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Subgroups of the Homeless: Street Kids

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Street kids are a feature of many cities, but only recently have they been included among the homeless. They were defined as runaways, throwaways, or youth in crisis. They had a place to live, even if it was a foster or group home or an institutional setting. However, many are without shelter at one time or another and face the same problems as the chronic homeless: the need for food and shelter, avoidance of victimization, and help for personal problems. In 1988, the National Institute of Mental Health funded three national demonstration projects on adolescent homelessness. We report findings from one of those, in Portland, Maine. The focus was individual, organizational, and systemic dimensions of the problem and how public policy can be responsive to the needs of this subgroup of the homeless.

Homelessness faces many different subgroups in the population. Before the 1980s, it was primarily a characteristic of older males, usually with drinking problems. They inhabited the skid rows and railyards of the nation. Over the next decade, social trends combined to create a much larger number of homeless and added entirely new groups. The deinstitutionalization of large state mental hospitals, which began in the 1960s, put many individuals on the street. A large percentage had serious mental health problems and minimal independent living skills. The Reagan era cutbacks in social services, particularly in the area of public housing, added a new homeless group: families with children. Owing to higher divorce rates, AFDC regulations, and the difficulty of maintaining the nuclear family in inner-city areas, many of the households were headed by females. These families represented the increasing "feminization of poverty."[1]

Children are usually discussed within the context of homeless families. They range in age from infancy to their early teens. By the late 1980s, one third of the homeless

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population were family members. Children constituted the fastest growing group among them.[2]

There is another subpopulation of homeless children about whom much less is known. This group consists of teenage adolescents, collectively known as street kids. They have many of the same problems as children in homeless families, especially in terms of their cognitive and social development. At the same time, they present different problems. A significant number come from abusive homes and have the personal problems that typify children from such an environment. Younger children in shelters, despite the difficulties of the setting, have the advantage of living within a nuclear family. Street kids do not enjoy this stabilizing influence — they have to face the full brunt of street existence on their own. Many have substance-abuse problems, are victims of sexual and physical violence, and have arrest and jail records stemming from street life.

Estimating the number of homeless is difficult. The obvious method, nightly shelter counts, provides some data, but does not include persons sleeping on the streets and other public places. For homeless street kids, the same problem exists. They present added difficulties since they frequently cycle from natural home, to an institution like a corrections center, then to the streets, and finally home again. For the short period they are on the streets, they are homeless, even if on a situational, not permanent basis.

Estimates about their number vary, but figures from accepted organizations suggest that the magnitude of the problem is significant. In 1985, the American Youth Work Center and the National Network of Runaway and Youth Services placed the total at 500,000.[3]

Studies emphasize the limited knowledge on this group. This generalization applies to all homeless children, but is even truer for adolescents. They are an extremely mobile group, making it hard to develop contacts for research purposes. Many have an inherent distrust of adults, further complicating the problem of data collection. The difficulties are compounded by definitional issues. Until recently, homeless children and adolescents were grouped with runaways.[4] Important dimensions of their lives remain unstudied:[5]

1. Health (birth outcomes, nutritional status, immunization status, lead levels, illnesses, access to health care)
2. General development (cognitive and social development, parent-child interaction, child abuse and neglect)
3. Education (school attendance, grade retention, special education, academic performance)

The small amount of existing research focuses primarily on the adolescent homeless in large urban areas. Only one major study examines youth who reside in smaller metropolitan areas. The findings indicate that they face the same risks as those in larger cities.[6]

The New England region has many smaller urban centers. In Maine, Vermont, and New Hampshire, no metropolitan standard area (MSA) has a population larger than 367,000, and two have fewer than 100,000.[7] Major studies have been conducted in the region's larger cities; for example, the pioneering work of Bassuk and Rubin on homeless families was done in Boston.[8] Far less is known about the problems of homeless children in New England's smaller urban areas.

This paper is based on the experiences of the Portland, Maine, Homeless Children's Mental Health Project. Portland, a middle-size city with a population of 62,670 in a metropolitan region of 205,700, presents an opportunity to investigate the challenges of adolescent homelessness in a small New England metropolitan area. We first discuss intervention. Next comes a short description of Portland's street kids. Finally, we analyze the service demands in responding to this group.

The Portland Homeless Children's Intervention

In December 1987, the Maine Department of Mental Health and Mental Retardation applied to the National Institute of Mental Health (NIMH) for funds to establish a mental health project for homeless adolescents. Funded in May 1988, along with two other projects in Vermont and the District of Columbia, it provided mental health and substance-abuse counseling, rehabilitation services, and case management to homeless youth in the Greater Portland area.

Drawing on documented needs and community expertise, the grant-writing team identified the major gaps in the system, which are listed in Table 1. The most glaring problem in Portland was the absence of a comprehensive community mental health center, a facility that could serve to coordinate and deliver the complex array of treatment services required by homeless youth. An additional constraint was the lack of data on the characteristics and service needs of this population. Even if a comprehensive program were in place, the limited information would have made it difficult to meet the full range of needs faced by homeless youths. Other problems were limitations of the shelter system, inadequate housing alternatives, few resources to aid youths in developing independent living skills, and a lack of interagency collaboration.

The city's Committee on Homeless Adolescents developed a twofold approach to addressing some of these needs. It successfully pursued state funding through the Department of Human Services to establish a low-barrier "safety net" shelter for homeless adolescents. The shelter met the number 1 and 2 needs listed in Table 1.

The city and state successfully joined forces to obtain funds from NIMH. These moneys, along with some from the Maine Office of Alcohol and Drug Abuse Prevention and Bureau of Children with Special Needs, funded the Portland project. This joint effort addressed the treatment, collaboration, and research problems identified in Table 1 (numbers 4, 6, and 10).

In the absence of a multiservice agency, which could have housed the project, it was necessary to hire a full staff. A director was named, employed by the Bureau of Children with Special Needs. The bureau, in turn, contracted with three nonprofit agencies to deliver services. Two therapists, one substance-abuse counselor, and one job rehabilitation specialist were hired. Their role was to function as a multidisciplinary team. Contracts were conditional on participation in the team, coordinated by the project director. A major challenge facing the project would be to foster the interagency collaboration required by this type of organizational design.

At a conceptual level, the intervention was designed to address a persistent obstacle in the delivery of human services. It is well documented that most systems lack integration, producing major gaps in services. The project focused squarely on this dimension, but as important, proposed to go substantially beyond it. It sought not only the coordination of services across agencies, but the design of a process that

Table 1

Gaps in Portland Homeless Adolescent Service System

1. A shortage of shelter beds (25 existing beds for some 200 homeless youth)
2. The inappropriateness or unacceptability of existing shelters for homeless "street" youth (youth's emotional/behavioral problems too severe; youth are "turned off" by structure, rules, parental consent requirements, of these programs)
3. Inadequate housing alternatives for older adolescents
4. Absence of mental health, substance-abuse, or crisis intervention screening, assessment and evaluation, and treatment services deliverable on site to severely emotionally disturbed homeless youth
5. Inadequate short-, medium-, and long-term mental health and substance-abuse inpatient or residential programs
6. Absence of a capacity to treat psychological (depression, anxiety disorders, post-traumatic stress syndrome from abuse, conduct disorder) and substance-abuse comorbidity
7. Absence of any mental health case management or community support services for youth
8. Inaccessibility and unavailability of personnel to ensure that older homeless youth gain appropriate educational, vocational, and independent living skills and employment
9. Lack of interagency and state-local collaboration on program development and delivery of mental health, substance-abuse, and rehabilitation services
10. Extremely limited data about the demographics, characteristics, treatment, and service needs of Portland's homeless youth

would require different staffs to act as a *multidisciplinary* team. In this way, gaps across different realms of knowledge and expertise would be bridged as well.[9]

More specifically, the intervention was designed to answer three major sets of questions, which reflect many of the concerns described at the beginning of this article.

1. What is known about homeless adolescents? What types of problems do they face? Are their problems in Portland, a middle-size city, similar or different from the large metropolitan areas in New England and the United States as a whole?

2. What service delivery challenges did the program face? How did it make contact with the youth? How were its mental health, substance-abuse, and job-training services delivered? What programmatic, staff, legal, and other types of hurdles had to be overcome?

3. What successes did the Project have in fostering interagency collaboration? Was it able to overcome the disciplinary barriers that existed among program staff?

The Homeless Adolescents in Portland

A specific goal of the project was to collect data on the street kids of Portland. As in most cities, facts on their personal problems, home environments, and service needs were virtually nonexistent. Anecdotal information from service providers was available, but provided little systematic guidance on the types of programs and approaches that were needed.

Data Collection

Four different agencies provided data on their adolescent clients. The recording instrument incorporated aspects of intake or screening forms used at the four programs. The original *n* for the study was 807. Removal of duplicate records reduced it by 24 percent to 614. This figure means that for the period of the data collection, one year (July 1, 1988 to June 30, 1989), more than six hundred youths sought services (food, shelter, counseling).

Prevalence of Homelessness

The McKinney Homeless Act states that any person who lacks shelter for a night is homeless.[10] While a starting point, the definition fails to consider the question of the frequency and duration of homeless episodes. Some persons are chronically homeless, that is, living in shelters and on the street for extended periods of time. Others may be homeless for short periods punctuated by stays with friends or relatives or in stable institutional settings.[11]

Defining adolescent homelessness is even more complicated. First, determination of the extent of situational versus chronic homelessness is necessary. Additionally, youth are on the streets for a variety of reasons. A frequent distinction is made between homeless adolescents and runaways. Some argue the characteristic which differentiates the groups is that homelessness is an involuntary condition. Runaways, in contrast, have made a choice to stay on the street.[12] If this contention is valid, some youths are on the street by choice whereas others have no other alternative. The term "throwaway" is often used to describe the latter individuals — they are on the street because their parents have thrown them out.

As in other cities, youth are on the streets of Portland for reasons other than homelessness. The agencies defined, at intake, just 13 percent as homeless. The number is in the middle of estimates made by other studies, in which figures range from 6 to 34 percent.[13] Youth were more likely to receive services for short-term personal and family problems (39 percent). Runaways constituted 25 percent of the population. Throwaways were only a small proportion, 3 percent, of the youth served by the agencies.

Portland shows greater differences from other cities in the origin of its street kids. Over a majority, 54 percent, are from outside the metropolitan area. These data contrast with other studies, in which the percentages from within the metropolitan region exceed 75 percent.[14] Situational homelessness may be higher in Portland because more youth are not from the immediate area. They lack ready access to the social supports provided by a home or institutional environment where they may previously have resided.

Despite the small number in Portland who are categorized as homeless, many are situationally homeless, that is, without permanent shelter for short periods. Data show that the youth are frequently on the streets. They have a history of multiple

residential placements, making them at risk of homelessness. Forty-four percent have five or more runaway episodes. Eighty-six percent have been in a shelter, foster care, group home, or residential treatment. Twenty percent have been in two of these settings and 22 percent in three or more.

The Problems of Portland's Street Kids

The major problems faced by Portland's youth mirror those of other adolescents on the streets of other cities. They include educational disabilities, involvement with the criminal justice system, disruptive home environments, substance abuse, and mental illness.

Education. The McKinney Homeless Assistance Act of 1987 states that homeless youth will have access to a "free, appropriate public education." This promise is far from fulfilled. Estimates vary on the number of homeless youths who actually attend school. In one study, reported figures on school enrollment ranged from as few as 43 percent to a high of 70 percent.[15] Even if the latter figure is correct, almost one-third are not receiving formal education. The consequences are obvious. These youths will be at a major competitive disadvantage in the job market, increasing the likelihood that they will remain homeless as they become adults.

Many Portland youth are not attending school. For the cases on which data are available (68%), 35 percent report that they do not go to school. This population also faces other educational hurdles. A significant number have handicapping conditions that affect their ability to perform in school. For the cases with complete information (missing data ranged from 54 to 75 percent), 22 percent have an educational handicap of some type. The most frequent condition is behavioral/emotional problems (49%). Many have special learning dysfunctions (30%). Problems with mental development or maturation account for 17 percent. The large number of missing values indicates the importance of more complete information on the educational needs of this population.

Special education problems are common for homeless adolescents nationwide. Evidence is accumulating that homelessness contributes to educational deficiencies. For homeless youths between five months and eighteen years, mental retardation and language delay rates were significantly higher than for the general population data.[16]

Justice System Involvement. Street life results in many confrontations with the criminal justice system. Drug use, prostitution, and beatings are common everyday occurrences. Findings from a survey of homeless adolescents in Hollywood, California, underscore the magnitude of this problem.[17] When asked their main source of income for the past thirty days, 37 percent cited illegal activities, among which were prostitution and drug dealing.

Portland's street youth have a similar history. Sixty-three percent have been charged with a criminal offense at one time or another. One issue, which the data do not resolve, is whether they are habitual offenders. Illegal activities may represent strategies for survival, a way to provide for basic needs. The observed behavior may be situational, not indicative of a generalized pattern of lawbreaking.

The policy questions are complex. How should cities respond to the lawbreaking behavior of homeless adolescents? Portland had a police crackdown on street kids involved in illegal activities in public places, many of a minor variety like verbal obscenities. Putting in jail a youth who acted this way only while homeless may

serve to place him or her one step closer to habitual offender status. A police record makes it more difficult to get a job. The result is that lawbreaking becomes an even greater necessity for survival. A cycle of illegal behavior may begin from which it becomes ever more difficult to escape.

Family Situation. A frequent generalization is that homeless adolescents come from conflictual and abusive family environments. A reason their housing problems persist is that going home is not a viable alternative for many. By definition, homelessness is residential instability. This condition continues, in part, because of the youths' family situations. Limited data are available on this connection, but a study of adolescent psychiatric inpatients reveals a relationship between the number of residential moves and parental separation and caregiver neglect and abuse.[18]

A troubled family environment is a common trait of Portland's street youth. Comparisons between the Portland sample and national data show the former group more seriously affected in major categories of family dysfunction.[19] Known or suspected cases include emotional conflict at home (66%), physical abuse by parent figure (37%), neglect by parent figure (31%), and family mental health problems (28%). In the national study, rates for all but one variable, emotional conflict at home (44%), were below 25 percent.

Sexual abuse rates in the Portland data are also higher, depending on the measure, than those reported for the Hollywood youth. In the latter study, 17 percent reported sexual abuse by family member or co-habitant.[20] In the Portland survey, 33 percent are cases of sexual abuse, known or suspected. A related measure is physical and sexual abuse by another family member — 21 percent known or suspected cases.

Substance-abuse History. Alcohol abuse is as commonplace among adolescent homeless as it is for adult homeless. Compared to national household samples, homeless adolescents are more likely to try alcohol earlier and say it affects their performance in work and school. They were eight times more liable to have a formal diagnosis of alcohol abuse and thirteen times a dual diagnosis of alcohol and drug abuse.[21]

Portland street youth show a similar level of substance abuse. Fifty-six percent of the adolescents engage in occasional or heavy use of alcohol or other drugs and 53 percent for alcohol specifically. Similarly, in the Hollywood sample, 48 percent met the criteria for diagnosis of either alcohol abuse or dependence.[22]

Mental Health. Adult studies show that approximately one third of the homeless have serious mental health problems.[23] Initially, it was thought that the prevalence of psychotic disorders might be lower among youth, because this type of affliction is usually associated with early adulthood or later. However, a study of almost one hundred youths found that 29 percent exhibited four or more psychotic symptoms on a standardized assessment instrument.[24] The authors emphasize the limited generalizability of their data and the lack of comparable studies. Nevertheless, the extent of psychotic symptoms suggests that homeless youths are a deeply troubled population. They require extensive mental health evaluation and intensive services targeted to their special needs.

Direct comparisons cannot be made with the Portland data because few of the clients were systematically assessed. However, the available information clearly shows the depth of known or suspected cases of mental health problems among the street

population. Defiant, angry behaviors are common (47%). Depression is a condition for 55 percent. Almost a majority (47%) have suicidal characteristics. An unresolved issue in homeless research, including adults as well, is whether mental health problems are a cause or result of homelessness. The answer is probably both. Also, preexisting conditions are likely to be significantly worsened by the rigors of street life.

Overall, the data indicate that those in the Portland sample face similar problems to street youth throughout the nation, including larger metropolitan areas. For certain personal and family problems, especially child abuse and neglect, their prevalence is even greater for Portland street kids. The small size of Portland and its location in the northeastern corner of the country has not insulated it from adolescent homelessness.

Table 2 provides a summary of the descriptive data, as well as correlations between each problem and homeless status. Positive correlations indicate that homeless — in contrast to runaway/throwaway/crisis — youth are more likely to have a problem. Of the eighteen separate correlations, ten are positive and statistically significant ($p <= .05$). The most marked differences exist for school attendance and learning dysfunctions related to mental development and maturation. Most of the correlations are in the weak to moderate level of strength, but the number of systematic differences means that the homeless are the more troubled part of the street population.

Experiences of the Portland Homeless Children's Project

The following discussion focuses on the experiences of the project in trying to meet two of its major goals. First, it was an experiment in providing coordinated services, namely, mental health and substance-abuse treatment and vocational training, to homeless adolescents. Second, it was an investigation into the design of interagency relationships to reduce gaps in the service system.

The Provision of Services

A major objective was to assess and provide crisis intervention and service referral for homeless youths who presented themselves at the shelter. The emphasis was on identification of individuals at immediate risk of suicide and other self-destructive behaviors and on relief of immediate psychosocial distress. As the data on Portland's street youth indicated, many suffer from serious personal and mental health problems.

The objective proved difficult to meet. It assumed several things: that the system's intake point is always, or most appropriately, the shelter, and that youth cooperate at intake. In recognition of these factors, a more informal method of identification, assessment, and triage was implemented. Log data indicate that many of the contacts with clients are quite informal. Only 15 percent involved case management activities, and 81 percent lasted one half hour or less. Through outreach work at various key locations — soup kitchen, drop-in center, streets — staff contacted youth and informally assessed their conditions and needs. Whenever possible, referrals were then made to the appropriate services.

For example, the substance-abuse counselor performed outreach to homeless youth several mornings per week at the breakfast soup kitchen, serving youth and adults. Her services provided an important addition to the morning soup kitchen. The mixture of adults and youth had negative and, at times, volatile effects. She

served at critical times as a stabilizing force. Moreover, morning offers a "window of opportunity" for a counselor to discuss the effects of substance abuse with youth in varying physical and emotional states. The soup kitchen had few professional staff, but many volunteers. The project worker was able to fill an important role, one which would otherwise have been missing altogether.

This type of cooperative arrangement was not anticipated. Some attention in the early stages of program planning focused on colocation, that is, staff located at other agencies and sites besides those of the project agencies. Other research emphasizes the necessity to bring services to the places where the homeless can be found.[25] Portland's experience supports this generalization.

A second objective was to get as many youths as possible into mental health treatment, case management, and where necessary, family mediation. The project was

Table 2

Characteristics of Portland's Street Kids

	Percent	Correlation with Homeless Status[a]
Residential Instability		
Five or more runaway episodes	44	-.02
Educational Problems		
Do not attend school	35	.39*
Educational handicap	22	.17*
Specific learning dysfunctions		
Special learning function	30	-.09
Behavioral/emotional	49	.10
Mental development or maturation	17	.25*
Criminal Justice Problems		
Charged with a criminal offense	63	.03
Family Environment Problems		
Emotional conflict at home	66	-.01
Physical abuse by parent figure	37	.10*
Neglect by parent figure	31	.18*
Family mental health problems	28	.002
Parental sexual abuse (known or suspected)	33	.18*
Physical and sexual abuse by another family member (known or suspected)	21	.10*
Substance-abuse Problems		
Occasional or heavy use of alcohol or other drugs	56	.14*
Alcohol (occasional or heavy use)	53	.15*
Mental Health Problems		
Defiant, angry behaviors	47	.08
Depression	55	.11*
Suicidal characteristics	47	.04

a. The correlation coefficient is Pearson's r. An asterisk denotes a statistically significant relationship at .05 or less.

most active in the service areas of counseling. A total of 1,465 contacts with youths were made. Eighty-four percent related to counseling.

A much smaller percentage of these contacts involved ongoing psychotherapy. At any given time, staff estimated that approximately ten youths were involved in therapy. The project found that youth want to talk, but accept relatively limited counseling. Unless special efforts are made, a very small number will find their way into therapy. Bridging this gap between counseling and therapy is a service priority for street kids.

As the descriptive data indicated, many youths come from family environments in which conflict and abuse are common. Family mediation was an initial goal of the project. These services were available to the project through a contract negotiated with a Portland area agency with extensive experience providing home-based counseling to families. Although this service was available, it was not used by project staff. Few project youths had sustained contacts with their families. Given the level of physical and sexual abuse many suffer, family contact was often neither appropriate nor advisable. Further, it was found that family mediation was most appropriate at an earlier stage in the development of crisis/runaway/homeless behavior, when children begin to appear out of control and noncompliant with family rules.

New approaches are required that allow youth to achieve more stable living arrangements. This idea is certainly not a new one, having been debated for some time. But the service system has not successfully responded, so the problem continues. Forty-one percent of Portland youth are state wards. Even with this status, Maine has not been able to keep these youths in a positive environment. Until better success in finding stable placement is achieved, kids will remain on the streets of Portland.

The project also provided vocational training. Of the 1,465 client contacts, 7 percent were employment related. Some street youth had a definite interest in securing employment. The project was not particularly successful in providing either vocational training or full-time employment. Very few youths were ready for training or had the background necessary to succeed in securing employment. Agency records revealed that only 19 percent have any history of employment and just 7 percent had actually held a job.

Vocational staff continued to revise expectations for the youths and techniques for assisting them. The assumption was that an individual's progress in mental health or substance-abuse treatment would keep pace with progress toward vocational goals. This expectation was not substantiated. Based on the challenges they encountered, vocational staff concluded that two factors were critical to future success. Intensive and sustained mental health treatment was necessary to help clients obtain and, especially, hold a job. Additionally, job coaching must accompany the therapeutic efforts for street kids to move into stable employment. One clear lesson is that you cannot simply connect them with a job opportunity and expect them to succeed. They have to grapple successfully with the personal difficulties that are important reasons they are unemployed. At the same time, they must learn the skills necessary to complete a successful interview and hold a job. The theory of the project correctly identified the importance of bridging the gap between mental health and vocational services. It was not effective in delivering and coordinating the two activities. The project was unable to improve significantly the employment prospects for most street youth.

Interagency Collaboration

This goal was met in a variety of ways: formal agreements between project agencies, staff locating in other organizations, and informal efforts at cooperation. The principal constraint, only partially overcome, was the lack of collaborative history in the service system. A vital lesson from the project is the significance of understanding the capacity of a system to collaborate before initiating interventions of this type.

A main objective was the creation of a mobile multidisciplinary team, utilizing outreach personnel from several community agencies serving adolescents. The mobile team was established, providing coordinated services to the target population. The extent to which it was truly "multidisciplinary" is questionable. The original grant envisioned a type and level of collaboration among team members that was very difficult to achieve, especially in the short to long term.

Consensus on how the multidisciplinary team should function was hard to achieve. Reasons were largely internal to the project itself. It had a complex management structure, which required staff to answer to "two bosses," their own agency heads and the director of the project. This arrangement, a type of matrix management, allows for flexibility in the assignment of staff resources, but has many points of potential organizational conflict. The question often arises, and did in the project, as to who has responsibility for staff; it was never fully resolved.[26]

Interagency cooperation was complicated by the inexperience of two agencies. The project focus on homeless youths was new for them. The initial period of program implementation was a learning process of considerable proportions. The agencies had to deal with new clients and work with agencies, inside and outside the project, with whom they had had limited interaction in the past.

The project also tried to link on site with state and community hospital psychiatric services. Case management was the primary means to achieve this connection. The results were not what was expected. The number of actual contacts was relatively small. The log data indicate mental health agencies constituted just 6 percent of the total service contacts. Again, the reasons stem from the particular nature of the homeless adolescent problem itself.

Readily accessible outpatient services were available solely at the Street Program, one of the participating agencies. Outpatient services for children are very limited in Portland — and many other cities as well. They were attainable only through mental health centers or private practitioners in traditional settings. Some adult outpatient facilities do serve adolescents. In most cases, the services do not address the most pressing needs of street kids. They focus on severe and prolonged mental illness rather than sexual abuse or issues related to street life.

Research conducted by the Maine Department of Mental Health and Mental Retardation on children admitted to the state psychiatric hospital shows that the availability of crisis services might have prevented many admissions.[27] Crisis interventions performed by project staff, and the daily (Monday through Friday) access by street youth to qualified therapists may have prevented some inpatient admissions. In selected instances, staff assisted clients through hospitalization, either at local facilities or at the state hospital.

Linkage to existing services is not, at this time, the most effective response to the mental health needs of street youths. Instead, a crisis intervention capacity is required first. The number of youths who require more traditional services, especially hospital-

ization, can be substantially reduced if agencies have the ability to respond to their crisis needs.

A rough number of the youths who benefit from crisis services can be derived from the logs. Over the eighteen-month duration of the project, 10 percent or 147 individuals sought help for a personal crisis. Fifty percent (733) met with staff on a spontaneous basis. Although most of these encounters were not the result of personal crises, they dealt with problems that would rapidly escalate if not confronted quickly.

Limited success was achieved in developing agreements with non-project agencies. An obstacle was limited collaboration within the entire service system. An interagency survey, conducted prior to implementation, provides evidence of the barriers. Agencies indicated whether they engaged in fourteen specific types of collaborative behavior. Activities ranged from formal arrangements, for example, cross-agency staffing and funding, through informal ones, such as referrals that can be done over the telephone. No more than 25 percent engaged in any function to a "considerable extent." Table 3 summarizes the data.

The potential difficulties in achieving interagency collaboration were not fully appreciated at the outset of the project. Similar to other examples of social planning for which the scope of the intervention was quite ambitious, insufficient attention was given to the existing capacity of the system.[28]

Table 3

Forms of Interagency Collaboration

Activity	Activity Occurs to a "Considerable Extent" (percent of agencies)[a]
1. Joint cross-agency assignment, joint use of staff, outstationing, or colocation of functions	25
2. Joint funding, purchase of services, budgeting/ accounting systems, or personnel administration	24
3. Interdisciplinary treatment teams	22
4. Joint diagnosis and evaluation	18
5. Joint training or technical assistance activities on homeless youths	18
6. Joint case conferences or case reviews	18
7. Joint information and referral	17
8. Joint needs assessment, planning, program development, and/or program evaluation	12
9. Joint intake, service, or discharge plan development	12
10. Supervisory or direct-care peer support networks	12
11. Joint monitoring and follow-up	11
12. Joint public education on issues relating to homeless children	6
13. Promoting youth peer support and/or peer counseling programs	0
14. Joint data systems, MIS, or record keeping on homeless children	0

a. The questions are drawn from the *Maine Child and Adolescent Service System Profile* developed by coauthor James Harrod. Data were collected from twenty agencies in March 1989. The staff of the project compiled a list of the agencies which, in their opinion, played major or supporting service roles for homeless youths. Some were shelters, while others provided basic services such as substance-abuse and medical treatment. Correctional agencies at the city and state level were also included. This type of sampling design is known as a key informant survey.

The project allocated staff resources for the purposes of collaboration among the participating agencies. None were provided for possible areas of interaction between the project agencies and other organizations within the system. A basic proposition in

interorganizational behavior is resource dependence. It states that organizations collaborate in order to gain resources. Without resources or some equally compelling reason, collaboration is resisted.[29] Rather than specifically targeting resources for systemwide collaboration, the designers of the project assumed that staff could network to produce the desired levels of coordination. Some staff did perform this function, but not to the extent that marked gains were made in the involvement of non-project agencies in service delivery. Throughout the course of the intervention, other agencies viewed project staff as additions to existing activities. To the other agencies it was more a case of resource supplementation than creating a condition of dependence. A greater level of resource dependence was necessary for sustained collaboration to occur.

A significant amount of resources was required to produce marked changes in interorganizational relationships. The reason was the emergent nature of the system. Homeless adolescents were not a new problem in Portland. Yet concerted systemwide efforts to address it was a recent development. Goals and alternative strategies were just being formulated. Agencies were only beginning to explore interorganizational strategies in a planned and coordinated sense. The idea of life cycle is an important explanation of how organizations change and develop.[30] The planners of the project failed to appreciate that the system was early in its life cycle, at an emergent stage. Their concept of collaboration was more appropriate for a system with a history of agency dependence on each other.

A subgroup of the homeless, street kids, has only lately received attention. Portland, Maine, adolescents who are homeless, runaways, throwaways, or youths in crisis face a number of problems. Data collected on these youths showed that a relatively small number are actually homeless. This group, however, are the most troubled part of the population. They have greater educational, family, substance-abuse, and mental health problems than other kids on the street.

A question was whether homeless youth in Portland were similar to those in other large urban areas of New England and the United States. The similarities were marked in terms of the prevalence of homelessness and their personal and social problems. Portland is not isolated from this dimension of the homeless problem. If this pattern is evident throughout New England, policy initiatives targeted for homeless adolescents must not assume that it is a problem only of the big cities.

Portland does differ in one major way from larger cities. The majority of street kids are from outside the metropolitan area. The service implications are major. Youths may have more difficulty in getting their service needs met in Portland. They do not have ready geographic access to their previous residences, where critical services and supports may be available. Whether other New England cities similar to Portland have this pattern of adolescent migration must be answered.

The project had mixed success in meeting its goals. Street kids are not an easy group to engage in service delivery. Agencies need a lot of time to work on multidisciplinary approaches. Collaboration within a service system, if resources are not available for this purpose, is hard to achieve. In this regard, we do not know whether Portland is a typical, middle-size New England city. However, the depth of problems faced by its street kids and the difficulty the project had in responding to their needs underscores the importance of new policy initiatives. Adolescents develop rapidly into adults. We do not have much time if this generation of street kids is to become something other than tomorrow's homeless adults. ❧

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Notes

1. For a description of the events associated with the rise of homeless families see Robert M. Hayes, "Homeless Children," in *Caring for America's Children*, Proceedings of the Academy of Political Science 37, no. 2 (1989): 58–69.
2. U. S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: A Twenty-seven City Survey* (Washington, D.C.: U.S. Conference of Mayors, December 1989).
3. Estimate appears in Family and Youth Services Bureau, U.S. Department of Health and Human Services, *Runaway and Homeless Youth: FY 1985, Annual Report to Congress* (Washington, D.C.: U.S. Department of Health and Human Services, 1985), 2.
4. Paul G. Shane, "Changing Patterns Among Homeless and Runaway Youth," *American Journal of Orthopsychiatry* 59, no. 2 (April 1989): 208.
5. Janice M. Molnar, William R. Rath, and Tovah P. Klein, "Constantly Compromised: The Impact of Homelessness on Children," *Journal of Social Issues* 46, no. 4 (Winter 1990): 109–24.
6. Les B. Whitbeck and Ronald L. Simons, "Life on the Streets: The Victimization of Runaway and Homeless Adolescents," *Youth and Society* 22, no. 1 (September 1990): 108–25.
7. U.S. Bureau of the Census, *City and County Data Book, 1988*, (Washington, D.C.: U.S. Government Printing Office, 1988).
8. E. L. Bassuk and L. Rubin, "Homeless Children: A Neglected Population," *American Journal of Orthopsychiatry* 57, (April 1987), 279–86.
9. For an analysis of the issues involved in human service integration, see R. Agranoff and V. A. Lindsay, "Intergovernmental Management: Perspectives from Human Services Problem Solving at the Local Level," *Public Administration Review* 43 (1983), 227–37.
10. The full title of the legislation is the Stewart B. McKinney Homeless Assistance Act, Public Law 100-77, July 22, 1987.
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12. Definitional questions related to various categories of street kids are addressed in Sally J. Hier, Paula J. Korboot, and Robert D. Schweitzer, "Social Adjustment and Symptomatology in Two Types of Homeless Adolescents: Runaways and Throwaways," *Adolescence* 25, no. 100 (Winter 1990): 761–71.
13. Two of the most comprehensive reports that compare homeless and runaway adolescents are David Shaffer and Carol L. M. Caton, *Runaways and Homeless Youths in New York City. A Report to the Ittleson Foundation* (New York: Division of Child Psychiatry, New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons, January 1984), and U.S. General Accounting Office, *Homelessness: Homeless and Runaway Youth Receiving Services at Federally Funded Shelters,* GAO/HRD-90-45/B-207593 (Washington, D.C.: U.S.G.A.O., 1989).

14. *Family and Youth Services Bureau. Annual Report to the Congress on the Runaway and Homeless Youth Program, Fiscal Year 1989* (Washington, D.C.: U.S. Department of Health and Human Services, 1989), 53; Shaffer and Caton, *Runaways and Homeless Youths in New York City*, 584.

15. Molnar, Rath, and Klein, "Constantly Compromised," 116.

16. Barbara Y. Whitman, Pasquale Accardo, Mary Boyert, and Rita Kendagor, "Homelessness and Cognitive Performance in Children: A Possible Link," *Social Work* 35, no. 6 (November 1990): 516–19.

17. Marjorie J. Robertson, *Homeless Youth In Hollywood: Patterns of Alcohol Use*. A Report to the National Institute of Alcohol Abuse and Alcoholism (Berkeley, Calif.: Alcohol Research Group, School of Public Health, June 1, 1989), 41.

18. Peter Mundy, Julia Robertson, Milton Greenblatt, and Marjorie Robertson, "Residential Instability in Adolescent Inpatients," *Journal of the American Academy of Child and Adolescent Psychiatry* 28, no. 2 (March 1989): 176–81.

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22. Ibid., 426–27.

23. Richard C. Tessler and Deborah L. Dennis, *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill* (Amherst, Mass.: Social and Demographic Research Institute, University of Massachusetts, February 9, 1989), 28.

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26. A general review of the concept of matrix organization is S. M. Davis and P. R. Lawrence, *Matrix* (Reading, Mass.: Addison-Wesley, 1977).

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29. This proposition and others related to interorganizational relationships are discussed in A. Van de Ven and G. Walker, "The Dynamics of Interorganizational Coordination," *Administrative Science Quarterly* 29 (1984): 598–621.

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