

## CHAPTER TWO: LITERATURE REVIEW

This study includes the creation and application of an evaluation process for a teen runaway shelter. The evaluation was created in collaboration with the shelter administrators, based on the program goals and mission statement. The evaluation was administered in survey form and was given to the teens who resided at the shelter, their parents, and the staff who work at the shelter. The following review of literature is designed to inform the reader about four distinct areas addressed in this study. It provides an overview of the research conducted to describe at-risk adolescents, the parents and families of at-risk adolescents, and the services available to at-risk teens and their families. The final section will give a broad-based overview of the research conducted on evaluation studies specific to this population.

### At-Risk Adolescents

Adolescence is a time of experimentation and differentiation from one's family of origin. It is a time when young people try on different roles, jobs, and activities to help them form a set of values and interests that they can call their own. Many adolescents and their families maneuver through this life cycle stage with relative ease and success. However, some adolescents develop problems during this stage that prevent the child from becoming a useful and productive member of society. These youth and their families are often identified as "at-risk" (Resnick & Burt, 1996).

Much of the previous research on "at-risk adolescents" has focused on adolescents who engage in risky behavior, such as substance use and abuse, early and unprotected sexual activity, membership in gangs, delinquent behavior including involvement with violence (assault, weapon use, rape and murder), running away from home, depressive symptoms including suicidal thoughts and self-injurious behaviors, and truancy and school drop-out (Dryfoos, 1998; Jessor, 1998; Garbarino, Schellenbach, & Sebes, 1986; Gary, Moorhead, & Warren, 1996; Royce, 1998; McKeown, Jackson, & Valois, 1998; Kipke, Simon, Motngomery, Unger, & Iverson, 1997; Buckner & Bassuk, 1997; Unger et al., 1998; Resnick & Burt, 1996). Recently, there has been a shift in the definition of "at-risk adolescents." It includes not only the engagement in risky behavior, but also the fact that some youth live in risky situations or environments, for example, areas of high crime

or gang activity (Resnick & Burt, 1996). Zelman (1996) presents a biopsychosocial model of risk that includes three components of risk: biological risk factors (i.e. genetic predisposition), psychosocial risk factors (i.e. parental psychopathology), and community risk factors (i.e. high crime rate neighborhoods). This global view of risk can also be found in Resnick and Burt's (1996) definition of risk that involves four components: "risk antecedents, risk markers, problem behavior, and outcomes" (p.174). They define risk as "the presence of negative antecedent conditions (risk antecedents), which create vulnerabilities, combined with the presence of specific early negative behavior or experiences (risk markers) that are likely to lead, in time, to problem behavior that will have more serious long-term health consequences (risk outcomes)" (p.174). Integrating the two theories, Zelman's (1996) biopsychosocial risk factors can be interpreted as subsections of Resnick and Burt's (1996) risk antecedents.

Conceptualized in this way, at-risk adolescents are part of a system that contributes to societal problems like teen pregnancy and parenthood, homeless and street youth, prostitution, escalated rates of teen mortality related to violence, AIDS and other STDs, and high rates of school drop-out (Resnick & Burt, 1996). Biological factors that are considered risk antecedents include genetic vulnerabilities, temperament, hyperactivity, cognitive and neuropsychological deficits, chronic ill health and a predisposition for sensation seeking (Zelman, 1996). Age can also be viewed as a biological factor, as younger adolescents tend to have less sophisticated decision making skills than their older peers (Steinburg & Cauffman, 1996) and often lack the ability to give consideration to the future consequences of their decisions (Unger et al., 1998).

Psychosocial risk antecedents include aggression, antisocial behavior of family members, substance abuse in the family, parental mental illness, marital problems, domestic violence, negative adult or peer role models, and dysfunctional parenting including emotional, physical and sexual abuse of the child (Dryfoos, 1998; Kennedy, 1991; Jensen & Rojek, 1992; Garbarino et al., 1986; Zelman, 1996). Given these factors, it is clear the family plays an important role in determining the level of risk an adolescent experiences. Numerous studies on runaway youth cite family discord, an inability to get along with parents, and physical or sexual abuse as the main reasons given by teens for

running away (Rohr, 1996; Kipke, Unger, O'Conner, Palmer, & LaFrance, 1997; Kipke, Palmer, LaFrance, & O'Conner, 1997; Farrington, 1990; Denoff, 1991; Olson, Liebow, Mannino, & Shore, 1980; Englander, 1984).

Community factors identified as risk antecedents include poverty, unsafe neighborhoods, overcrowding, few opportunities for employment, and local gangs (Parnell & Vanderkloot, 1989; Zelman, 1996; Ensminger & Juon, 1998; Dryfoos, 1998; Resnick & Burt, 1996). From a systemic perspective, community risk factors not only affect the adolescents who live in them, but the entire family as well. Overcrowding and poverty, for instance, will have an adverse effect on the parental subsystem, which will then, in turn, raise the level of risk for the adolescent in the home. Although the above biological, psychosocial and community factors are considered antecedents for risk, they certainly do not guarantee at-risk behaviors in adolescents. Youth who act out, runaway, and engage in at-risk behaviors cut across every race, ethnic group, religious orientation, and social class (Gary et al., 1996).

The Youth Risk Behavioral Surveillance System (YRBSS) (Kann, et al., 1995) monitors health risk behaviors among America's youth. The 1995 YRBSS report summarizes high school data from both a national school-based survey conducted by the Center for Disease Control and 35 state and 16 local school-based surveys conducted by local educational agencies from February through May 1995. The national survey used a three-stage cluster sample design with random selection to produce a sample that was representative of students in grades 9-12 from all 50 states and DC in both public and private schools. The state and local surveys used a two-stage cluster design with random selection to produce a sample that represented students in grades 9-12 from their particular jurisdictions. The national survey produced 10,904 completed questionnaires from 110 schools. The state and local surveys had sample sizes that ranged from 309 to 5,987.

Results from the 1995 YRBSS report indicate that during the 30 days preceding the survey, 20% of high school students had carried a weapon, 51.6% had drunk alcohol, 34.8 % had smoked cigarettes, and 25.3% had used marijuana. In the 12 months preceding the survey, 8.7% of high school students had attempted suicide. More than half

(53.1%) of high school students had sexual intercourse in 1995 and 45.6% of these sexually active students had not used a condom at their last act of sexual intercourse. In 1995, 2% of high school students had ever injected an illegal drug.

There are certain factors that have been identified as protecting adolescents from becoming “at-risk.” Average or above-average intelligence, an easy disposition, the ability to plan, and positive social skills with family and friends have been found to contribute to a healthy and positive transition through adolescence (Institute of Medicine, 1994; Rutter, 1987). Supporting the family systems theory concerning at-risk teens is the fact that the quality of interaction teens have with their parents has been found to affect their school performance, peer relationships and interpersonal behaviors (Zelman, 1996). One of the most important relationships that can help protect adolescents from becoming “at-risk” is a positive relationship with at least one parent.

Some adolescents and their families seek treatment to help them cope with the stress and conflict that arise around adolescent high risk behavior. Other families are able to manage the problems without seeking outside help. And still other families continue to struggle. At times, conflict becomes so intense and intolerable that the adolescent chooses to run away or the parents decide to kick the youth out of the house. Much research has been done on runaway and homeless youth populations, but few have distinguished between “runaway,” “throwaway,” “pushout,” “homeless youth,” “street youth,” and “system kid” (Gary et al., 1996).

Runaways have been defined in several different ways, ranging from “a child who leaves home voluntarily with the knowledge that he will be missed” (Olson et al., 1980, 167) to “a person under eighteen years old who absents himself or herself from home or place of legal residence...at least overnight...without the permission of parents or legal guardians” (U.S. Government Accounting Office, 1989). Some researchers include children who have been “pushed out” of their homes (Kurtz, Kurtz, & Jarvis, 1991), or children who run from residential placements, institutions or unhealthy social service placements (Rotheram-Borus, 1991) in the definition of a runaway. But youth who leave home voluntarily, youth who are kicked out or pushed out by their parents, and youth who ran from a hospital, group home or foster care placement may have different presenting

problems and service needs that may be missed when combining all of these types of runaways together in a study. For instance, “throwaways,” youth who were left behind when parents relocate or are overtly directed to stay away, are more likely to have been victims of physical violence before they leave home and more likely to stay away from home longer than adolescents who leave home voluntarily (Finkelhor, Hotelling, & Sedlak, 1990).

Just as there is little distinction between the types of runaway youth in the literature, there is also not always a clear distinction between runaway youth and homeless or street youth. Resnick and Burt (1996) made an effort to distinguish the groups in the following way: homeless youth have been defined as “youth who have no parental, substitute, or institutional home and who may have left with the parent’s knowledge” (179) and “street kids” describe youth who have been homeless or are long-term runaways and have been able to maintain themselves on the street, often using prostitution, theft, or some other illegal means, to do so. Distinguishing these youth can help researchers better understand their study’s population and subject pool. However, in the same way that many of the risk antecedents and high risk behaviors are intertwined and related in many and varied ways, the runaway and homeless populations are related and intertwined. Teasing them apart may do more to limit the research than enhance it. Understanding the progression of events and circumstances that take kids from various stages of high risk behavior, to running away and into alternate placements and possibly to life on the streets can help researchers and practitioners better serve this population of at-risk teens.

The homeless and runaway portion of at-risk teens are a significant portion of the adolescent population in general. The estimates of teens who run away or are forced away from home each year range from 750,000 to two million, with many of these kids experiencing brief to prolonged periods of homelessness (Robertson, 1992; Rohr, 1996; Unger, et al., 1998). That means approximately one in eight teens will run away from home before the age of eighteen. These runaway and homeless teens report high rates of psychological problems, including depression, suicidal ideation and ADHD (Unger, et al., 1997). In theory, if researchers and practitioners could effectively serve the at-risk

adolescent population before the conflict at home became intolerable to either the adolescent or the parents, the number of kids who run away or are thrown away each year could be drastically reduced. This would include not only increased research and treatment for the teens, but also for the families in which they live.

#### Parents of At-Risk Adolescents

It has been argued that no other social system has a greater impact on the development of the adolescent than the family (Zelman, 1996; Rutter, 1987; Institute of Medicine, 1994). Parenting any adolescent can be a challenging task. Adolescence is a time of great change for families: the adolescent's physical and sexual maturity, the change in the dynamics of the parent-child relationship, and the change in the adolescent's value system (Gordon, 1975; Marcia, 1987; Dryfoos, 1998). Adolescence is a period of time when both the teen and the parents have to work out what these changes will mean for them.

Garbarino et al. (1986) identified three ways in which parenting a teen is different from parenting a child. Each of these differences has the potential to contribute to mistreatment of the adolescent. The first difference they present is that the adolescent has more power than the child. Not only is the adolescent physically stronger, but they also have more power to contribute to and influence family conflict, to harm themselves or others, or to physically leave the family. This shift in power can often frustrate and anger parents when adaptive and flexible responses to the new dynamics are not employed.

The second difference is that adolescents have more peer and adult-friend relationships that will influence their decision-making process. The parent of a teen must come to terms with all of these new and influential relationships. Adolescents have many more adults and peers in their social realm with whom they spend their time who will influence them as they develop a new set of values (Buysse, 1997). Parents may perceive these relationships as threatening, especially the highly intimate or sexual relationships their teen develops. Some parents are particularly vulnerable to feeling displaced because of their own life history and current needs (Buysse, 1997).

Finally, the cognitive abilities of the adolescent are usually more advanced than the child's (Garbarino et al., 1986). Because teens have more advanced logical thinking

skills and can reason more like an adult, parents are faced with a higher level of complexity when dealing with their adolescent. Parents no longer have the same “room for error” when discussing issues with their teens that they do with younger children. Adolescents have a broader base of experience and more advanced thinking skills that demand parents use sophisticated parenting skills in order to be effective.

Given all of these differences, it makes a lot of sense that most parents report the adolescent years to be the toughest and the most challenging (Garbarino et al., 1986). Not only do parents experience a great amount of pressure and stress when learning how to rearrange the power in the family, but they may feel rejected by their adolescents new focus on peers and differing value systems. Many parents who did not abuse their children when they were younger experience such a difficulty with their child’s transition through adolescence that they inevitably abuse their teen. Families can be at-risk for adolescent maltreatment when they are not prepared for these changes in power and alliance and when they do not have the skills to cope or the support systems in place to help them manage this time of great change.

Research shows that abusive families can be differentiated from nonabusive families by their behavior during the 5-10% of parent-teen interactions that are negative (Garbarino et al., 1986). The behavior both types of families present during the positive parent-child interactions does not appear to be statistically significant in distinguishing abusive and non-abusive families. During negative parent-teen interactions, non-abusive families are able to quickly de-escalate the situation and the parents can maintain a position of power without using physical force. Abusive families are not able to terminate the conflict, rather they become engaged around escalating the conflict. Because these conflicts center on power and influencing the behavior of others, and teens have the advantage of the aforementioned changes in strength, outside support and cognitive abilities, the mistreatment of adolescents can often resemble spouse abuse, rather than abuse of a young child (Garbarino et al., 1986).

Along with these challenges are the recent social differences in the family system that can make parenting a teen an even greater challenge. Many families no longer have the support of two parents that they once had. Approximately 31 percent of American

adolescents live with only one parent, usually the mother (Dryfoos, 1998). Although some earlier studies indicate that more runaways come from single parent families than two-parent families (D'Angelo, 1974; Johnson & Peck, 1978), more recent studies indicate that the teen's perception of the parent-teen relationship is more important than the number of parents in the home. It is the quality of care rather than the quantity of care-givers that is significant to the healthy development of the adolescent (Parnell & Vanderkloot, 1989; Dryfoos, 1998; Kipke, Palmer, et al., 1997; Englander, 1984). Single parent families, then, can be viewed as simply having the potential for at-risk factors. If a single parent has to work outside the home, it may be harder to provide the supervision and emotional support required to raise a low-risk teen. But this does not imply that single-parenthood is a risk factor. Many single parent families raise healthy low-risk teens. One high functioning, effective parent is better than two low-functioning, ineffective parents (Dryfoos, 1998).

There has been an abundance of research on which style of parenting is most effective for raising healthy, low-risk children. Parents not only influence their child's development by the community in which they raise them (i.e. low income vs. well-to-do) and the schools they send them to, but also in the way they interact with them on a daily basis. The manner in which parents guide children through life can greatly effect children's interpretations of their strengths, weaknesses, and resources, which in turn, can effect their level of risk. Baumrind (1973, 1978) developed a typology of effective parenting that has become well accepted by researchers and clinicians alike. The typology is based on the interaction of the parent with the child regarding the balance between the quality of support and affect and the quality of control. Four parenting types are identified. Authoritative parents are rated high in demand/control and high in support and responsiveness. They give their children the limits and structure they need to feel safe and the flexibility to learn from their own mistakes. Authoritarian parents are rated high in demand/control and low in support and responsiveness. These parents are punitive and have little respect for their children as a separate decision-maker. Permissive parents are rated low in demand/control and high in support and responsiveness. They are very warm parents who do not implement or enforce any rules

or structure in the household. Disengaged parents are rated low in demand/control and low in support and responsiveness. These parents are neglectful and often ignore their children.

Research has shown that children in authoritative homes consistently perform better in school, show higher levels of self-efficacy, demonstrate healthier coping styles, report less anxiety and depression, have higher self-esteem, and are less likely to engage in delinquent behavior (Steinberg, Mounts, Lamborn, & Dornbusch, 1991; Kipke, Palmer, et al., 1997; Dryfoos, 1998). The positive effects of authoritative parenting transcend ethnicity, socioeconomic class and family structure (Steinburg et al., 1991). Conversely, authoritarian, permissive and neglectful styles have been consistently correlated with teens who are less socially competent, have lower self-esteem, and are more likely to engage in negative behavior (Resnick & Burt, 1996). For example, Willis and his colleagues (1994) found adolescents raised in a “permissive” household are more likely to engage in substance abuse, as are adolescents who are raised in a household with a parent who is a substance-abuser. Also, adolescents raised by disengaged parents are more likely to engage in risky sexual behaviors.

Research on homeless adolescents and runaways indicates that teens of parents with negative parenting styles, along with other negative risk markers such as family conflict, violence and abuse, as unhealthy and cause for exit from the home (Gullotta, 1979; Kipke, Palmer, et al., 1997; Gutierrez & Reich, 1981; Dryfoos, 1998; deMan, Dolan, Pelletier, & Reid, 1993). Gullotta (1979) found that runaway teens reported that their parents wanted to have too much control over them and that their parents did not listen to them. Englander (1984) found that runaway girls perceived their parents as less accepting and less restrictive.

Kipke, Plamer et al. (1997) conducted a study in which 409 homeless adolescents rated their parents’ style of parenting. With 23 parenting descriptors, four styles emerged: Supportive/Emotionally Available; Intrusive/Unavailable; Detached; and Problems with Drugs/Law. The majority of adolescents reported having parents or guardians who could be characterized as intrusive, emotionally unavailable, detached and who had experienced problems with drugs or the law.

Homelessness and running away behavior may also be related to another parent-child issue: attachment (Gullotta, 1979). Attachment has been defined as a “lasting psychological connectedness between human beings” (Bowlby, 1969, p.194). Attachment between parent and child runs on a continuum between secure attachment and unattached. Most children fall somewhere in the middle (Magid & McKelvey, 1987). Children who are chronically abused or neglected during their early years of development often struggle with attachment issues due to a break in the normal bonding process (Keith, 1996).

If children have not been raised to feel attached to their parents, to feel that they can trust their parents and feel secure at home, running away may not be a response to the immediate conflict at hand, but to the deeper lack of trust and acceptance at home. Silbert and Pines (1981) propose that for youth who have experienced chronic mistreatment from their parents, running away may be a healthy response to an intolerable situation. But the youth who did not learn to form attachments at home will have trouble forming attachments to the service providers they may meet on the street and will therefore have trouble utilizing the services that could potentially help them to get off of the street and into a healthier living environment (Stefanidis, Pennbridge, MacKenzie, & Pottharst, 1992). These programs, and the people who provide services to at-risk youth, are an integral part of helping at-risk teens and their families develop the skills and access the resources they will need to become healthy, productive members of society.

#### Services and Programs for At-Risk Adolescents and their Families

Services for at-risk youth and their families exist in a variety of forms. School programs, hotlines, outreach services, outpatient therapy, drop-in centers, runaway shelters, and free or low-cost medical centers are available in a variety of settings to serve the needs of this population. With anywhere from one million to four million runaway adolescents and their families in need of services each year (Dryfoos, 1998), it is imperative to identify and address the specific needs of this hard to reach population. Many of these youth have experienced physical, sexual, or verbal abuse, lived through intense family conflict, or grown up in unsafe neighborhoods. They may have been involved in gangs, abused drugs and alcohol, practiced unsafe sex at an early age, and/or

suffered from clinical depression or other mental health issues. Certainly, many of these teens have a myriad of needs that have to be addressed. Their parents, who may have individual substance abuse, family history and/or mental health issues, as well as the conflict with their teen, also have a host of needs to be addressed.

At-risk adolescents who have run away often have primary physical needs that need to be addressed including food, clothing, shelter, and medical attention (Fruedenberger & Torkelsen, 1984). After these needs are met, they have similar needs to the ones most at-risk kids who stay at home have. All of these adolescents need a safe place to go where they can interact with healthy, supportive adults (Dryfoos, 1998). They have daily living skills that need to be addressed, including social skills (i.e. conflict resolution, communication) and job skills. They need to be encouraged and supported in completing their educational goals. They also need therapeutic counseling to address the biological, family and community issues that contribute to their “at-risk” label (Resnick & Burt, 1996). They need group counseling and psychoeducational groups to address the antecedents and consequences of their at-risk behavior, including substance abuse, pregnancy, HIV/AIDS, physical violence, and gang membership. These needs, at the most basic level, are congruent with the simple statement the Center for Youth Development and Policy Research of the Academy for Educational Development determined was necessary for all youth: “Safe places, challenging experiences, and caring people” (Dryfoos, 1998, p.5).

Dryfoos (1998) maintains that the most important factor for these at-risk adolescents is an attachment to a caring and healthy adult. In a perfect world, that adult would be a parent. When a parent is not available, a mentor, teacher, coach, counselor, or other adult can make a tremendous difference. Some parents, if provided the proper services, can learn how to provide their teen with the love and support needed. Parents who are homeless need services that will provide the immediate physical needs of the family, including food, clothes, medical services, and shelter. These parents, along with the other parents of at-risk youth, need counseling services to address the conflict they are currently experiencing with their teen. Parents need individual sessions or groups that provide psychoeducational services that include parenting, conflict resolution,

communication, and anger management skills. Some parents will need treatment to address their substance abuse, past family history, and/or domestic violence issues. (Kipke, Palmer, et al., 1997; Dryfoos, 1998; deMan, et al., 1993).

There are many different types of programs that address the needs of at-risk youth and their families. These programs can be separated into two basic categories: prevention and treatment. Some researchers argue that prevention should be the primary way we treat at-risk youth (Lorion, Price & Eaton, 1989; Blau & Gullotta, 1993; Meyer, 1994). Prevention programs aim to identify at-risk youth and work with them to prevent future risky behavior and avoid complications in a successful transition into adulthood. These programs usually focus on one of three areas: delinquency, substance abuse and teen pregnancy (Dryfoos, 1998). They often focus on increasing knowledge and changing attitudes about the given behavior. Programs such as the Boys and Girls Club, Children at Risk, the SUN Group Program, and Big Brothers/Big Sisters have all been identified as effective prevention programs (Schonberg & Tellerman, 1997; Dryfoos, 1998; Royse, 1998).

At-risk adolescents who do not benefit from prevention efforts will obviously then need treatment programs to address their needs. Some at-risk youth seek services from private practitioners (Freudenberger & Torkelsen, 1984), but most, due to lack of parental support and/or financial and insurance limitations, seek services from community agencies. These agencies not only provide shelter for runaway and homeless youth, but also counseling and crisis intervention services. Some offer a range of services to include medical treatment, employment training, educational and GED programs, transitional living components, alcohol and drug counseling and treatment and family counseling. The majority of agencies offer local referrals for services that they themselves do not provide (National Network of Runaway and Youth Services, 1991).

One of the major drawbacks of some prevention and intervention programs is the limited population to which it is offered (Dryfoos, 1998; Resnick & Burt, 1996; Pillen, 1990). Some programs designate services only to youth or families that meet specific criteria (i.e. girls currently between the ages of 14 and 17 and currently pregnant) and then only address the identified problem, leaving the youth without services for other

potential problems (i.e. counseling to address a history of sexual abuse by a parent and substance abuse, and no short term shelter while she cannot stay at home). Recently, researchers have begun to agree that comprehensive services, which treat a wide range of at-risk youth and their parents and address the whole person rather than one presenting problem, are the most successful and efficient way to provide services to this growing population (Dryfoos, 1998; Pillemer, 1990; National Network of Runaway and Youth Services, 1991; Fruedenberger & Torkelsen, 1984; Christopher, Kurtz, & Howing, 1989; Resnick & Burt, 1996; Peterson, 1995).

Dryfoos (1998) outlines several factors that effective comprehensive service agencies have in common. Programs that can address the needs of at-risk adolescents early have a better rate of success, because the longer a teen prescribes to a certain behavior or value system, the harder it is to change. Effective programs provide one-to-one attention and relate to teens at a developmentally appropriate level. These programs empower the teens who seek out their services, giving them the skills and the motivation and support to achieve their goals. Successful programs encourage parental and familial involvement. They attend to the cultural needs of their clients. They involve community police and provide safe havens for children and parents. They offer incentives for reaching goals. They are comprehensive, integrating many components under one roof, where teens and parents can feel supported because many of their needs are being met by a coordinated staff. Many of the most effective programs are intensive and attempt to achieve long-term involvement of the youth and families in the program.

Family involvement, as mentioned earlier, is key to the youth's success in a treatment program. Tolan, Ryan, and Jeffe (1988) report that adolescents who had familial involvement in the diagnostic and treatment process were more likely to stay with treatment longer and were more likely to reach their goals than adolescents who did not have family involvement. Farmer (1996) reports that disaffected teens were more likely to return home successfully after court removal if the teen had made regular visits home before returning permanently. This suggests that parental involvement, through regular contact and with the provision of services, is most decidedly beneficial for the adolescents' success in any type of treatment or service program.

Because the peer group is also one of the more powerful influences on adolescents (Schonberg & Tellerman, 1997), group therapy is often a very successful program component of agencies that serve at-risk teens. Groups provide an opportunity for youth to normalize their struggles, feel a part of a larger cohesive network, and learn on an interpersonal level, all of which are important to the development of adolescents (Yalom, 1975). Corder (1994) reports that high-risk youth list the opportunity to express feelings and to learn from others about themselves as helpful aspects of group work. Tucker, Herman, Brady and Fraser (1995) found that a group format that focused on self-esteem and assertiveness behaviors produced clinically significant changes in adolescent females as compared to girls who did not participate in the group. This research adds to Dryfoos' (1998) summary of effective program components; group work should be included as a successful component of effective programs.

Given the research on effective program components for at-risk teens, it is useful to then study the programs that serve at-risk teens. Do they serve the population they target? Do they include effective program components such as group work and parental involvement? One conglomerate study attempted to provide descriptive data on the service agencies that work with at-risk youth and their families. In 1989, the National Network of Runaway and Youth Services (1991), a national, non-profit organization that represents approximately 900 organizations that serve runaway, homeless and other at-risk youth, sent out a 95 question survey to 450 community-based runaway and homeless youth centers. One hundred and eighty-five surveys were returned, representing 45 of the 50 states. The agencies that returned surveys reported that they served a total of 404,279 young people with residential and non-residential services. Agencies provided services to slightly more females (53%) than males (47%). The majority of the adolescents (54%) were between 15 and 17 years old, 38% were 14 years old or younger, and 9% were 18 years old or older. Six percent of the youth served by the agencies identified themselves as gay or lesbian. African American youth were over-represented in the youth who received services, as compared to national population averages (20% compared to 14%). Other nationalities were served in numbers consistent with national population statistics, with whites representing almost 65% and Hispanics about 10%. Youth served

represented all socio-economic classes, with the majority coming from working class and poor families. The agencies that responded represented rural, urban and suburban communities, with 45% of the agencies serving a population area of more than 500,000.

Agencies reported 45% of the youth served had substance abuse problems, with approximately 15% of all youth reporting an addiction to an illegal substance. Thirty-one percent had experienced physical abuse, 21% had experienced sexual abuse, and a little less than 10% reported suffering from an STD. Sixty-five percent of the agencies who responded provided clients with sexual and/or physical abuse counseling.

Agencies actually provided an average of 14 different services to address the multiple problems of at-risk youth. These services include shelter, counseling, crisis intervention, hotlines, medical treatment, employment training, transitional living programs, and alcohol and other drug counseling and treatment. Commonly, the agencies provided appropriate referrals for services they did not provide on site. Nearly all of the agencies offered both individual and family counseling and 30% provided full psychological evaluations. Thirteen percent offered medical services and 27% had drug treatment programs. Many of the agencies have easily-accessible 24-hour centers where teens can drop in to receive services. Forty percent of the agencies sponsored outreach programs that reached an average of 900 youth per agency.

Many of the agencies surveyed provided some form of longer-term programs for the teens. Thirty-seven percent provided educational tutoring, 31% provided employment training, and 20% had on-site alternative schools. Transitional living programs that motivate and support teens to build independent living skills were offered by 30% of the agencies surveyed.

In all, a total of 9,554 beds or host-home placements were available in 1989 by the 151 agencies that responded. These agencies provided 50,012 teens with shelter and turned 10,769 teens away due to lack of available space or resources. Sixty-one percent of the teens who received emergency shelter services returned to their families, 26% went to alternative living arrangements and 13% returned to the street or some other unstable living situation.

The National Network of Runaway and Youth Services concluded that adolescents are faced with an array of different interrelated problems and that the majority of agencies designed to serve at-risk youth are using a comprehensive approach to meet the needs of this population. Agencies employ an average of 32 staff members who are trained in a variety of areas. Volunteers were found to be an invaluable resource, with an average of 35 volunteers trained and employed by each agency in 1989. The majority of the responding agencies, with an average budget of \$500,000 or less, and receiving most of their funds (76%) from the public sector, still managed to provide an average of 14 different services to at-risk youth and their families.

Although there is extensive research of the types of agencies and services offered, there has not been sufficient research done of the effectiveness of these types of programs (Pillen, 1990). If effective programs exist, they need to be thoroughly evaluated, documented and clearly described to ensure successful replication. Obstacles and problems need to be honestly identified so that new programs will not spend valuable funding replicating ineffective interventions (Dryfoos, 1998).

#### Evaluations of Services for At-Risk Adolescents and their Families

Although research has been conducted on adolescent mental health services, there is very little research designed specifically to determine what actually works effectively in the treatment of adolescents. For example, what components of a specific program contribute to change? How can that success be replicated elsewhere (Cornsweet, 1990; Pfeiffer, 1989; Pratt & Moreland, 1996)? There is even less research conducted on the effectiveness of mental health programs that assist at-risk adolescents and their families. Because programs that serve at-risk adolescents are rarely evaluated, the evaluation of general mental health services available to adolescents and their families must provide a basis for evaluation studies on programs that serve at-risk teens, such as runaway shelters.

The purpose of evaluation is to improve a program, not to prove a hypothesis (Stufflebeam & Shinkfield, 1985). Evaluations provide information used for program appraisal, program adjustment, and for developing or clarifying a program's identity (Harinck et al., 1997). Successful program evaluations will describe actual program participants in relation to the program's targeted population of participants. They will

measure program impact with research questions based on the program's stated goals and objectives using strictly confidential methods (Sonenstein, 1997; Leber et al., 1996; Hadley & Mitchell, 1995). Effective evaluations detail how, and how many, clients have benefited from the services provided. They help ascertain what happens in the program that makes a difference or what barriers may keep clients from benefiting from program services (Mordock, 1995). Program evaluations serve to feed back information to the organization concerning its level of functioning, its strengths and its weaknesses. As Mordock (1995) states, "evaluation is actually verification" (p.3). What organizations want to know is did the implementation of the program result in clients reaching their target objectives?

Also important to evaluation research is program replication. A formal evaluation is often the best way to provide the information needed to prove a new idea is worth repeating elsewhere (Knickman & Jellinek, 1997). If a program is found to be successful in achieving its desired results and the components are described accurately in enough detail, it can then be replicated in other areas to serve a greater number of clients. Evaluations can be very useful in identifying and describing interventions that can be employed and imitated at other sites (Harinck et al., 1997). This information can save programs much time and money when it comes to program development. They will no longer have to waste precious hours and funds to reinvent the wheel. By way of previous evaluations, they will have information on what effective interventions should be replicated, and how to accomplish this, and what ineffective interventions should not be employed.

The CIPP model is often used to plan the implementation and evaluation of counseling programs (Hadley & Mitchell, 1995). This model presents four aspects of program evaluation: context evaluation, input evaluation, process evaluation and product evaluation. Context evaluation and input evaluation both deal with the planning and implementation of a new program. Context evaluation seeks to understand what unmet needs exist for planning a new program. Input evaluation asks what resources and constraints exist in the implementation of such a program.

While context and input evaluation look at program planning, process evaluation and product evaluation both deal with the refining of an existing program. They are both parts of impact evaluation methods that seek to provide information that will be useful in making major decisions about the continuation, expansion, or reduction of a program (Rossi, 1982). Process evaluation studies a program's daily activities: the activities and interventions used, the implementation of activities by staff, and the timeliness of these activities. It assesses the degree of program cogency: are the program strategies consistent with the delivery modalities in both intent and intensity (Sambrano, Springer & Hermann, 1997)? Process evaluation produces feedback that can help the staff carry out program plans as intended, or to modify plans if they were found to be somehow ineffective. Results from process evaluations not only provide feedback to the organization, but can give consumers accountability information on the program; potential clients will then know whether a program delivers what it proposes.

Product evaluation is used to measure, interpret and judge the effectiveness of a program (Stufflebeam & Shinkfield, 1985). Process evaluation results can be useful in helping to interpret product evaluation results because knowing what was actually done in the program plan helps in understanding why clients interpret a program as effective or ineffective (Hadley & Mitchell, 1995). Product evaluation provides information that helps ascertain to what extent program objectives are being achieved (Isaac & Michael, 1981). The effects of the program services are studied to determine if any "recycling decisions" need to be made, specifically if one an activity or intervention should continue, terminate, be modified or refocused (Hadley & Mitchell, 1995). This includes finding both the strong and weak components of a program. This is often done using self-reports from the clients and workers in a program (Harinck et al., 1997).

Self-report methods are used widely in program evaluations because explanations from clients are usually more informative and revealing than explanations from administrators or providers (Mordock, 1995). Beyond randomized, true experimental data, client reports are the most convincing evidence an organization has to verify whether program goals were achieved (Campbell, 1995). Self-report methods have been shown to yield substantial information in an effective and reliable manner (Ascher,

Farmer, Burns, & Angold, 1996). Self report can not only assess the level of client satisfaction, but also the clients' experiences of the program process, their interpreted views of program strengths and weaknesses, and their ideas about how and why program components are effective or not. Pratt and Moreland (1996) suggest gathering self-report information from multiple sources, clients as well as program staff, to get a broader picture of what aspects of the program are effective and what may be contributing to the effectiveness.

Researchers state that evaluation researchers should work collaboratively with program planners, staff, and other key administrators to determine the design of the evaluation study, how to determine program effectiveness and what areas should be studied for program improvement (Hadley & Mitchell, 1995; Harinck et al., 1997; Heflinger, 1992). According to many researchers (Berk & Rossi, 1990; Hadley & Mitchell, 1995; Harinck et al., 1997; Heflinger, 1992; Pratt & Moreland, 1996; Weisz, Weiss, & Bononberg, 1992), the cooperation of the key stakeholders is essential for successful evaluation studies. Without their support, data collected may be meaningless to the organization and may never be utilized to improve the program. Consumers, funding agencies and staff would then not have an opportunity to benefit from the evaluation findings. Miles and Huberman (1994) have found that because there are so many diverse audiences for evaluation findings, successful researchers are now more inclined to gather both quantitative and qualitative data. To insure the data sought actually gets collected, Leber et al. (1996) suggest incorporating the evaluation into the program routine to keep the study from being experienced as an interference by the clients or the staff. If the clients are disrupted by the data collection, they may not respond with thoughtful answers, or they may not respond at all.

Evaluation studies are usually based on the goals and objectives stated in the program's service or mission plan. Most runaway shelters will have a program mission based on the needs of their client population as indicated by research studies. The needs of at-risk teens can be addressed with components that deal with substance abuse education and prevention, safe-sex and STD/HIV education, anger management, learning effective coping skills, limit setting, clearly defining boundaries, and decreasing family

conflict (Denoff, 1991; Gullotta, 1979; Adams & Munro, 1979; Dryfoos, 1998; Jessor, 1998; Kipke, Unger, et al., 1997; Royce, 1998; Buckner & Bassuk, 1997). Of course, these components need to be delivered by staff who will connect with teenagers in a positive way. The staff then need to deliver services in a way that teens can adequately understand and benefit. Determining what type of staff and program delivery is successful is accomplished through the aforementioned evaluation process.

Researchers have found that many of the evaluation studies on adolescent mental health services are not designed to adequately measure the effectiveness of a program (Cornsweet, 1990; Curry, 1991; Pfeiffer, 1989). Many evaluation studies fail to describe the program adequately. Some studies do not assess progress or change made by the client between admission and discharge (Pfeiffer, 1989). Often, they lack rigorous research designs and do not have large enough sample sizes (Bickman, 1996). Pratt and Moreland (1996) state that many evaluations do not address multiple variables that contribute to program effectiveness and do not include feedback from more than one subset of the program, i.e. client and staff. They have determined that understanding what the staff and participants perceive as program strengths and weaknesses is an important and missing part of many program evaluations. It has also been noted that few studies have had adequate collaboration between the researcher and the stakeholders of the program being evaluated (Hadley & Mitchell, 1995; Harinck et al., 1997; Heflinger, 1992).

Schram and Giovengo (1991) conducted an evaluation of Threshold, an independent living program for homeless adolescent females. The residential treatment program was designed to help young women at risk for reaching adulthood without the skills, values and attitudes necessary to care for themselves. Threshold offers young women who have either been involved in prostitution or who are at high-risk for prostitution a series of progressively more independent living experiences.

The participants in the program represented a subset of at-risk teens, specifically, teens at-risk for prostitution. They presented with many of the same high-risk behaviors that the larger population of at-risk teens do: poor school performance, running away, substance abuse, and self-destructive behaviors. To participate in the Threshold project,

the young women had to be 16-18 years of age with a history of emotional, physical or sexual abuse and a history or high-risk of prostitution. They could not have a current drug addiction or assaultive behavior, and they must be committed to eliminating their prostitution involvement.

Threshold has a three phase format. Phase I is an initial stabilization period of four to six months when clients are assessed for their level of motivation. Clients are asked to participate in house activities, chores, and school. The rules are clearly defined and limits are externally imposed upon the teens. The clients are expected to design contracts with staff that address their individual goals and needs.

During Phase II, the clients are permitted to move into a house designed to hold four girls and two infants, if necessary. The house is staffed by a live-in foster parent and two full-time staff members. The young women may carry house keys, have friends over, and spend unsupervised time alone in the house. They must attend weekly house meeting and participate in weekly sessions with their case-workers. Goals of clients typically include employment and education, with an emphasis on autonomy. The house rules are kept to a minimum in order to encourage internal development of cause and effect relationships. Phase II usually lasts six to eight months.

Phase III consists of clients living independently in the community. Clients are encouraged to maintain contact with the staff and attend weekly support meetings. Most clients spend six months in this phase, but some choose to access the support for a year or more.

The evaluation of Threshold began with each client receiving a series of assessments, including medical evaluation, health knowledge assessment and a battery of various psychological tests. The staff found this procedure hard to schedule and the clients found the process to be intrusive and tiring. Many clients complained and some refused to participate in this process all together. Plans to collect follow-up data were abandoned and other outcome measures were developed.

The evaluation process developed after the initial approach was abandoned consisted of three components. The first component was descriptive, providing profiles of the young women involved in the program. The second part described the presenting

problems of the clients and the services provided to address these problems. The third component described client outcomes and compared them to client profile and presenting problem.

The client profile portion of the study found that of the 24 clients served during the two-year period, 75% had been out of the house for over a year. The typical client was a white female with a median age of 17.8 years who had been out of her home for 2 or more years before entering the Threshold program. Nearly all of the clients in the program had a history of sexual and physical abuse. Two-thirds of the clients had prior convictions for criminal behavior, most of which were minor misdemeanors. Many of the young women had experimented with one or more of the following drugs: alcohol, marijuana, crack, and acid. It is unclear how the researchers gathered this data, whether it was in the form of written questionnaires at intake, a series of informal interviews over the course of several weeks of Phase I, or some other procedure.

To determine client outcomes, researchers used data from the client files of the 24 participants who entered Phase II during the evaluation period. Data from the files included social history information, criminal, school and medical records, abuse reports, and prior placements. Researchers also used data obtained from Threshold intake information, results from psychological evaluations performed at the Adolescent Clinic, and progress logs and reports. Phase III adjustment information was also collected to determine the longer-term adjustment in the community.

Project records showed that while in the program, 50% of the Phase II participants realized the goal of employment and that 63% regularly attended school. Nearly all clients received individual and group counseling from staff and participated in project-sponsored recreational activities. Results were also broken down into percentages of women who received specialized counseling services like substance abuse or parenting counseling.

To determine the extent to which clients acquired the skills necessary to live independently, clients were assessed at discharge and then again six months later. Adjustment outcomes were divided into three categories: positive, negative and neutral. A positive outcome occurred when a client met the participation requirements of the

program, completed the goals of her treatment plan, had a stable living situation, was employed or in school, and was not engaging in substance abuse or criminal activity, including prostitution. A negative outcome occurred when a client was not able to complete one or more of the positive outcome criteria. A neutral outcome occurred when adjustment information was incomplete or not available.

Forty-two percent of the participants received positive outcome ratings and 33% received negative outcome ratings. The remaining 25% were determined neutral due to lack of information. A chi-square was performed to determine any associations between client profile and client outcome. Two variables were found to be correlated to positive outcomes: no conviction record and less than one-year involvement in street life.

The Threshold evaluation addressed many important components discussed earlier in this section. The evaluation described actual program participants and they were consistent with the program's targeted population (Sonenstein, 1997). They used both their general program goals and the client-specific treatment plan goals as a basis for measuring program impact (Sonenstein, 1997; Hadley & Mitchell, 1995). As a replication of the Boston Bridge Project, the Threshold project addressed Knickman and Jellineck's (1997) statement that program replication is an important evaluation component.

Missing from the Threshold evaluation is information about how or why the program is successful. Mordock (1995) states that effective evaluations detail how clients have benefited from the services provided. The Threshold evaluation clearly defines the program, its structure and components, but it does not explain how or why these components help clients. The program is based on Browne and Finkelhor's (1986) model of traumagenic dynamics, which provides a theory as to how and why the program components benefit victims of sexual and physical abuse. The theory, though, is not tested by the evaluation. Which components do clients believe are the most helpful? To what do clients attribute their success or failure?

The evaluation of Threshold provides an excellent example of an outcome study done on an adolescent residential treatment program for high-risk teens. The preliminary data collection had to be abandoned due to an inadequate and uncomfortable collection

process. The data collection process was refined, and the study continued. Data collection procedures for the client profiles are unclear. Self-report results may have produced different results than documented histories received from other agencies.

Outcome measures were qualified as positive, negative, or neutral. Splitting the participants with available information into two groups, positive or negative, is based on an all or nothing system of goal completion. To avoid this, researchers could investigate within the negative outcome group, how many of the six qualifying criteria for positive outcomes each had completed. Or to provide a more flexible notion of success, researchers could examine how many of the six criteria were a problem for the client upon intake and how many they had accomplished upon discharge and then maintained for six months after discharge.

In summary, at-risk teens are a population in need of services if they are to become healthy, productive adults. Unresolved conflict between parent and teen can often contribute to the risk of abuse to the teen and acting out behaviors by the youth that often include running away. Both parents and teens need services that will address their immediate needs, such as food and shelter, as well as medical, educational, and mental health needs. There are many services available to at-risk teens and their families, but few have been adequately evaluated for effectiveness.