THE FORGOTTEN CHILDREN

Unaccompanied Runaway and Homeless Youth

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Executive Summary

Runaway and homeless youth are one of the most vulnerable populations worldwide. Among minor street-living youth, 90% are between 16-17 years old. These youth are most often disconnected from family, and underserved by communities, left to fend for themselves on the fringes of our society. With limited rights and privacy, they have little access to services and supports needed to survive independently. Providers also experience legal barriers in serving youth, as well as limited guidance for interventions and from policy. Intervention recommendations, including outreach, drop-in centers, housing and support services are discussed in this paper. Randomized clinical trials are needed to confirm the efficacy of chosen intervention approaches in order to guide effective policy recommendations. However, in order to increase access to services, state laws need to expand services and supports to youth, and mandatory reporting laws for homeless youth need to be modified. Language of delinquency, runaway and curfew laws needs to be amended to protect agencies that serve these youth. Further, youth need to be added to local communities' plans to end homelessness, and state and local agencies should review and amend policies that may be barriers to serving unaccompanied homeless youth.

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By the age of eighteen years, 18 percent of US children will leave home overnight without their parents' permission or run away. Many of these children (40 percent) will run away more than one time, which is a significant risk factor for homelessness in adulthood. Running away from home is not a rare event, and it is associated with a range of correlated problems, including dropping out of school, alcohol and drug use, depression/suicide, and teenage pregnancy. Runaways, also referred to as homeless youth, who do not seek shelter services live directly on the streets or in abandoned buildings or couch surf among friends' homes. Living on the streets is associated with high mortality rates; runaway and homeless youth are 12 times more likely to die than housed youth are. Usual causes of death are untreated illness, suicide or assault. In Columbus, Ohio, it is conservatively estimated that 1,500 unaccompanied youth will experience homelessness annually.

Twenty-one to 60 percent of runaway and homeless youth report that they experience physical and/or sexual abuse.

Many think youth leave home to seek adventure, or because they do not want to follow the rules that parents have set for them. Perhaps this idea is perpetuated by popular lore, for instance, the novel *Tom Sawyer* (Twain, 1876). This novel depicts Tom and Huckleberry Finn leaving home to become pirates and experiencing a series of adventures along the way. However, the book also describes Huck Finn's father as the town "drunk," who locks Huck in the cabin when he leaves and beats him when he returns. Huck leaves home because he is tired of his confinement and fears the beatings will worsen. *Tom Sawyer* was written in 1876, but even today runaways report that a conflictual family environment is the primary reason they leave home. In fact, 21 to 60 percent of runaway and homeless youth report that they experience physical and/or sexual abuse. Therefore, modern-day runaways are usually running from, rather than toward, something. In addition, a large proportion of runaway and homeless youth (30 percent) are asked to leave home ("throwaways" or "push-outs") because their parents are unwilling or unable to care for them (e.g., because of alcohol or drug use, the youth is gay, lesbian, bisexual or transgendered, or because of mental health problems). Given the prevalence of runaway and homeless youth, and the significant health and social concomitants, intervention and policy efforts focused on preventing and ending homelessness should be a top priority of local, state and federal governments as well as the community. This paper explores the link between policy and intervention for runaway and homeless youth, culminating in specific intervention and policy recommendations, especially for the state of Ohio, for ending homelessness among our youth.

Intervention and Policy

History

From the 1600s to the 1800s, runaways were some of the first immigrants to the United States. They left impoverished and oppressed conditions to seek their fortunes in America. Before and after the Civil War, children from poor families left home to seek employment in industrial plants. Many ended up on street corners when they were not needed in the plants. Child labor and indentured servitude were acceptable sources of labor at the time. By the end of the 1800s, the government had become increasingly involved in runaway behavior, and cultural norms shifted to children being viewed as dependent on their parents and needing supervision. When parents could not provide for their children, they were placed in alternative living situations. This change in norms led to the development of special judicial institutions to manage "troublesome youth." Reform schools in the late 1800s were similar to prisons, and runaways were regarded as delinquents. In the 1930s, the Great Depression saw an upsurge in the number of runaways and those who left with the consent of their financially struggling parents. At this time, the police and juvenile courts had primary responsibility for addressing the problem of runaway teens, and a shift away from considering runaways as incorrigible delinquents began. Instead, individual pathology was considered the cause of running away. This is significant because conceptualizations of the etiology of running away tend to guide the interventions employed. Running away among teens occurred, but was not well publicized, into the 1940s and 1950s, when training schools and mental hospitals became the primary interventions to address the problem. However, by the 1960s, running away reached middle- and upper-income families, and research began to document reasons that youth run away. In 1968, the American Psychiatric Association categorized running away as a behavior disorder, the "runaway reaction," and in 1974, US Congress passed the first legislation focused on runaways: the Runaway Youth Act. Running away was now an issue for middle America.

Current

Although the "runaway reaction" was removed as a mental disorder in 1980, youth who run away from home today can be taken into custody by law enforcement in virtually every state. Running away is a status offense in eleven states. The criminalization of running away dates back to the late 1800s, when it was perceived as a delinquent behavior. Recently, the Coalition for Juvenile Justice (CJJ) has cited research showing that status offense behaviors (e.g., running away, truancy, and curfew violation) are often the result of unmet child and family needs, and that pushing these youth into the juvenile justice system leads to worse individual and community outcomes. The CJJ urges system reform and the implementation

of research-supported policies, programs, and practices that effectively meet the needs of youth, their families, and the community, without involvement of the juvenile justice system (CJJ, 2009).

Today, runaway and homeless youth programs are authorized by the Runaway and Homeless Youth Act (Juvenile Justice and Delinquency Prevention Act, Pub. L. No. 93-415, 88 Stat. 1109 [1974] [title 42, section 5601 et seq.]), as amended by the Runaway, Homeless, and Missing Children Protection Act of 2003 (Pub. L. No. 108-96). Congress funds programs to prevent victimization of homeless youth and seeks to ensure access to education, employment training, healthcare, drug and alcohol treatment, and other social services. The Basic Center Program provides grants to support emergency shelters for youth. The Street Outreach Program was written to support street-based outreach and education to runaway, homeless, and street youth, many of whom have been sexually abused or are at risk of sexual abuse. Recognizing that many youth cannot, or will not, return home and that shelters cannot provide a long-term solution to homelessness, Congress created the Transitional Living Program (TLP) for older homeless youth as part of the 1988 amendments to the Juvenile Justice and Delinquency Prevention Act of 1974. The first TLP for homeless youth (ages sixteen to twenty-two) was funded in 1990. Most of the TLP programs are underfunded, and states are given the flexibility to assign rules to the housing, which are often so restrictive (e.g., abstinence-based housing) that most street-living youth cannot follow them.

Aside from the federal statutes allocating funding to runaway and homeless youth programs, local policies are detailed within cities' ten-year plans to end homelessness. In recent years, more than three hundred communities have developed such plans. Unfortunately, few cities have included homeless youth within them. For example, Columbus, Ohio, has not included homeless youth in their plans to end homelessness. As such, Columbus, which is the fifteenth largest city in the nation, has limited services available focused on engaging homeless youth and ending homelessness. In 2009, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act mandated that the US Interagency Council on Homelessness (USICH) produce a "national strategic plan." Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (USICH, 2010) includes goals to end veteran and chronic homelessness by 2015, and to end homelessness among children, families, and youth by 2020. Among youth specifically, the plan notes the importance of providing individual goal setting, linkage to ongoing support services connected to mainstream resources, independent living skills training, housing, connection to supportive adults and networks, employment, and education. However, a dearth of research limits knowledge on how best to intervene with these youth, as well as the effectiveness of policies focused on ending youth homelessness, especially at the local level.

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Many have argued that policy should be evidence based. According to the World Health Organization, evidence-informed health policy-making is characterized by systematic and transparent access to, and appraisal of, evidence as an input into the policy-making process. In practice, few evidence-based interventions guide policy. However, the Coalition for Evidence-Based Policy (CEBP) Top Tier Initiative states that "well-designed and implemented randomized controlled trials (RCT), preferably conducted in typical community settings, and that produce sizable, sustained benefits to participants and/or society, can assist policy officials in their decision making process." (CEBP, 2008) The coalition only identified one such evidence-based intervention-guiding policy for those experiencing homelessness. The "Critical Time Intervention" is a case management program to prevent recurrent homelessness among adults with severe mental illness. In addition, according to Stanhope and Dunn (2011), "the purpose of research is both to increase the accountability of government policies in relation to effectiveness, and also to identify areas of improvement" (275). Therefore, intervention research, including RCTs, is an important vehicle to offer necessary evidence for policy makers.

The Problem

Even though research, especially RCTs, should inform policy decisions for how best to intervene in youth homelessness, few studies have been conducted, which has led to a lack of evidence to guide policy making. Also, more research is needed to support the use of current federally funded programming: runaway shelters and outreach and independent living programs. Although research on the reasons for running away began to appear in the 1960s, it was not until the 1990s that the first intervention study was published. This study tested an HIV-prevention intervention for runaway teenagers (Rotheram-Borus et al. 1991). In the twenty-three years since that trial, a small number of investigators have sought to identify methods to improve the lives of runaway and homeless youth and their families. A literature review identified fourteen intervention studies that focused on a wide range of outcomes and subpopulations (shelter recruited, street recruited) using randomized and nonrandomized designs, as well as six service evaluations, five international studies, and seven qualitative studies (Slesnick et al. 2009). Many times, interventions focus on a single outcome, such as HIV risk or substance use. In order to end youth homelessness, it is important to know effective strategies and interventions that comprehensively address the multiple needs of homeless youth.

Mandatory reporting for unaccompanied homeless minors creates a system in which youth avoid care in order to avoid being returned home or reported to child protective services.

A practical barrier to effectively ending homelessness among youth is that unaccompanied homeless minors do not have legal authority to engage in contracts, consent for their own treatment or medical care, or obtain an identification card, limiting access to needed services and supports. And agencies that serve homeless minors are at risk for being charged with contributing to the unruliness or delinquency of a minor, interference with the custody of a minor, and harboring a minor runaway. Similarly, although homelessness, in itself, is not an automatic reporting event in Ohio, the Ohio Revised Code § 2152.421 mandates reporting of abuse or neglect. So homelessness caused by either of those two actions needs to be reported. Mandatory reporting for unaccompanied homeless minors, 91 percent of whom are between sixteen and seventeen years old, creates a system in which youth avoid care in order to avoid being returned home or reported to child protective services. Homeless minors rarely perceive the child welfare system or parents as reasonable sources of protection, usually because of repeated betrayals or abuse.

Intervention Recommendations

In addition to policy gaps and legal barriers, evidence to guide practice is lacking. Few would deny that in order to end homelessness among youth, housing is essential. However, before housing can be offered, youth have to be identified and engaged into services, as many youth are hiding on the streets from the service system. Ensign and Gittelsohn (1998) report that when homeless youth do seek assistance, they prefer clinics that cater to the needs of homeless youth and rarely seek care at clinics that serve homeless adults. The researchers note that homeless youth avoid adult shelters and services because they are often preyed on by the older homeless adults (ibid.). Until recently, Columbus, Ohio, did not have targeted services available to address homelessness among youth, and street-living homeless youth had the choice of using the local runaway shelter or going into child welfare. As in other cities around the country, most street-living youth avoid both options and remain hidden and at risk on the streets. The current system of care, shelters, and child welfare/foster care does not meet the needs of all street-living youths, and evidence-based, viable, and acceptable alternatives are needed. Below, comprehensive best-practice options are reviewed and recommendations are offered that are based on the available research.

Outreach

Trust and relationship building are central components of outreach services for homeless youth.

Outreach involves contacting/engaging individuals within nonoffice settings. Homeless service providers converge on the conclusion that outreach is the first step toward engaging homeless populations with more intensive intervention (Chamberlain and MacKenzie 2004; Tsemberis and Elfenbein 1999; Woods et al. 2002). Through the Runaway and Homeless Youth Act, Congress funds the Street Outreach Program. However, few recent studies have tracked the success of outreach or provided guidance on successful outreach strategies. Research on outreach programs appears to have peaked in the 1990s. While some studies report the successful efforts of outreach teams in identifying and engaging high-risk and hidden adults into HIV-prevention programs (Andersen et al. 1998; Cunningham-Williams et al. 1999) and severely mentally ill homeless adults into housing (Johnsen et al. 1999; Tsemberis and Elfenbein 1999), only one study (Gleghorn et al., 1997) was identified that reported outreach efforts with homeless youth, with the goal of engaging youth with an HIV-prevention intervention. Gleghorn et al. (1997) reported that 58 percent of homeless youth who met an outreach worker utilized HIV-prevention services. Trust and relationship building are central components of outreach services. Gleghorn et al. (1997) noted that some of the youth who engaged into services had many contacts with an outreach worker prior to enrollment, suggesting that trust building was occurring. Some studies indicate

that individuals who are homeless distrust outreach workers because outreach workers are perceived to deliver empty promises and to not be genuinely motivated to assist them (Kryda and Compton 2009). Therefore, the task of developing a relationship with the client should be the focus of outreach, not as a prelude to dealing with goals, skills, and supports, but as a central aspect of the outreach program (Goering et al. 1997). Following a strengths-based model of case management, "Finding housing and income were typical initial client goals. Reconnecting to social supports and obtaining suitable treatment were usually subsequent goals" (Goering et al. 1997, 609). A strengths-based model of case management (Rapp 1993) emphasizes the relationship between the case manager/outreach worker and the client, includes a focus on strengths rather than pathology, and utilizes interventions that are client driven with aggressive outreach as the preferred method. This approach appears to be particularly potent with those experiencing homelessness.

Drop-In Centers

Identification and engagement of youth require outreach; they also require an accessible place for youth where they can build trust to engage in more intensive services. Drop-in centers offer a place for homeless youth to develop supportive relationships, and they serve as a bridge between the streets and more traditional and intensive services. The centers provide basic needs, such as food, showers, a washer and dryer, and clothing, and have few demands and rules. Although not many studies detail the efficacy of drop-in centers, drop-in centers likely ease the challenge of meeting engagement and, ultimately, reintegration goals. These centers are more acceptable to youth and are more likely to successfully engage difficult-to-engage homeless youth into intensive services than runaway shelters are because they are low demand and focus on building trust (Robertson and Toro 1999; Slesnick et al. 2008). Given the barriers to service engagement, drop-in centers offer an opportunity to provide youth with access to multiple services. A one-stop shop, in which multiple agencies offer services such as medical care, HIV testing, job training, education, prenatal care, legal services, mental health/substance use intervention, and so on, overcomes barriers associated with a fragmented system of care. Bringing services to the youth also overcomes barriers of lack of transportation and trust. Drop-in centers may be critical in preventing continuing homelessness into adulthood, and could serve as the "front door" to other needed services for this population.

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One of the biggest challenges associated with drop-in centers is funding. Most drop-in centers are open for limited hours and staffed by volunteers. In Columbus, the Ohio State University's College of Education and Human Ecology opened a research-based drop-in center in October 2006 named Star House. In 2013, Star House had served 531 unduplicated homeless youth but was on the verge of shutting down given the lack of local funding.

In response, an effort was made to educate the community regarding the homeless youth problem. The Ohio Attorney General's Office (Mike DeWine) provided a Victims of Crime Grant to the Star House in the spring of 2013. Also, state representatives, Cheryl Grossman and Mike Stinziano, championed an amendment to the State Budget Bill approved by Governor John Kasich that included funding for Star House.

Star House is the only research-based drop-in center for youth in the country. Research indicates that drop-in centers ease engagement into more intensive services and that youth who utilize more intensive services within the drop-in, including case management and mental health/substance use counseling, report significantly reduced homelessness, alcohol and drug use, depressive symptoms and victimization experiences event to one year post-baseline.

Housing

Most of the information on the impact of housing interventions, such as supportive housing, relates to homeless adults with mental illness. The Housing First Model is designed to empower clients and is structured with few demands, as recommended by several homeless youth researchers (e.g., De Rosa et al. 1999; Robertson 1991). Housing First was developed by Pathways to Housing to provide immediate access to independent apartments and supportive services for vulnerable, chronically homeless individuals, without any prerequisites for sobriety or participation in psychiatric treatment (Tsemberis and Asmussen 1999). The central tenet of Housing First is that consumers have choice/control over "where they live, how they live, who they allow to live with them, who enters the home, to abstain from substance use or not, to comply with treatment demands or not, and the support that they receive" (Greenwood et al. 2005, 225). Unlike Housing First, "most programs have rules that restrict clients' choices (e.g., abstinence) and that when violated are used as grounds for discharging the client" (Tsemberis, Gulcur, and Nakae 2004, 651). Therefore, Housing First is consumer driven, especially in regard to the ability of the client to have choice.

Research supports the connection between housing choice and maintaining housing, mental and physical health, and life satisfaction.

Empowerment theory (Zimmerman 2000) focuses on how individuals are able to increase perceived and actual control in their lives. Nelson, Aubry, and Lafrance (2007) applied this theory to Housing First by suggesting that choice in housing provides an empowering setting that should lead to a sense of personal control (self-efficacy) and better outcomes. Research supports the connection between housing choice and maintaining housing, mental and physical health, and life satisfaction (Nelson, Aubry, and Lafrance 2007; Srebnik et al. 1995; Tsemberis, Gulcur, and Nakae 2004). Housing First has shown success with homeless adults (Tsemberis, Gulcur, and Nakae 2004; Padgett, Gulcur, and Tsemberis 2006), and cities are beginning to include it within their strategies to end homelessness. However, its effectiveness with youth is not known. Other unknowns include how much housing support is needed for youth to maintain their housing independently.

Support Services

Given that fragmentation of service provision is a significant barrier for homeless individuals to receive the care they need, one response is to implement a fully integrated treatment model in which a unitary system of care is provided (e.g., case management integrated with substance use/mental health treatment, employment, and education, offered by one counselor), as recommended by several researchers (Drake et al. 2004; Kasprow et al. 1999; Zerger 2002), rather than a model linking individuals to various care providers in a parallel fashion. When providing these services, the US Administration for Children Youth and Families, which administers the funds for basic centers, outreach, foster care, and independent living programs, underscores the importance of utilizing concepts of Positive Youth Development in communities' efforts to serve those youth. This concept focuses on building up positive influences in youths' lives, especially with the goal of helping them transition off the streets, and it is in contrast to a deficit model approach. The predominantly used deficit model focuses on ameliorating identified deficits in the individual (alcohol/drug use, HIV risk, mental health, etc.), and it often ignores an individual's strengths, as well as resources and supports in the youth's environment that can be accessed and leveraged. Furthermore, any intervention for homeless youth must be developmentally appropriate and recognize that youth are not miniature adults. This can be difficult and confusing to providers as homeless youth can appear adultlike, having obtained premature independence with adult-level concerns, activities, and behaviors. Nonetheless, interventions must recognize the developmental tasks and struggles of these youth (e.g., identity and sexual development, relationship negotiation, and so on).

Policy Recommendations

Some have concluded that the cultural shift in the late 1800s to children as dependent on their parents for care also resulted in the loss of rights and privacy for minors. Society assumes that children under eighteen do not need rights because their parents, or child welfare, will protect them. In fact, tens of thousands of unaccompanied homeless youth in our country do not have the protection of their parents or child welfare. Without a parent or guardian's approval, a youth cannot receive medical care, obtain an identification card needed for employment and housing, enter a shelter, or receive services. These are basic steps that would allow a youth to survive independently in his or her community. Without laws to provide them with rights, these youth lack access to appropriate services they need to be safe and stable. Because state laws differ in regard to runaway and homeless youth, the following recommendations are intended for the state of Ohio.

1. A state law is needed that expands the services and supports available to unaccompanied homeless minors (such as allowing minor youth to consent to ongoing talk therapy and medical care and to independently obtain an identification card) and modifies mandatory reporting laws for older unaccompanied homeless youth.
2. Language of current delinquency, runaway, and curfew laws needs to be amended to protect agencies that serve these youth.
3. Youth need to be added to local communities' plans to end homelessness so that funding and coordinated comprehensive services to end homelessness among youth can begin. Government agencies, nongovernmental organizations, and communities working together will have much greater success preventing chronic homelessness into adulthood than any well-intended individual or community effort working alone will.
4. Policies guiding intervention should be based on best-practice options, and research providing evidence supporting the effectiveness of these practice options should be funded.
5. State and local agencies should review and amend policies that may be barriers to serving unaccompanied homeless youth.

Conclusions

Unaccompanied homeless youth are America's forgotten children. Runaway shelters and child welfare (e.g., foster care) are not viable or acceptable options for many homeless youth. These youth hide on the streets from a system that has not served them and from parents who have not protected them. They are left to fend for themselves on the fringes of society, surviving through any means available to them. Homeless youths' survival skills parallel those of adults, yet they survive without many of the rights and social status available to adults. Homeless youth rarely access services, and providers rarely serve homeless youth partially because of the multiple legal barriers and lack of intervention guidance and policies on their behalf.

Kofi Annan, former Secretary-General of the United Nations, stated, "Young people should be at the forefront of global change and innovation. Empowered, they can be key agents for development and peace. If, however, they are left on society's margins, all of us will be impoverished. Let us ensure that all young people have every opportunity to participate fully in the lives of their societies" (Annan, 2001). In light of limited RCTs assessing comprehensive intervention components to end homelessness, practice recommendations, based on available evidence, were offered in this paper. Recommendations were made to amend state of Ohio laws to increase the rights and privacy of homeless minors and to protect agencies that seek to serve these forgotten children. Local policies tied to funding should include plans to end homelessness among youth. These policies need to address barriers to serving youth and should be based on evidence-based or best-practice options, with research, especially RCTs, guiding policy recommendations.

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About the Crane Center for Early Childhood Research and Policy (CCEC)

Established in 2013, the Crane Center for Early Childhood Research and Policy (CCEC) is housed within The Ohio State University's College of Education and Human Ecology. The mission of the CCEC is to stimulate research and influence practices and policies that enhance the well-being of children, with respect to their cognitive, social-emotional, and physical development.

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