Intervening in the Lives of Runaway and Homeless Youth

Street-Living Youth

Living on the streets good for mental or cal health. Adolescents young adults who do not an option to return home example, because of abuse because they are not welcome) and who refuse the option foster care are one of the marginalized and vulnerable groups in society. Addressing homelessness is not easy - searchers and policy e recognize that homelessness is a social problem with - plex causes. Economic social conditions; social service acceptability and accessibility; and family and individual level variables all interact to cause and sustain homelessness. While homelessness is a social problem, intervention is often focused on the individual. Social change is slow and difficult, and those currently suffering cannot wait until social policy, laws, and social and family services work together to prevent homelessness from occurring.

For homeless youth, living on the streets is often an adaptive strategy for escaping from untenable living situations. Moreover, living on the streets for any long period of time requires significant survival skills. Yet despite their unique strengths and skills, homeless youth are at far higher than average risk for alcohol consumption, illicit drug use, physical and sexual abuse, depression, teen pregnancy, and survival sex. Even with the high rates of mental health and related problems, most homeless youth do not receive needed services. Most avoid the shelter system because they do not want their parents contacted—as is usually required by runaway shelters—or because they do not want to be placed in foster care. Drug addicted and emotionally vulnerable homeless youth often do not conform to the behavioral expectations of treatment programs, and leave or are asked to leave prematurely.

This is a population difficult to reach, engage, and maintain in treatment. What is more, there are many barriers to successfully serving homeless youth. Therapists and health care providers are reluctant to provide services to unaccompanied minors without legal guardian consent. Youth are reluctant to seek or receive services from adults who have not proven trustworthy and who have the power to contact parents, the police, or social services. Minors cannot independently sign a lease for housing, and without housing, it is difficult for youth to obtain and maintain employment and education. Lack of transportation, knowledge of available services, and insurance can also be barriers to receiving assistance. Also, many communities have few, if any, services to offer homeless youth, and may not even have a drop-in center, which can be a gateway for homeless youth to access more services.

Identifying effective interventions is essential to preventing homeless youth from becoming chronically homeless adults. Yet there is a dearth of efforts to develop and evaluate interventions with street youth. In one of the only studies on homeless youth, Cauce et al.[1] reported the findings of Project Passage, an intensive case management program which was evaluated against a drop-in center's treatment as usual, or 'regular' case management. Few outcome differences were found between the regular case management and case management provided by Project Passage on depression, problem behaviors, and substance use at 6 months.

Homeless youth present intertwined problems, and intervention efforts will need to address these complex issues if they are to be successful in helping youth initiate and maintain positive change. Development of a comprehensive intervention that addresses substance use, HIV risk, social stability, and physical and mental health issues is an important goal. In an attempt to address the multiple needs of homeless youth, we engaged homeless youth from a drop-in center in an individual therapy program called Community Reinforcement Approach (CRA), originally developed for adult substance abusers by Meyers and Smith.[2] CRA uses operant conditioning principles, offering rewards (e.g., social/relational reinforcement, financial rewards, and vocational reinforcements) to encourage clients to reach treatment goals. Often this is one of the first times in the youth's life that he or she is being rewarded for positive behavior. This reinforcement for positive behavior can break negative habits of interaction and allow youth to connect to positive social networks. Our intervention helps youth see these connections—including connections to adults working at the drop-in—in a positive light. At the same time, we teach youth the skills they need to increase and maintain positive social connections. More

specifically, our intervention relies on three basic strategies:

1. We engage street living youth by offering unconditional positive regard and by meeting immediate basic needs—offering a place for youth to rest, have meals, shower, and access medical care. We reassure youth that parents, police and social services will not be contacted upon learning that the youth a runaway. An open door policy is needed so that youth have easy access to their therapist.

2. We retain youth in treatment by earning trust and building hope Therapy begins with a focus on primary goals identified by the youth, such as finding employment, pursuing education, regaining custody of children, acquiring stable housing, building better relationships, or being happier. Identification of those goals, and reinforcing participation in treatment through achieving mini-goals, helps to build the therapeutic connection.

3. Once trust is established, which can take days or weeks, treatment then focuses on behaviors and problems that may interfere with the youth meeting his or her primary goals. These behaviors or problems may include substance use, sexual risk, unaddressed trauma from physical/sexual abuse, depression and anxiety, underdeveloped interpersonal and employment-related skills, and low self-efficacy.

There is no magic to working successfully with homeless youth. Utilizing a client-centered and trust-building approach to engage and maintain youth is necessary before proceeding further therapeutically with the youth. Increasing youths' skills to interact successfully with individuals and the human service system is important for acquiring housing, jobs, and social services. Helping the youth manage substance use and cope with mental health difficulties is necessary for maintaining successful connections with the larger social system.

To test the effectiveness of our approach, we randomly assigned 180 youth (118 males, 62 females) between the ages of 14 and 22 to our intervention, CRA, or to treatment as usual (TAU) through the drop-in center. Compared to TAU, youth assigned to CRA as described above attended more treatment sessions, and they significantly reduced their frequency of substance use (37% v. 17% reduction

the streets) up to 6 months.[6] Youth in both conditions improved in many other behavioral domains including internalizing and externalizing problems, and emotion- and task-oriented coping. These findings suggest that homeless youth can be engaged and retained in therapy and can respond positively to intervention efforts.

While our intervention shows some success, there are many barriers in the larger social and policy context that make it difficult for homeless youth to achieve and sustain positive outcomes. As mentioned previously, minors cannot sign for housing without a guardian's co-signature, and many homeless youth do not want or know how to contact their parents. For many, the foster care system is not an option because that system has already failed them. Homeless young adults between the ages of 18 and 24 tend to avoid adult shelters because they are preyed upon by older homeless people, and many cities do not have alternate services, such as drop-in centers, for homeless youth. Even though many who serve homeless youth are passionate and do what they can to raise community awareness and to push for policy change, they will not be successful until there is a higher level of public commitment to making these changes happen.

Shelter-Residing Youth

Shelter-residing youth tend to be younger than street-living youth. Most shelter-residing youth have never spent a night on the streets, and most return to a home situation following their shelter stay. Youth staying in runaway shelters report that their greatest needs concern living arrangements, family relationships, and communication with their parents. It appears that family relationships should be an important target of intervention for these runaway youth. Improving and clarifying family communication, cohesion, boundaries, and expectations may help to reunify runaway youth with their families, prevent future runaway episodes, and repair the negative impact of high levels of family conflict. Intervention can begin at the shelter, but adolescents stay at the shelter for only a brief time so intervention must extend beyond their stay.[7]

With these goals in mind, we developed Ecologically-Based Family Therapy (EBFT). In developing EBFT, we drew on the Homebuilders family preservation model; however, EBFT includes significantly fewer sessions (16) than is typical for Homebuilders. Both of these family-based approaches share the assumptions that 1) time-limited, intensive, and comprehensive therapeutic services should be provided in accordance with the needs and priorities of each family, and 2) most children are better off with their own families than in substitute care.[3] Treatment is provided in the family's home or wherever the youth might be residing (e.g., a shelter or foster home). Consistent with an ecologically-based framework for understanding and intervening in behavior, in addition to providing family therapy, the EBFT therapist serves as a therapeutic case manager and facilitates and coordinates appointments for family members to address

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various areas of need including medical care, job training, and self-help programs.

In EBFT, both family and individual sessions are used and problems such as substance use and running away are addressed directly. At the beginning stage of therapy, participants are encouraged to consider that current problems and their solutions reside *between* individuals rather than *within* individuals. This is accomplished through the use of such techniques as reframes (e.g., "Maybe Johnny runs away because he knows that you will spend more time with him when he returns and not because he is trying to punish you") and relational questions or interpretations (e.g., "Perhaps you question your ability to hold the family together when Johnny does not go to school?"). Other intervention strategies include cognitive-behavioral techniques that are utilized to interrupt problem behavior patterns so that new skills can be taught, practiced, and applied outside the therapy context. Treatment was guided by the EBFT manual,[4] in which more detailed information regarding the intervention format and guidelines can be found.

Two randomized controlled trials have evaluated EBFT. Youth (N = 240) between the ages of 12 and 17 were recruited through two runaway shelters in the Southwest. To be eligible for participation, adolescents had to satisfy DSM-IV diagnostic criteria for substance abuse or dependence. Youth were randomly assigned to EBFT or TAU at the runaway shelter, and were assessed at 3, 9, and 15 months post-baseline. Overall, at 15 months, youth in both treatment groups showed improvement in family and individual functioning, including depression/anxiety, family conflict and cohesion, and externalizing problems. Youth assigned to EBFT showed a greater decrease in substance use than those assigned to TAU.[5]

Conclusion

While our interventions with runaway and homeless youth improved behavior, integration of treatments into the community requires funding as well as buy-in from those in the trenches. Many shelters are not equipped to deal with youth who have substance abuse and/or mental health problems. Moreover, most cities do not have drop-in centers to provide a place for homeless youth to congregate. Given the constellation of problems of this high-risk group of adolescents, and the potential for preventing continued runaway episodes or chronic homelessness, community and governmental support is needed if we are to significantly impact this social problem.

References

1. Cauce, A. M., Morgan, C. J., Wagner, V., Moore, E., Sy, J., Wurzbacher, K., Weeden, K., Tomlin, S., & Blanchard, T. (1994). Effectiveness of intensive case management for homeless adolescents: Results of a 3-month follow-up. Special Series: Center for Mental Health Services Research Projects. *Journal of Emotional and Behavioral Disorders, 2,* 219-227.

2. Meyers, R. J., & Smith, J. E. (1995). *Clinical guide to alcohol treatment: The Community Reinforcement Approach.* New York: Guilford Press.

3. Nelson, K. E., & Landsman, M. J. (1992). *Alternative models of family preservation: Family-based services in context.* Springfield, IL: Thomas.

4. Slesnick, N. (2000). Treatment manual: *Ecologically-Based Family Therapy for substance abusing runaway youth.* Unpublished manuscript.

5. Slesnick, N., & Prestopnik, J. L. (2005). Ecologically-based family therapy outcome with substance abusing runaway adolescents. *The Journal of Adolescence, 28,* 277-298.

6. Slesnick, N., Prestopnik, J. L., Meyers, R. J., & Glassman, M. (2007) Treatment outcome for homeless, street-living youth. *Addictive Behaviors, 32,* 1237-1251.

7. Teare, J. F., Furst, D. W., Peterson, R. W., & Authier, K. (1992). Family reunification following shelter placement: Child, family, and program correlates. *American Journal of Orthopsychiatry, 62,* 142-146.

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