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Bleak and hopeless no more Engagement of reluctant substance-abusing runaway youth and their families

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Abstract

Runaway/homeless shelters document high levels of substance abuse among runaway youth, at least double that of school youth. These youth present a constellation of problems and research suggests that this population may be unique in the range and intensity of associated problems. Most studies to date have collected self-report data on these youth; virtually no research has examined treatment effectiveness with the population. Given the void of treatment outcome research with these youths, there is need for identifying potent interventions. Given that issues of engagement and retention must assume prominence in the development of new treatments, this article presents a family-based treatment engagement strategy successfully employed with a sample of substance-abusing youth staying in a southwestern shelter. Youth and primary caretakers are engaged separately by the therapist utilizing motivating factors appropriate to context of the families' lives and to the developmental position of the client. © 2000 Elsevier Science Inc. All rights reserved.

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1. Introduction

Stereotypes that homeless and runaway youth are beyond help inhibit many prevention and health care providers from serving runaway and homeless youth (Stango, 1995). Rotheram-Borus (1991) criticizes the widely held opinion of one reviewer for the *Journal of the American Medical Association* who wrote of the “bleak and hopeless future” of runaway and homeless youth and concluded that “the problem is so huge, so inevitable; nothing can be done” (cited in Rotheram-Borus, 1991).

Indeed, numerous barriers impede successful intervention including: (1) stressful situations encountered by living on the street, (2) lack of education, job skills, medical care, and social services, (3) increased alcohol and other drug use and (4) the unrealistic stereotypes of these youth held by care providers (Stango, 1995). Although estimates of youth who run away from home each year range from 500,000 to 4 million (Athey, 1995; Sullivan & Damrosch, 1987; Weiner & Pollack, 1997) homeless youths, like homeless

families, are increasing in number (Kurtz et al., 1991), with estimated increases in homelessness ranging from 10–38% annually. Clearly, the need for intervention is great; however, runaway and homeless youth are an understudied and underserved population (Rotheram-Borus et al., 1994). Information from the few studies to date has focused on categorizing types of runaways and their behaviors and on their reasons for running.

The general consensus is that runaway youth are difficult to engage and maintain in therapy (Morrissette, 1992, Smart & Osborne, 1994). This is a population perceived as “difficult to work with” (Kufeldt & Nimmo, 1987). Although several excellent procedures are available to engage substance-abusing adults (Garrett et al., 1997; Johnson, 1973, 1986; Meyers & Smith, 1997; Stanton, 1995; Thomas & Ager, 1993), and adolescents (Szapocznik et al., 1988) into treatment, no engagement procedures have been identified for runaway/homeless substance-abusing teens and their families. This article will (1) review issues that these youth face, (2) review available engagement strategies for substance-abusing youth, and (3) provide an overview of a family-based treatment engagement strategy applied successfully to a sample of substance-abusing runaway youth who stayed at a Southwestern runaway shelter.

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2. Problem behaviors

Runaway and homeless youth constitute a vulnerable population that faces a multitude of problems. Studies document high rates of alcohol consumption and illicit drug use, physical and sexual abuse, depression, teen pregnancy, and frequent prostitution within this group (Johnson et al., 1996; Zimet et al., 1995). Several studies report high rates of comorbid diagnoses among homeless youth (Schweitzer & Hier, 1993; Warheit & Biafora, 1991), including the finding that 33–50% of these youth have attempted suicide (Feitel et al., 1992; Mundy et al., 1990; Rotheram-Borus, 1993; Sibthorpe et al., 1995) compared to studies of youth in general, which indicate that from 2–13% have done so (Earls, 1989; Garrison, 1989; Smith & Crawford, 1986; Velez & Cohen, 1988).

The level of current drug involvement in runaways is at least double that of school youths (Forst & Crim, 1994). The substance abuse rate of homeless/runaway youths is estimated to range from 70–85% (Rotheram-Borus et al., 1989; Shaffer & Caton, 1984; Yates et al., 1988) and three studies found between 30% and 40% of runaways had used intravenous drugs (Anderson et al., 1994; Pennbridge et al., 1992; Yates et al., 1988). Koopman et al. (1994) compared drug use behaviors of a non-runaway sample of youth to a runaway sample, and found that runaways are three times more likely to use marijuana (43% vs. 15%), seven times more likely to use crack/cocaine (19% vs. 2.6%), five times more likely to use hallucinogens (14% vs. 3.3%), and four times more likely to use heroin (3% vs. 0.7%).

Substantial evidence shows that homeless youth run from a family situation characterized by poor primary caretaking practices, violence, neglect and sexual abuse (Crespi & Sabatelli, 1993; Whitbeck & Simons, 1990). Kufeldt et al. (1992) surveyed 391 runaways at a shelter in Calgary and found that poor communication with primary caretakers was the most often mentioned reason for running, as well as fighting with family members. Teare et al. (1992) found that in their sample of shelter youths, those not reunified with their family had higher levels of hopelessness, suicide ideation and reported more family problems than those reunified. Hence, engaging primary caretakers in counseling with their youth is almost always advisable, given their involvement in precipitating the running away behavior (Rohr & James, 1994).

3. Available adolescent engagement strategies

The lack of motivation among adolescent substance abusers to get treatment is well-documented. For example, in a study of treatment engagement, Szapocznik et al. (1988) reported that 62% of youth between the ages of 12 and 21 were unwilling to come to treatment. Thus, treatment of adolescents with substance use problems is challenged by their lack of motivation to change, their difficult engagement and their premature termination (Feigelman, 1987; Stark, 1992).

Szapocznik et al. (1988, 1989, 1990) have developed an intervention called the Strategic Structural Systems Engagement (SSSE), to address the challenge of effectively engaging families of substance-abusing youth into treatment. The goal of this engagement strategy is to begin the work of diagnosing, therapeutic joining, and restructuring the family with the very first (pre-therapy) contact, thereby facilitating engagement (Santisteban et al., 1996) into therapy. This strategy often works to engage the entire family through one member, usually the most powerful family member, parallel to unilateral family therapy (Thomas & Santa, 1982). SSSE assumes that the same dysfunction within the family that maintains the presenting symptom will manifest itself during the engagement phase as resistance to entering treatment. The strategies utilized in SSSE use the same strategic, structural, and systemic concepts and techniques that are used during therapy, but focus on identifying and removing the family's resistance to therapy. Their results were quite pronounced, 93% of the substance abusers and their families in an intensive engagement condition were engaged into treatment, compared to 42% of the engagement as usual group (Szapocznik et al., 1988). Moreover, 77% of substance users in the experimental condition completed treatment, compared with 25% in the control condition.

Szapocznik's intervention has proven highly successful for engaging non-runaway substance-abusing youth and their families. However, evidence is accumulating that substance-abusing youth staying at a runaway/homeless shelter represent a unique population that overshadows the population of non-runaway substance-abusing adolescents in rates of substance use, high risk behaviors, resistance to treatment, as well as family and psychological problems. Hence, the issues of the intact families versus families with a child on the run differ and likely require a unique strategy. First, runaway/homeless children staying at a shelter are frequently not communicating with their primary caretakers or communicate ineffectively with them, which precludes engagement of the family through one member. Secondly, Szapocznik and his colleagues begin the engagement process through a highly motivated family member who calls and requests services, whereas, in the runaway sample, neither the primary caretaker nor the child is requesting treatment, other than for the youth to stay at the shelter. Finally, Szapocznik's intervention is based upon diagnosing and restructuring the family system with the very first contact. Often, among families of runaway youth, the adolescent has not been in the home for weeks or months and engagement must focus on rebuilding connections, or reintegrating a member into a collapsed system, and less so on restructuring an intact system. Families of substance-abusing runaway/homeless youth are diverse in the issues they must face, which may include poverty or unemployment, primary caretaker alcohol or drug use, lack of support and primary caretaking skills. But many share the common theme of family chaos, or the lack of an organizational structure.

Meyers and Smith's (1997) Community Reinforcement and Family Therapy (CRAFT) intervention was originally

developed to engage adult drug users through a concerned significant other (CSO), although a clinical trial is currently underway to evaluate its effectiveness with substance-abusing adolescents and their families (Waldron et al., 1999). A CSO may call the treatment facility stating that their child has a substance abuse problem but refuses treatment. These CSOs are brought into treatment and are taught communication and operant-based engagement strategies that apply positive and negative consequences appropriate to the substance-abusing individual, the goal of which is to engage the resistant substance abuser into treatment. This program is two to three times more successful at engagement of resistant substance abusers than the two most popular methods used in the United States, the Johnson Institute Method, and ALANON (Meyers et al., 1999; Miller et al., 1999). As with Szapocnik's engagement strategy, Meyers et al.'s strategy begins with a motivated family member, which given the level of hopelessness and chaos in runaway adolescents and their families, is often unavailable.

According to Foote et al. (1994), "the issues of engagement and retention must assume prominence in the development of new treatment approaches." In view of the aforementioned dearth of established intervention procedures, to address the engagement of a unique population sorely requiring intervention, this article proposes the following procedures. These procedures have been employed successfully with a sample of youth staying at an urban southwestern runaway shelter. This intervention operates under the assumption that family members can mend relational issues before the family connections disintegrate entirely. Youth diagnosed with drug or alcohol abuse/dependence who have the legal option of returning to a home situation (either with primary caretaker, sibling, extended family, or foster family) are engaged into a 16-session behavioral, family-based intervention. The therapist utilizes strategies reflecting different motivating and developmental factors to engage youth and primary caretakers with the goal of meeting together for family therapy. These strategies are described within four progressive engagement stages: contact, presentation, evaluation, and negotiation. New Mexico is a culturally diverse area, with roughly equal proportions of Hispanic Americans, Native Americans, and European Americans. Youth engaged into this program represent this ethnic composition.

4. Youth engagement

4.1. Contact

The contact phase of engagement involves approaching youth to discuss the treatment program. In order to facilitate engagement and reduce distance or separateness between the therapist and client, the therapist should use and understand language from the youth's culture. The contact phase may be the most critical as if contact is unsuccessful, the youth will not proceed to the next phase of engagement.

Many youth show suspiciousness within seconds after the approach, hence the therapist must be confident, nonthreatening and able to "roll with resistance."

T: John? Hi, my name is Dan, and I'd like to talk with you about a project we're running. Do you have a few minutes?

C: What kind of project?

T: It's a project where we work with kids who don't live at home.

C: Yeah, well what am I going to have to do?

T: You don't have to do anything that you don't want to do, I'd just like to talk to you for a few minutes. Let's go back to my office and talk there.

C: Can we talk here?

T: Some of the things we talk about are private, so it's probably best if we don't talk around other people.

C: How long will it take?

T: Just a few minutes, but you can take off whenever you want to. Okay?

C: Okay.

Versus a traditional approach:

T: John? My name is Dan, I'm a therapist, and I'd like to talk to you about a treatment program we're providing to youth who stay at the shelter.

C: I'm not interested in any treatment.

T: We provide excellent treatment to substance-abusing youth and their families.

C: I've had plenty of excellent treatment, and I'm not talking to my family. No thanks.

As mentioned, the first contact is critical, the youth's experience with the therapist during the initial contact will heavily influence his or her decision to continue. Hence, the therapist must take cues from the client in order to assess their interpersonal style and utilize the appropriate verbal and nonverbal skills based upon this analysis. The therapist may employ an informal, friendly, and at times humorous approach for those youth who appear outgoing and open, and a more soothing, serious approach for those youth appearing uncomfortable and fearful. Successful contact is accomplished through meeting youth at their level.

4.2. Presentation

The goal of the presentation phase is to present the treatment program in a manner which the youth finds appealing and non-threatening. In this phase, the therapist does not ask personal questions; his or her task is only to present the program and build rapport. This approach attempts to reduce

the awkward pressure of a first meeting experienced by the youth, and allows the youth to observe and evaluate the therapist. The therapist will state that many other youth who stayed in the shelter have participated in the program and have generally been pleased with it. In essence, the message is relayed that others who are similar to the client have participated and benefited from the program, and the client may benefit as well. However, adolescents who have recently arrived at the shelter are apprehensive and unclear as to the requirements placed upon them, and must be told that the program offered to them is voluntary, and is not a required part of the shelter program.

T: Ok. Thanks for coming in to talk. I don't work for the shelter; actually, I'm a counselor for a program through the University, and we work with kids who come to the shelter. Usually, when somebody stays at a shelter, it's because something in their life or in their family isn't going too well.

C: Yeah, my mom kicked me out last week so I took off.

T: Uh huh. Well, we've worked with a lot of kids in that situation who have stayed here, and in fact we're working with some who are staying here right now who have really liked meeting with a counselor. Of course, it's completely your choice to participate and no one is going to make you do anything that you don't want to do. But if you're having trouble with parents or with the police, we may be able to assist you in dealing with them.

The shelter in which youth stay does not provide formal treatment, but rather provides crisis intervention and placement from the shelter within 5–10 days. Many youth are not seeking psychological services, and they are especially uninterested in addressing their drug and/or alcohol use. That is, they are likely to respond negatively to suggestions that it may be helpful to address these issues, and emphatically state, "I don't have a drug problem!" Hence, the therapist is advised to avoid discussion of the therapy as drug and alcohol treatment. Instead, the engagement approach appeals to the youth's perceived needs and motivators. In this way, the therapist is described to the youth as an ally, to be used in whatever capacity that an ally may be useful. For example, allies are often useful when dealing with family members, probation officers, court appearances, and the school system. This approach is nonconfrontational, developmentally appropriate, and seeks to empower youth through the therapist being "at their service."

In a traditional therapeutic context, the task of the therapist is to remain neutral, and to confine intervention to the office. The intervention in which runaway/homeless youth are engaged utilizes an ecological approach in which the therapist's aid is not confined to the office, but rather, is extended to multiple systems which impinge upon the child. In contrast to a traditional approach, the therapist cannot be perceived as removed or even neutral toward the client. Rather, the boundary moves toward the client with the therapist being partial toward the youth and their plight.

C: Look, I don't need any counseling.

T: The way that we approach it is that when things aren't going well at home, it sometimes seems like you've got an awful lot of people to deal with, like parents, the police, social workers, and school officials. Are you having a hard time with that?

C: Yeah.

T: That's where a counselor can really help you out. It can really be great to have an ally on your side. Do you know what an ally is?

C: Yeah. Somebody to help you.

T: Right. It's somebody on your side. Somebody who can kind of intervene between you and all of the people making demands on you. So if you're having a problem with your mom, the ally would be able to sit in and help with talks. Or if you're having other problems, our counselor won't just stay in the office, he or she will go out and help you to get a job or meet with your probation officer. We just want to help!

Several issues are generally characteristic of runaway youth, which, if incorporated into the presentation of the particular treatment program being offered to these youth, will likely enhance the probability that they will engage into treatment. Many of these youths have experienced physical and/or sexual abuse in their lifetimes, have comorbid anxiety or mood disorders and feel alone in their struggles. Hopelessness is a common symptom displayed by these youth, in which they feel that nothing can be done to repair their relationships or life situation. The engager is knowledgeable about the issues youth face, and provides support through understanding.

Youth are also likely to fear judgment, shame, betrayal, and therapy itself. The therapist is direct about the client's situation (e.g., homelessness, legal trouble), and tells youth, who may have been told by various adults that they are "no good," that they have survived as best they could in a difficult situation. As described to youth, the treatment approach encourages understanding between family members; it does not assign fault or blame, but seeks to repair a connection that may have been lost during their struggle. Shame about being in their position, and engaging in high-risk sexual and drug behaviors, is thus reframed in terms of relational connections rather than as intrapersonal failure.

C: Well, if you talk to my mom she's just going to tell you that I lie and that she doesn't want me back in her house.

T: Whatever your mom has to say is her opinion, but it seems to me that you've done what you could in a tough situation. Family problems are not just one person's fault. Usually they're problems where people aren't communicating and aren't understanding each other.

C: She doesn't understand anything and she tells me if I'm going to sleep around and do drugs not to come home. So I don't.

T: It sounds like you and your mom really don't understand where each is coming from.

Confidentiality is emphasized in the presentation phase. Youth are told that information revealed to therapists either alone or in the family situation is not revealed to anyone without a signed consent, with the exception of legal reporting requirements. Specifically, youth are informed that probation officers, family members and shelter staff are not provided information regarding clients' substance use or illegal behaviors. Youth are told that if the therapist released confidential information without their consent, no youth would participate in therapy and the therapist would also be in violation of their ethics code. The potential for reporting during therapy is less than it would otherwise be for homeless youth not in a shelter, as the shelter conducts a risk assessment at intake and files the appropriate reports with Child Protective Services.

Finally, this phase includes education regarding the therapy process, which serves to demystify and normalize the process. Youth are informed of the length of meetings and that people do not need to be "crazy" to be in therapy. Rather, therapy provides a forum for discussion of issues, hopes, and fears, among "normal" people. Youth are told that having an ally in the room during discussions often helps resolve and clarify issues.

T: All of our meetings are confidential. Do you know what that means?

C: That you don't tell anyone what we talk about.

T: Right. We don't tell anyone: not the shelter staff, not social workers, not the police, and not parents. If we did, nobody would tell us anything, right? But it would also be unethical for us to tell other people what we talk about in therapy, unless it involves risk to you or others. Okay?

C: Okay.

T: So here's the deal with the counseling. We would like to meet with you once or twice a week for the next 15 weeks. Sometimes it just helps to bounce your ideas off of someone who's on your side, to make things clearer. It's your choice about how you want to move forward. You don't have to meet with the counselor and you can quit therapy at any time and nothing bad will happen. Let's try it out for a week or two and if you don't like it, you can quit.

4.3. Evaluation

Youth often feel powerless to change their situation. Through the engagement process, not only are they given

hope that change is possible and that they are not alone, but also that they have complete control in deciding whether to move forward. This stage evaluates and addresses the youth's motivators or reinforcers and concerns, and may be likened to a functional analysis (Meyers & Smith, 1995). The therapist begins by asking the youth a relatively safe question, "What brings you to the shelter?" The therapist's task is to identify those points that the youth presents that may serve to motivate them into therapy, and reinforce prosocial behaviors, as well as explore triggers for using behaviors. Once motivational factors are identified, the therapist will begin to establish some positive reinforcers (i.e., making it to sessions, being honest) with the goal of instilling hope. Again, in this way, a seemingly hopeless situation begins to appear less formidable, especially with the aid of an ally.

T: So what happened that you're staying here now?

C: I'm here because I didn't like it at my Mom's house.

T: You didn't like it at your Mom's? How come?

C: We fought all the time, and I can't stand her boyfriend.

T: What did you fight about?

C: Everything.

T: What's wrong with her boyfriend?

C: He takes her side on everything, I just can't stand him.

T: So much that you feel like you can't live there?

C: I'm not going home as long as he is there.

After identifying motivators (e.g., wanting to go home, reducing family conflict, addressing relationship issues), and exploring possibilities for overcoming the obstacles, the therapist discusses concerns and answers questions that the adolescent may have. Concerns may range from wanting to avoid a particular family member, from having had negative experiences with treatment in the past, fear that the primary caretaker(s) will not participate in the therapy, or fear that primary caretakers will discover that the youth has used drugs or has engaged in certain high-risk behaviors. Each concern should be validated and systematically addressed. Success depends on the youth becoming convinced that the therapist understands him or her and is invested in helping. Upon agreeing to participate, this decision is reinforced. That is, youth are reminded that the therapist is their ally, that he or she will create a safe context for therapy, and will call to negotiate a meeting with the primary caretakers.

T: So what kinds of things would make you *not* want to do this counseling?

C: If my mom hears I'm in therapy she's going to know I use drugs.

T: I'm *your* therapist, I wouldn't want to do anything that might make things *more* difficult for you. If you believe that telling your parents you use drugs would make life much harder, I will not betray that confidence. It may be that at a later point in our work together you might feel more comfortable about telling her, and we can plan together how to do it—but that's up to you.

4.4. Negotiation

At times, the youth and therapist will negotiate before the youth agrees to participate in therapy. Concerns of youth in the evaluation stage may be that they do not want their drug use, hang-out spots or crimes which they have committed to be discussed in sessions. These concerns are related to confidentiality, and they are assured that all but the legal reporting requirements will remain confidential. Youth may also state that they do not want to meet with their primary caretakers at all. This may be the result of feeling angry or alternatively, fearful that further rejection may occur. The therapist may state that he or she respects the clients' concerns, and restate to the youth that he or she is in control of deciding what is tolerable. The outcome of the negotiation phase may be that the therapist meets alone with the youth with an agreement that the youth will remain open to re-evaluate the situation at a later point. To date, in our program, no youth initially resistant to meeting with primary caretakers ($n = 45$) has declined to meet with them after the fourth individual session.

5. Primary caretaker engagement

Engagement of primary caretakers of runaway adolescents is challenged by several factors. Primary caretakers whose youth are in the shelter may have individual drug and alcohol problems, distrust of the mental health system, and marital or financial stressors. Moreover, primary caretakers often express hopelessness, "I've already been through this a number of times and nothing has helped," anger, "My son needs to grow up first," fear, "He will blame me," and defensiveness, "She's done it to himself. It's not my problem, I did everything I could."

5.1. Contact

The goal of this phase with primary caretakers is to gain approval from them to move on to the next phase of engagement. Contact is initially made with a phone call, which limits the therapist's ability to assess the client's nonverbal response. Hence, the therapist is advised to attend to the client's tone and initial verbal response and tailor his or her own approach accordingly. First, the therapist identifies himself or herself and states that in talking with the primary caretaker's child regarding the possibility of meeting to-

gether, the child expressed some interest. In the initial contact phase, the therapist does not solicit a response from the primary caretaker; instead the therapist is advised to empathize with the primary caretaker's situation, and acknowledge that primary caretakers experience feelings of frustration or hopelessness regarding the situation with their child. The therapist may state that sometimes youth do not realize the impact they have on the people close to them, and that their child might be surprised by the pain the primary caretaker is feeling. The empathy and support expressed by the therapist will hopefully serve to make the primary caretaker feel comfortable in hearing more about the program.

5.2. Presentation

At the end of the presentation phase, the primary caretaker should feel interested about the possibility of support and assistance for their situation with their child. Care is taken to ensure that primary caretakers have been given enough information about the program to be able to frame questions for the evaluation phase and so that they do not feel pressured into participating in therapy. Parallel to the adolescent presentation phase, the therapist does not ask personal questions of the primary caretaker, reducing pressure and allowing the primary caretaker to evaluate the therapist. The therapist also notes that he or she is available to help and will want to help in the ways that the primary caretaker finds beneficial. The therapist may also note to the primary caretaker that many other primary caretakers who had felt frustrated and hopeless about their situation have tried the program, working to re-establish a broken connection. Thus, the therapist communicates his or her expertise in working with others in similar situations and reduces the client's experience of isolation.

Again, as in the youth's presentation phase, the therapy process with the primary caretaker is briefly described (e.g., number of sessions, confidentiality). In addressing potential fears and defensiveness, the therapist takes the primary caretaker off the hook by stating that the model of intervention is nonblaming and by stressing that his or her child needs and wants help. The therapist states that he or she needs the assistance of the primary caretaker to provide the best help possible to the child.

5.3. Evaluation

Again, as in the youth's evaluation phase, the primary caretaker's motivators or reinforcers are evaluated and concerns are systematically addressed. In assessing the primary caretakers' motivators the therapist may ask, "What would you like to see happen with your child?" This question not only provides the therapist with direction to motivate and provide hope to the primary caretaker, but it serves to deflect the focus away from the primary caretaker's anger toward the youth. The therapist addresses each motivator by presenting the therapy context as a forum for resolving and improving the chances for the desired outcome.

Questions and concerns are then addressed. For example, primary caretakers may have already been through therapy and did not experience it as helpful. When assisting the primary caretaker in deciding whether or not to agree to therapy, it may be useful to state, “Research shows that runaway/homeless youth who reconcile with their parents report improvements in many areas including depression, substance use, etc. Your child wants to talk with you in a therapeutic context, and though I’m aware of your concerns and frustration, how do you feel about trying one more time?”

5.4. Negotiation

If the primary caretaker remains hesitant to meet with the youth, the therapist may offer to meet alone to discuss concerns, either in the family’s home or at the shelter, depending on the primary caretaker’s preference. The therapist states that many primary caretakers are initially reluctant to meet with their youth for reasons that are understandable, but that sessions alone with the primary caretakers and youth are often useful in preparing for a family meeting. Primary caretakers are reminded that the decision to participate in therapy is completely voluntary, and that they may discontinue the therapy, even after the first meeting. It is also possible that when exploring the primary caretaker’s hesitancy, logistical difficulties (barriers to treatment), rather than disinterest in therapy, are the cause.

5.5. Barriers to treatment

Primary caretakers may express interest, but be hesitant about meeting, because they do not have transportation, gas money, time, or someone to watch their young children. In response to these concerns, the therapist acknowledges the difficulty and states:

T: It would be unfortunate to have anything interfere with this important work. We are aware of the many demands placed upon parents, and it is our goal for therapy to be helpful and not a drag. Hence, we will work together with you to make our meetings helpful. Because many other parents have similar difficulties and demands, we are prepared to meet in your home. We are flexible about meeting times, and will work with your schedule in arranging a time for the sessions.

The therapist may determine that a second phone call will be necessary to continue the engagement process in order that the primary caretaker may take time to consider the offer of assistance.

6. Conclusion

Runaway/homeless youth are an understudied and ignored population, primarily due to methodological challenges in locating, treating and retaining youth in treatment. Moreover, shelters, the primary intervention for these

youth, are overcrowded, and many shelters are not equipped to treat youth for drug, alcohol, high risk behaviors, and family problems beyond crisis intervention. The current article provides strategies used successfully to engage reluctant substance-abusing runaway youth and their families into treatment. Each stage in the engagement process (contact, presentation, evaluation, and negotiation) provides goals and interventions utilizing developmentally appropriate and motivational techniques specific to the population being addressed. As noted by Rotheram-Borus (1991), alcohol, drug use and related problem behaviors can only be addressed in the context of these youths’ lives.

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