constantly peppy (laughs). Right now I have one of my favorite staff. She relates her problems to us, too. Like she tells us some things that she's going through right now and making it seem like we're not the only ones that are having issues. So like knowing that we're not alone in the stress factor. Also, just a positive upbeat attitude, just making you feel better about yourself that's always good. —Focus group participant (Omaha, NE)

They've clocked out at 5 [p.m.]. They're not getting paid for when they're picking us up at 3 a.m. or coming to our house at 3 a.m. They're not getting paid for those hours, they're doing it because they love us, they care, like we're their kids. —Focus group participant (Omaha, NE)

Focus group participants were also asked about bad experiences accessing services that made them not want to return, as well as services that they chose not to use.

[Agency Name] is the only service that I've ever gone through that I—that made me not wanna go back. Cuz they're just – they're not kind there at all. I don't think I've ever dealt with one nice person inside [Agency Name] that actually seemed like they cared. —Focus group participant (Tucson, AZ)

Oh, being able to fill out the paperwork, like she said. Taking forever, like after you even get in the building. If you're late, like you're there at like 11 a.m., you won't get out of there until like 4 p.m. in the afternoon cuz they gotta go through everything. All kinds of paperwork for you. Just to get your services. And then you gotta wait 'til a month to get it [the service]. —Focus group participant (Tucson, AZ)

[Agency Name]… I went in there for what they call [Program Name]. It's for women only, like they do it every night. And like, you go and like sleep on this cot in their hallway and shit. That's scary. F-ck that. I'd rather sleep outside cuz there's at least a way to get away from that. There's like, they're crazy in there. They [other homeless youth] come in high and drunk and it doesn't matter [to staff]. —Focus group participant (Austin, TX)

People will be taking your stuff while you sleep. If you don't sleep with your stuff, you gonna get robbed and it's too much. —Focus group participant (Austin, TX)

I actually, when I didn't have insurance, I went to the [Agency Name] to get free medical care because I was homeless. And listen to this, this lady I had, I ended up having scabies because I bought clothes from [Agency Name] and I didn't wash them, so that's really disgusting guys, by the way [that the agency didn't wash the clothes], it [scabies] wasn't like gross or anything. And so I had to get an ointment to take care of it so they're prescribing it and she's like looking over my scabs and everything, and she looks at the stretch marks on my stomach and she's like, "Oh, did you just have a baby?" "No, I did not." She was like, "Oh, you're just fat." I'm like, "Excuse me?" I was so pissed off and disrespected and the nurses like, they were taking down my name, they were like, "Oh, how do you spell that," and I told them how to spell it, and they were like, "What's your last name," and I was like, "[name]." She was like, "You don't look a [name])." I was like, "Are you kidding me?" —Focus group participant (Omaha, NE)

EASIER LIVES

As a final general question regarding services, focus group participants were asked what would make their lives easier on any given day. Many participants said that money and stable housing would make their lives easier.

I would, what would make my life easier is having a place, being already, like, having my own place where I know I can do my own things and get my stuff done with school and everything, I don't know, that would make my life easier. —Focus group participant (Austin, TX)

Money. —Focus group participant (Austin, TX)

Um, if my job would give me more hours. Instead of cutting them, cuz they just cut them, and I'm used to working like, 10-hour shifts and like 5 to 6 days a week. And now I'm working, like I'm lucky if I even get 2 days with 4 hours. —Focus group participant (Tucson, AZ)

Money. Straight up. —Focus group participant (Tucson, AZ)

Cheap childcare, like somewhere that you're not going to be afraid to leave your kids cuz every place I've found that's like affordable, I wouldn't leave my daughter there for 2 seconds by herself. So cheap, like, good childcare. —Focus group participant (Tucson, AZ)

I want to teach myself how to budget better or be taught. I don't know… Saving, budget, spending. All that good stuff. —Focus group participant (Tucson, AZ)

A vehicle. That's my problem. —Focus group participant (Tucson, AZ)

Respect. Lot of people out here don't know how to respect each other. —Focus group participant (Minneapolis, MN)

I would say stable housing. —Focus group participant (Minneapolis, MN)

I think there should be more classes on how to manage money. Because I think being young, and having all these material things, you don't always think about what you really actually need. —Focus group participant (Omaha, NE)

Also I'd say some of them needs to be, because a lot of them's [job applications] online now, and some homeless people don't have the access to Internet, so if they could put more out written ones as well as the online ones instead of just online, then people can actually do it and get their jobs. —Focus group participant (Omaha, NE)

DISCUSSION

This report provides a portrait of young people experiencing homelessness in 11 cities nationwide. The ultimate goal of the study was for the SOP grantees that participated in the study to obtain information from a subset of homeless street youth to learn about their service needs. The expectation is that these data will help to inform service design to better meet the needs of street youth. The findings in this report are not from a nationally representative sample of street youth; instead, the report provides detailed information on the experiences and service needs of the 873 homeless street youth who participated in the interviews and focus groups.

Research has continued to demonstrate that family rejection has a serious impact on LGBT young people's physical health and behavioral health, including substance use (Ryan, Huebner, Diaz, & Sanchez, 2009), and is often the cause of LGBT youth becoming homeless. LGBT youth rejected by their families were more than 8 times as likely to have attempted suicide, nearly 6 times as likely to report high levels of depression, more than 3 times as likely to use illegal drugs, and more than 3 times as likely to be at high risk for HIV and STDs, compared with LGBT youth who were not rejected by their families (Ryan et al., 2009).

Consistent with national estimates of 20–40 percent street youth identifying as LGBT (Ray, 2006), this study indicated that one-third of street youth reported being lesbian, gay, or bisexual. However, the percentage of youth who identified as transgender—6.8 percent—is 3 times that of a recent national estimate of transgender homeless youth (Durso & Gates, 2012). This finding may be due to the inclusion of grantee sites in several large urban centers that are more accepting of transgender youth and/or provide more culturally appropriate services. The sites that reported[1] higher rates of transgender youth in their sample are Austin (8.2%), Chicago (14.8%), Seattle (21.0%), and New York (23.3%).

Compared with their lesbian, gay, and bisexual peers, transgender homeless youth experience higher levels of victimization and non-acceptance, which leads to a relatively higher percentage of them experiencing chronic homelessness and living on the streets. In the SOP sample, transgender youth were more likely to report experiencing any type of victimization while homeless, compared with non-transgender youth (74.4% vs. 59.7%, $p<.04$).

The literature indicates another population that is overrepresented among homeless street youth: foster care youth. In the SOP sample, more than half (50.6%) had at some point in their lives stayed in a foster home or group home. These youth were significantly more likely than their street peers who had not been in foster care to experience a longer duration of homelessness (27.5 months vs. 19.3 months), depressive symptoms (66.4% vs. 57.1%), victimization (76.2% vs. 66.9%), inpatient drug or alcohol treatment, and arrest (67.7% vs. 55.9%).

These findings are consistent with other studies of foster care youth and homelessness. Every year, more than 24,000 youth "age out" of foster care by reaching a certain age, usually 18, but in some states 21 (Toro,

Dworsky, & Fowler, 2007). Research has consistently demonstrated the association between leaving institutional or foster care and experiencing homelessness. A California study of youth who were homeless in San Francisco found that 25 percent of street youth had become homeless after their most recent separation from foster care, a group home, or juvenile detention (Toro et al., 2007). Another study found that 25 percent of adults experiencing homelessness were formerly in foster care (Burt, Aron, Douglas, Valente, Lee, & Iwen, 1999).

Young people who have been in foster care and use homeless shelters have been found to stay in shelters longer and use them more often than other youth (Park, Metraux, & Culhane, 2005). Many youth who "age out" or transition from an established, structured system like foster care share similar characteristics with homeless youth who may be fleeing or forced from their homes, such as lack of self-sufficiency skills, lack of financial resources, poor mental health and post-traumatic stress disorder, physical health challenges, and greater rates of substance abuse. Many existing programs targeted to youth who age out of foster care miss the many foster care youth who are released from the foster care system shortly before age 18 and sent back to their family of origin. In most cases, there has been no resolution of the family issues that led to the youth being in foster care in the first place, and many of these youth are especially vulnerable, given their problematic family histories and their limited skills at coping on their own. Many youth run away from foster care before they turn 18, and the majority of runaway youth simply fall through the cracks (Courtney & Heuring, 2005).

For the SOP study, lifetime pregnancy rates were 47.3 percent for females and 25.8 percent for males (impregnating a female), with 14.1 percent of males unsure whether someone had been pregnant with their child. About 9 percent of the young women were pregnant at the time of their interview, with another 5 percent unsure if they were currently pregnant. The lifetime rate of pregnancy for the SOP sample of young women was higher than that found in other samples of homeless girls, which ranged from 27 percent to 44 percent (Greene & Ringwalt, 1998; Solorio, Milburn, Weiss, & Batterham, 2006). The rate of current pregnancy for the SOP sample of youth was similar to that of other studies, which ranged from 10 percent to 20 percent (Greene & Ringwalt, 1998; Solorio et al., 2006). Fourteen percent (14.2%) of the participants reported caring for children at the time of their interview, which suggests a special population of homeless street youth who are experiencing not only the stress of being on the street and getting their own needs met but also the stress of meeting the needs of their child or children.

Studies of symptoms experienced by homeless youth indicate high rates of depressive symptoms and co-occurring conduct and substance abuse problems (Cauce et al., 2000; Whitbeck, Hoyt, & Bao, 2000; Whitbeck & Crawford, 2009a). Although the SOP study did not use diagnostic instruments, the CES-D nonetheless provides information on depressive symptoms experienced by the participants. More than half of the youth (61.8%) scored above the CES-D cutoff, indicating that a majority of those interviewed struggled with symptoms of depression and were possibly at risk for experiencing clinical depression. And, given what is known about factors contributing to youth homelessness, it is not surprising that 71.7 percent of participants reported experiencing major trauma at some point in their lives, with 79.5 percent reporting that they had experienced symptoms of post-traumatic stress for more than 1 month.

[2] The transgender rates were obtained through personal communication with each of the SOP sites. The data are from the site-specific SOP reports.

Furthermore, among homeless youth, depression and post-traumatic stress have been found to co-occur with substance abuse. Many youth self-medicate with alcohol and other substances to experience some relief from the challenges of living on the streets and from their psychological symptoms. All studies of runaway and homeless youth have documented rates of alcohol and substance use in excess of those found for housed youth. The 12-month substance use rates for the SOP youth were consistent with those found in other homeless youth studies: 73.2 percent for alcohol, 64.6 percent for marijuana, and 37.5 percent for hard drugs (intravenous drugs, inhalants, cocaine, and methamphetamine). Rates were lower for past month use at 59.1 percent for alcohol, 55.1 percent for marijuana, and 13.2 percent for hard drugs (Cauce et al., 2000; Whitbeck & Crawford, 2009a). Alcohol and drug abuse are well documented in the literature as being associated with increases in other high-risk behaviors, such as risky sexual behaviors, and with increased likelihood of victimization. In the SOP sample, past year binge drinking, marijuana use, and illicit drug use were associated with a significantly higher likelihood of being victimized, and illicit drug use was also associated with decreased likelihood of using a condom when engaging in vaginal or anal sex.

Not all negative consequences of living on the streets are emotional and psychological. Myriad stresses, from hunger and malnutrition to poor sleep, substance abuse, and risky sexual behavior, can lead to negative health consequences. However, when speaking of service needs and barriers to services, youth in the SOP sample did not identify health concerns or barriers to health care as key concerns in either interviews or focus groups. Although some focus group participants suggested that more educational programs about drug addiction should be available, barriers to substance abuse and mental health services were not mentioned by participants. The SOP sample may be similar to youth in the Midwest Study (Whitbeck & Crawford, 2009b) in that the majority of the youth interviewed saw themselves as basically in good health. However, given that 20.3 percent of the sample reported a past sexually transmitted infection (STI) and 4.6 percent were unsure whether they had ever had an STI, at least some of the street youth interviewed have some health issues for which treatment is needed.

An alternative explanation may be embedded in the other types of service needs that were identified by the youth in the sample. The types of service needs youth identified pertained to meeting basic needs: access and challenges related to safe shelter (55.3%), education (54.6%), and employment (71.3%), and access to basic supports like transportation (66.6%), clothing (60.4%), and laundry facilities (54.0%). Focus group participants discussed the need for better training for shelter staff, characteristics of desirable and helpful staff, and the need for help navigating bureaucracy related to obtaining personal records

and proof of identity. It may also be that street youth need to have more basic needs for survival met before they might consider obtaining services for health, mental health, and substance abuse issues or that problems and risk behaviors among youth experiencing homelessness cannot be treated apart from the needs of the whole person (Kraybill & Zerger, 2003; Slesnick, Dashora, Letcher, Erdem, & Serovitch, 2009). Addressing one area in isolation from the other areas is not likely to be as effective as an intervention that addresses multiple and overlapping areas of need (Bronfenbrenner, 1979).

Youth living on the street do not experience universally negative outcomes. Based on the Rosenberg Self-Esteem Scale, 83 percent of the study participants scored in the normal range, with the remaining 17 percent scoring in the low range. Additionally, participants reported that there are a number of people in their lives they can turn to for support such as money, food, and a place to stay. Those most likely to give the youth aid without asking for anything in return were a parent, other relatives, or friends. In addition, just under half of the participating youth indicated they currently had a romantic partner. Consistent with findings in previous research (Johnson, Whitbeck, & Hoyt, 2005), the SOP youth relied on their street peers for support, safety, and subsistence, although some had friends with housing with whom they maintained a relationship after becoming homeless. As previous research suggests, homeless peers and associates often form a social support system of youth facing similar challenges (Johnson et al., 2005; Whitbeck & Hoyt, 1999) even though these peer groups may lead to behaviors that are counter to social norms (Robert, Pauzé, & Fournier, 2005).

LIMITATIONS

Although these findings provide valuable knowledge about a particularly vulnerable population of street youth, several study limitations must be considered. First, the sample of youth for the participant interviews and the focus groups is not a nationally representative one, and caution should be used in generalizing the findings. Second, homeless street youth are a transient and hard-to-reach population, which can lead to sample bias in studies. RDS was employed in this study to overcome this bias, but in the majority of cities, RDS was only moderately effective and did not yield as many participants as originally designed. Although initial "seed" recruitment was timely, referral "seeds" were not. Therefore, a convenience sampling approach was employed to supplement the RDS approach and to obtain a focus group sample. Because this survey did not use a random sample, the results are not generalizable to all homeless street youth. However, because of the large sample size and the number of cities involved in the study, this study is likely more representative than other studies of street youth.

In addition, demographic information for the 217 youth who participated in the focus groups was not collected, which prevented comparative analyses between youth who participated in the interviews and those who participated in the focus groups to explore any significant differences between the two groups. Another limitation involves the analyses which compare LGBT and non-LGBT youth based on the entire sample, including all 11 sites; regional differences may exist that are not reflected in the results of this report. Socially desirable responses are always a concern when conducting interviews that inquire about sensitive personal information. Although data collection methods were implemented to optimize the comfort of youth responding to the survey, it is possible some of the findings may be underreported.

Finally, this study, due to the cross-sectional design, was intended to offer providers and policymakers a snapshot of homeless street youth and their service needs to provide insights into potential service enhancements and areas where more research is needed. Other information important to further understand homeless street youth may have been excluded by the scope of the study.

RECOMMENDATIONS

The SOP Data Collection Study furthers our understanding that homeless youth are a very diverse group and, as such, require an array of services and supports that can be tailored to their unique needs. A number of key findings from the SOP study have policy, practice, and research implications.

Unlike other social services in the United States (e.g., child welfare, mental health, substance abuse), efforts focused on serving homeless youth do not have a coordinated system of care. Instead, individual providers around the country procure federal, state, local, and nonprofit funds to operate. Better coordination among homeless youth and other social service providers can strengthen efforts to better serve the homeless youth population. Interagency cooperation could be augmented by linkages between community nonprofit and local government agencies that serve the same youth (e.g., child welfare, mental health, and juvenile justice). Bringing together stakeholders from all parts of the youth-serving community can help build the needed continuum of care—prevention, early intervention, longer-term services, and aftercare—for homeless youth. Consolidating resources and forging service alliances among these stakeholders can further develop a homeless youth continuum of care that includes coordinated screening, assessment, intake, referral, and data systems.

IMPLICATIONS FOR POLICY

It appears that there are too few emergency shelter programs available to homeless youth to meet the existing need. A larger investment is required to prevent youth from sleeping on the streets. More flexibility in shelter response would allow access to youth who have been turned away because they have reached the maximum stay or exceeded age restrictions. Communities may also want to consider innovative alternatives to emergency shelter, such as host homes.

A larger investment is also needed to reunify youth with their families when possible and deemed appropriate. Family reunification can not only help to end a current episode of homelessness, but also prevent future homelessness by addressing the reasons why a youth left home. Because emotionally connecting youth to their family has been found to positively impact positive youth outcomes, efforts should be made to emotionally connect youth to family, when deemed appropriate, even if physical reunification is not possible.

IMPLICATIONS FOR PRACTICE

Data gathered in this study also indicate ways services provided to youth experiencing homelessness can best meet their needs. They inform best practices in case management and appropriate interventions.

INTENSIVE CASE MANAGEMENT

Street outreach programs serve a vital role in a coordinated system of services for all homeless youth. SOP services are limited and focused on getting youth off the streets and providing some basic living essentials and service referrals. In addition to SOPs, street youth may also use drop-in centers and emergency shelters. All of these programs provide opportunities to further engage street youth in needed services. Intensive case management includes 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, and open-ended service provision. A focus on screening and assessment should include careful matching to services and tracking the progress of youth. All youth experiencing homelessness are not the same. The findings that a large percentage of the youth in the SOP study sample is LGBT and that they experience barriers to services suggest more efforts are needed to better serve these youth in particular. Screening, assessment, and monitoring of risk and protective factors are crucial to understanding the needs of all homeless youth, matching those needs to culturally appropriate interventions, and monitoring progress over time.

TARGETED SUPPORTIVE SERVICES AND INTERVENTIONS

The elevated rates of substance abuse, mental health problems, and exposure to trauma experienced by the participants in the SOP Data Collection Study prior to becoming homeless suggest more intensive interventions and supports for youth are needed to help prevent youth from becoming homeless. Most homeless youth have significant experience with trauma. As seen with the SOP study sample and with LGBT youth in particular, traumatic experiences can include multiple types of abuse, neglect, and exposure to violence prior to and after becoming homeless.

It is essential that intervention strategies are trauma-informed in all aspects of how they approach and support young people to facilitate healing and recovery, including engagement or reunification with families when it is appropriate. Youth also need interventions to enhance skills, competencies, and existing strengths to help them to reach positive developmental milestones and become healthy, productive adults. Barriers to use of services and interventions that were identified by LGBT study participants included lack of LGBT-friendly policies and staff. Services and programs need to be especially sensitive to LGBT and other special populations, like youth who have been in foster care and pregnant and parenting youth, who are overrepresented in the homeless youth population and are at even higher risk of experiencing health and mental and behavioral health issues.

CORE OUTCOMES AND PATHWAYS

Appropriate interventions should target and help develop the protective factors a youth is lacking as well as decrease the risk factors with which a youth is burdened. Practitioners working with homeless youth may find it especially helpful to utilize a strengths-based perspective to empower the young people they work with to become masters of their own lives. The majority (83%) of the study youth reported having good self-esteem, as well as having friends, parents, or relatives they can rely on for help. Focusing on protective factors has considerable advantage in working with homeless youth because it is their strengths in overcoming difficulties that can mitigate negative outcomes. Improvements in risk and protective factors can serve as pathways to achieve better outcomes, such as stable housing, permanent connections, well-being, and education or employment. Achieving sustainable gains in these four outcomes can help put youth on a path toward a healthy adolescence and positive transition to adulthood.

RESEARCH IMPLICATIONS

The limited amount of high-quality empirical research on homeless youth leaves many gaps and questions for future research. Three main areas that require additional research are: (1) the causes, scope, and demographics of youth homelessness; (2) the efficacy of interventions; and (3) system planning and infrastructure.

SCOPE AND DEMOGRAPHICS

The ability to accurately describe the scope and characteristics of youth experiencing homelessness is important for the planning, funding, and design of interventions and recruitment strategies that address the diversity of the homeless youth population. Comprehensive multi-method approaches that include point-in-time counts, shelter and street outreach, and household surveys are needed to reach youth where they are to obtain an accurate prevalence estimate of the homeless youth currently in the United States. In addition, more needs to be known about populations of youth that are overrepresented in the homeless youth population—such as LGBT, pregnant and parenting, and foster care and juvenile justice-involved—to better serve these youth. The SOP Data Collection Study found similar patterns of overrepresentation for special populations of youth, but the sample was not representative, nor could findings be disaggregated by site due to the small sample sizes. Future studies will need large enough samples of these youth to determine geographical differences, as well as identify possible pathways that may be specific to these populations moving into and out of homelessness.

EFFICACY OF INTERVENTIONS

Few intervention studies have been conducted with homeless youth, and particularly street youth. Although the effectiveness of certain interventions has been demonstrated, very few studies have employed rigorous methodologies. Much of the research literature is limited by small convenience samples, lack of long-term follow-up, lack of control or comparison groups, and high sample attrition. More research is needed to identify which interventions work best, with whom, and under what conditions. Intervention development will need to consider the cognitive and emotional developmental stages of youth and recognize that the specific content or targets of interventions may need to vary based upon the reasons why youth become homeless and the length of homelessness. More quantitative and qualitative studies are needed to explore the outcomes for homeless youth, and the pathways through which they exit, or fail to exit, homelessness. Also, more longitudinal studies are needed to understand how various factors at the individual, peer, family, and community levels affect both short-term and long-term outcomes.

SYSTEM PLANNING AND INFRASTRUCTURE

More research is needed to identify best practices that include use of youth-friendly screening and assessment tools and processes for identifying and referring youth for needed services. Best practices also need to be identified, implemented, and assessed using coordinated data systems that can monitor and measure progress toward decreasing homelessness. Moreover, there is a need to support providers in coordinating services, measuring outcomes, making adjustments, and improving service delivery at the individual youth, family, and systems levels. Information about the characteristics of the various populations using homeless youth services and programs can allow planners to better design and target program interventions and to advocate for appropriate policy revisions at the local, state, and federal levels. Development of instruments that can identify homeless youth based on typologies that categorize their levels of risk, protection, and time spent on the streets can help providers better anticipate and match the needs of the youth to existing services and inform any needed changes to the service array.

REFERENCES

Achenbach, T. M. (1991). *Manual for the child behavior checklist/4-18 and 1991 profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Auerswald, C. L., & Eyre, S. L. (2002). Youth homelessness in San Francisco: A life cycle approach. *Social Science & Medicine, 54*(10), 1497–1512.

Bailey, S., Camlin, C., & Ennett, S. (1998). Substance use and risky sexual behavior among homeless and runaway youth. *Journal of Adolescent Health, 23*(6), 378–388.

Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34*(10), 844–850.

Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve.* Retrieved December 9, 2015, from http://webarchive.urban.org/UploadedPDF/homelessness.pdf

Cauce, A., Paradise, M., Ginzler, J., Embry, L., Morgan, C., Lohr, Y., & Theofelis, J. (2000). The characteristics and mental health of homeless adolescents: Age and gender differences. *Journal of Emotional and Behavioral Disorders*, 9, 220–239.

Clements, K., Gleghorn, A., Garcia, D., Katz, M., & Marx, R. (1997). A risk profile of street youth in northern California: Implications for gender-specific human immunodeficiency virus prevention. *Journal of Adolescent Health, 20*(5), 343–353.

Coryn, C. L. S., Gugiu, P. C., Davidson, E. J., & Schroter, D. C. (2007). Needs assessment in hidden populations using respondent-driven sampling. *Evaluation Journal of Australasia, 7*(2), 3–11.

Courtney, M. & Heuring, D. H. (2005). The transition to adulthood for youth "aging out" of the foster care system. In D. W. Osgood, E. M. Foster, C. Flanagan, & G. Ruth (Eds.), *On your own without a net: The transition to adulthood for vulnerable populations* (pp. 27–67). Chicago, IL: University of Chicago Press.

Daddis, M., Braddock, D., Cuers, S., Elliott, A., & Kelly, A. (1993). Personal and family distress in homeless adolescents. *Community Mental Health Journal, 29,* 413–422.

Dennis, M. L. (1991). *Changing the conventional rules: Surveying homeless people in non-conventional locations.* Presented at the Fannie Mae Annual Housing Conference, Counting the Homeless: The Methodologies, Policies, and Social Significance Behind the Numbers, Washington, DC.

Dunn, M., & Krehely, J. (2012). *Supporting gay and transgender youth most in need: White House conference turns spotlight on housing and homelessness issues impacting gay and transgender population.* Retrieved December 9, 2015, from https://cdn.americanprogress.org/wp-content/uploads/issues/2012/03/pdf/lgbt_homelessness.pdf

Durso, L. E., & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless.* Retrieved December 9, 2015, from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf

Ensign, J., & Bell, M. (2004). Illness experiences of homeless youth. *Qualitative Health Research, 14,* 1239–1254.

Farber, E., Kinast, C., McCoard, W., & Falkner, D. (1984). Violence in families of adolescent runaways. *Child Abuse & Neglect, 8*(3), 295–299.

Gaetz, S. (2004). Safe streets for whom? Homeless youth, social exclusion, and criminal victimization. *Canadian Journal of Criminology and Criminal, 46*(4), 423–456.

Greenblatt, M., & Robertson, M. J. (1993). Homeless adolescents: Lifestyle, survival strategies and sexual behaviors. *Hospital and Community Psychiatry, 44*(12), 1177–1180.

Greene, J. M., Ennett, S. T., & Ringwalt, C. L. (1997). Substance use among runaway and homeless youth in three national samples. *American Journal of Public Health, 87*(2), 229–235.

Greene, J. M., & Ringwalt, C. L. (1998). Pregnancy among three national samples of runaway and homeless youth. *Journal of Adolescent Health, 23*(6), 370–377.

Gwadz, M. V., Cleland, C. M., Quiles, R., Nish, D., Welch, J., Michaels, L. S., Gonzalez, J. L., & Leonard, N. R. (2010). CDC HIV testing guidelines and the rapid and conventional testing practices of homeless youth. *AIDS Education and Prevention, 22*(4), 312–327.

Hammer, H., Finkelhor, D., & Sedlak, A. (2002). *Runaway/thrownaway children: National estimates and characteristics.* Retrieved December 9, 2015, from https://www.ncjrs.gov/pdffiles1/ojjdp/196469.pdf

Heckathorn, D. D. (2002). Respondent-driven sampling II: Deriving valid population estimates from chain-referral samples of hidden populations. *Social Problems, 49,* 11–34.

Heckathorn, D. D., Semaan, S., Broadhead, R. S., & Hughes, J. J. (2002). Extensions of respondent-driven sampling: A new approach to the study of injection drug users aged 18-25. *AIDS and Behavior, 6*, 55–67.

Hoyt, D., Ryan, K., & Cauce, A. (1999). Personal victimization in a high risk environment: Homeless and runaway adolescents. *Journal of Research in Crime and Delinquency, 36*, 371–392.

Hyde, J. (2005). From home to street: Understanding young people's transitions into homelessness. *Journal of Adolescence, 28*(2), 171–183.

Janus, M. D., Archambault, F., Brown, S., & Welsh, L. (1995). Physical abuse in Canadian runaway adolescents. *Child Abuse & Neglect, 19*(4), 433–447.

Janus, M. D., Burgess, A. W., & McCormack, A. (1987). Histories of sexual abuse in adolescent male runaways. *Adolescence, 22*, 405–417.

Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2005). Substance abuse disorders among homeless and runaway adolescents. *Journal of Drug Issues, 35*(4), 799–816.

Kang, M. J., Slesnick, N., & Glassman, M. J. (2009). *Street living and shelter residing youth: Differences in their experiences and problems.* Poster presented at the biennial meeting of the Society for Research on Child Development, Denver, CO.

Kaufman, J. G., & Widom, C. S. (1999). Childhood victimization, running away, and delinquency. *Journal of Research in Crime and Delinquency, 36*(4), 347–370.

Kennedy, M. R. (1991). Homeless and runaway youth mental health issues: No access to the system. *Journal of Adolescent Health, 12*(7), 576–579.

Kidd, S. A. (2003). Street youth: Coping and interventions. *Child and Adolescent Social Work Journal, 20*(4), 235–261.

Kipke, M. D., Unger, J. B., O'Connor, S., Palmer, R. F., & LaFrance, S. R. (1997). Street youth, their peer group affiliation and differences according to residential status, subsistence patterns, and use of services. *Adolescence, 32*, 655–669.

Kosciw, J. G., Diaz, E. M., & Greytak, E. A. (2008). *The 2007 National School Climate Survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. Retrieved December 9, 2015, from http://www.glsen.org/sites/default/files/2007%20National%20School%20Climate%20Survey%20Full%20Report.pdf

Kraybill, K., & Zerger, S. (2003). *Providing treatment for homeless people with substance use disorders: Case studies of six programs.* Retrieved December 9, 2015, from http://www.nhchc.org/wp-content/uploads/2011/09/CA05RCaseStudies-FINAL5.pdf

Kufeldt, K., & Nimmo, M. (1987). Youth on the street: Abuse and neglect in the eighties. *Child Abuse & Neglect, 11*(4), 531–543.

Kurtz, P. D., Kurtz, G. L., & Jarvis, S. V. (1991). Problems of maltreated runaway youth. *Adolescence, 26,* 544–555.

Lewinsohn, P. M., Seeley, J. R., Roberts, R. E., & Allen, N. B. (1997). Center for Epidemiologic Studies Depression Scale (CES-D) as a screening instrument for depression among community-residing older adults. *Psychology and Aging, 12*(2), 277–287.

MacLean, M. G., Embry, L. E., & Cauce, A. M. (1999). Homeless adolescents' paths to separation from family: Comparison of family characteristics, psychological adjustment, and victimization. *Journal of Community Psychology, 27*(2), 179–187.

Mallett, S., Rosenthal, D., & Keys, D. (2005). Young people, drug use and family conflict: Pathways into homelessness. *Journal of Adolescence, 28*(2), 185–199.

Marshall, E. J., & Bhugra, D. (1996). Services for the mentally ill homeless. In D. Bhugra (Ed.), *Homelessness and mental health* (pp. 99–109). New York, NY: Cambridge University Press.

Marshall, R. D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *American Journal of Psychiatry, 158*(9), 1467–1474.

McCarthy, B., & Hagan, J. (2001). When crime pays: Capital, competence, and criminal success. *Social Forces, 79*(3), 1035–1060.

McKinney-Vento Homeless Education Assistance Improvement Act of 2001, 42 U.S.C. §§ 11431-11435 (2015).

Molnar, B. E., Shade, S. B., Kral, A. H., Booth, R. E., & Watters, J. K. (1998). Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse & Neglect, 22*(3), 213–222.

Mounier, C., & Andujo, E. (2003). Defensive functioning of homeless youth in relation to experiences of child maltreatment and cumulative victimization. *Child Abuse & Neglect, 27*(10), 1187–1204.

Noell, J., Rohde, P., Seeley, J., & Ochs, L. (2001). Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents. *Child Abuse & Neglect, 25*(1), 137–148.

Oetting, E. R., Beauvais, F., & Edwards, R. (1998). Alcohol and Indian youth: Social and psychological correlates and prevention. *Journal of Drug Issues 18(*1), 87–101.

Park, J. M., Metraux, S., & Culhane, D. P. (2005). Childhood out-of-home placement and dynamics of public shelter utilization among young homeless adults. *Children and Youth Services Review, 27*(5), 533–546.

Patel, D. R., & Greydanus, D. E. (2002). Homeless adolescents in the United States: An overview for pediatricians. *International Pediatrics, 17*(2), 71–75.

Peled, E., Spiro, S., & Dekel, R. (2005). My home is not my castle: Follow-up of residents of shelters for homeless youth. *Child and Adolescent Social Work Journal, 22*(3–4), 257–279.

Pennbridge, J., Yates, G., David, T., & MacKenzie, R. (1990). Runaway and homeless youth in Los Angeles County, California. *Journal of Adolescent Health Care, 11,* 159–165.

Pergamit, M., Cunningham, M., Burt, M., Lee, P., Howell, B., & Bertumen, K. (2013a). Counting homeless youth: Promising practices from the Youth Count! Initiative. Retrieved December 9, 2015, from http://www.urban.org/publications/412876.html

Pergamit, M., Cunningham, M., Burt, M., Lee, P., Howell, B., & Bertumen, K. (2013b). *Youth Count! process study.* Retrieved October 7, 2015, from http://www.urban.org/research/publication/youth-count-process-study/view/full_report

Quintana, N. S., Rosenthal, J., & Krehely, J. (2010). *On the streets: The federal response to gay and transgender youth.* Retrieved December 9, 2015, from https://cdn.americanprogress.org/wp-content/uploads/issues/2010/06/pdf/lgbtyouthhomelessness.pdf

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385–401.

Ray, N. (2006). *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness.* Retrieved December 9, 2015, from http://www.thetaskforce.org/static_html/downloads/HomelessYouth.pdf

Reid, P., & Klee, H. (1999). Young homeless people and service provision. *Health & Social Care in the Community, 7*(1), 17–24.

Remafedi, G. (1987). Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics, 79*(3), 331–337.

Riley, D. B., Greif, G. L., Caplan, D. L., & MacAulay, H. K. (2004). Common themes and treatment approaches in working with families of runaway youths. *The American Journal of Family Therapy, 32*(2), 139–153.

Robert, M., Pauzé, R., & Fournier, L. (2005). Factors associated with homelessness of adolescents under supervision of the youth protection system. *Journal of Adolescence, 28*(2), 215–230.

Robertson, M. J. (1991). Homeless youth: An overview of recent literature. In J. H. Kryder-Coe, L. M. Salamon, & J. M. Molnar (Eds.), *Homeless children and youth: A new American dilemma* (pp. 33–68). New Brunswick, NJ: Transaction Publishers.

Robertson, M. J., & Toro, P. A. (1999). Homeless youth: Research, intervention, and policy. In L. B. Fosburg & D. L. Dennis (Eds.), *Practical Lessons: The 1998 National Symposium on Homelessness Research* (pp. 3-1–3-32). Washington, DC: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services.

Rosario, R., Schrimshaw, E. W., & Hunter, J. (2012). Risk factors for homelessness among lesbian, gay and bisexual youths: A developmental milestone approach. *Children and Youth Services Review, 34,* 186–193.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Rossi, P. H., Wright, J. D., Fisher, G. A., & Willis, G. (1987). The urban homeless: Estimating composition and size. *Science, 235,* 1336–1341.

Rotheram-Borus, M. J., Mahler, K. A., Koopman, C., & Langabeer, K. (1996). Sexual abuse history and associated multiple risk behavior in adolescent runaways. *American Journal of Orthopsychiatry, 66,* 390–400.

Runaway and Homeless Youth Act of 2008, 42 U.S.C. §§ 5701-5752 (2015).

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 123–346.

Ryan, K. D., Kilmer, R. P., Cauce, A. M., Watanabe, H., & Hoyt, D. R. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse & Neglect, 24*(3), 333–352.

Salganik, M. J., & Heckathorn, D. D. (2004). Sampling and estimation in hidden populations using respondent-driven sampling. *Sociological Methodology, 34,* 193–239.

Schweitzer, R. D., Hier, S. J., & Terry, D. (1994). Parental bonding, family systems, and environmental predictors of adolescent homelessness. *Journal of Emotional and Behavioral Disorders, 2*(1), 39–45.

Slesnick, N., Dashora, P., Letcher, A., Erdem, G., & Serovich, J. (2009). A review of services and interventions for runaway and homeless youth: Moving forward. *Children and Youth Services Review, 31*(7), 732–742.

Slesnick, N., Kang, M. J., Bonomi, A. E., & Prestopnik, J. L. (2008). Six- and twelve-month outcomes among homeless youth accessing therapy and case management services through an urban drop-in center. *Health Services Research, 43*(1), 211–229.

Solorio, M. R., Milburn, N. G., Weiss, R. E., & Batterham, P. J. (2006). Newly homeless youth STD testing patterns over time. *Journal of Adolescent Health, 39*(3), 443.e9–443.e16.

Stewart B. McKinney Homeless Assistance Act of 1987, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 42 U.S.C. §§ 11301 – 11481 (2015).

Sullivan, P. M., & Knutson, J. F. (2000). The prevalence of disabilities and maltreatment among runaway children. *Child Abuse & Neglect, 24*(10), 1275–1288.

Thompson, S. J., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: Perceptions of services and providers by homeless young adults. *Evaluation and Program Planning, 29*(1), 34–43.

Thompson, S. J., Pollio, D. E., & Bitner, L. (2000). Outcomes for adolescents using runaway and homeless youth services. *Journal of Human Behavior in the Social Environment, 3*(1), 79–97.

Thompson, S. J., Safyer, A. W., & Pollio, D. E. (2001). Differences and predictors of family reunification among subgroups of runaway youths using shelter services. *Social Work Research, 25*(3), 163–172.

Toro, P. A., Dworsky, A., & Fowler, P. J. (2007). Homeless youth in the United States: Recent research findings and intervention approaches. In D. Dennis, G. Locke, & J. Khadduri (Eds.), *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research* (pp. 6-1–6-33). Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development.

Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology, 32*(3–4), 305–317.

Tyler, K. A., Hoyt, D. R., Whitbeck, L. B., & Cauce, A. M. (2001). The impact of childhood sexual abuse on later sexual victimization among runaway youth. *Journal of Research on Adolescence, 11*(2), 151–176.

Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce, A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence, 19*(5), 503–520.

U.S. Census Bureau, U.S. Department of Housing and Urban Development, & U.S. Interagency Council on the Homeless. (1990). *Conference proceedings for Enumerating Homeless Persons: Methods and Data Needs.* Retrieved December 9, 2015, from http://files.eric.ed.gov/fulltext/ED332076.pdf

Van Leeuwen, J. M., Hopfer, C., Hooks, S., White, R., Petersen, J., & Pirkopf, J. (2004). A snapshot of substance abuse among homeless and runaway youth in Denver, Colorado. *Journal of Community Health, 29*(3), 217–229.

Votta, E., & Manion, I. G. (2003). Factors in the psychological adjustment of homeless adolescent males: The role of coping style. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(7), 778–785.

Whitbeck, L. B., Chen, X., Hoyt, D. R., Tyler, K. A., & Johnson, K. D. (2004). Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *The Journal of Sex Research, 41,* 329–342.

Whitbeck, L. B., & Crawford, D. M. (2009a). Substance abuse patterns among homeless and runaway adolescents across time. In L. B. Whitbeck (Ed.), *Mental health and emerging adulthood among homeless young people* (pp. 91–106). New York, NY: Psychology Press.

Whitbeck, L. B., & Crawford, D. M. (2009b). Health and services utilization. In L. B. Whitbeck (Ed.), *Mental health and emerging adulthood among homeless young people* (pp. 171–186). New York, NY: Psychology Press.

Whitbeck, L. B., & Hoyt, D. R. (1999). *Nowhere to grow: Homeless and runaway adolescents and their families.* New York, NY: Aldine de Gruyter.

Whitbeck, L. B., Hoyt, D. R., & Ackley, K. A. (1997). Abusive family backgrounds and later victimization among runaway and homeless adolescents. *Journal of Research on Adolescence, 7*(4), 375–392.

Whitbeck, L. B., Hoyt, D. R., & Bao, W. N. (2000). Depressive symptoms and co-occurring depressive symptoms, substance abuse, and conduct problems among runaway and homeless adolescents. *Child Development, 71*(3), 721–732.

Whitbeck, L. B., & Simons, R. L. (1993). A comparison of adaptive strategies and patterns of victimization among homeless adolescents and adults. *Violence and Victims, 8*(2), 135–152.

Wright, J., & Devine, J. A. (1992). Counting the homeless: The Census Bureau's "S-Night" in five cities. *Evaluation Review, 16,* 355–64.