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Ethical Considerations for Research and Treatment With Runaway and Homeless Adolescents

MELISSA A. MEADE and **NATASHA SLESNICK**
Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico

Abstract

Ethical considerations for working with runaway and homeless youth in research and treatment settings are presented. Issues of parents' and adolescents' consent for research and treatment are discussed, with particular attention given to the lack of explicit guidelines for working with abused and neglected youth. The principles of beneficence and justice are discussed as they apply to intervening with a high-risk, multiproblem population. The authors offer a rationale for allowing adolescents to self-consent to research and treatment. They argue that in many circumstances, requiring parental consent may not be in the youth's best interest and may preclude his or her participation in treatment and research programs.

Keywords

ethics; homeless adolescents; runaways; treatment consent

HOMELESS AND RUNAWAY YOUTH represent a large, distressed subgroup of adolescents in need of research and treatment attention. One in eight children will run away before reaching age 18 (Nye & Edelbrock, 1980), and this figure increases to one in four for single-parent households and households with more than eight persons. These youth present with high rates of clinical depression (ranging from 29% to 83.6%; Shaffer & Caton, 1984; Unger, Kipke, Simon, Montgomery, & Johnson, 1997; Yates, MacKenzie, Pennbridge, & Cohen, 1988), high rates of psychotic symptoms (Mundy, Robertson, Robertson, & Greenblatt, 1990), and other affective and anxiety disorders (Shane, 1991).

Runaway and homeless youth also show higher rates of alcohol and drug use than children who live at home (Forst & Crim, 1994), with reported rates of substance-use problems ranging from 70% to 95% (Booth & Zhang, 1997; Rotheram-Borus et al., 1989; Shaffer & Caton, 1984; Yates et al., 1988). These youth often engage in illegal activities, including prostitution, theft, truancy, and the sale and distribution of narcotics (Deisher, Farrow, Hope, & Litchfield, 1989; McCarthy & Hagan, 1992). Intravenous drug use, compromised judgment due to drug use, and risky sexual practices place them at increased risk for contracting HIV (Rotheram-Borus, Feldman, Rosario, & Dunne, 1994).

Runaway and homeless youth have been described as understudied and underserved (Rotheram-Borus et al., 1994). There is a void of research examining treatment interventions with this population, and many treatment providers are not equipped to effectively address the range of problems these youth face. The lack of research and intervention may be explained partially by this population's lack of social stability, which creates difficulties in tracking youth, scheduling appointments, and maintaining youth in therapy or research protocols. In this

Address correspondence to Natasha Slesnick, University of New Mexico, Center on Alcoholism, Substance Abuse, and Addictions, 2650 Yale SE, Albuquerque, NM 87106; tash@unm.edu (e-mail).

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article, we identify the impediments to research and treatment, which include ethical issues associated with obtaining informed consent, reporting requirements, and barriers to accessing services.

Because runaway and homeless youth are disconnected from their families and from society in general, they constitute one of the most vulnerable segments of our society. Given the range of problems these children face, they are clearly in need of psychological services. Runaway and homeless youth rely on those employed in their interests (social workers, health-care providers) to assist them; these children have limited resources and diminished power in an adult-centered system. Unlike other children, most of whose adult family members ensure that their children are protected, runaway and homeless youth often are victims of family abuse or have been exploited by other adults and neglected by system workers.

There are inherent ethical questions involved in working with this population. Challenges lie in our interpretation of ethical principles as they apply to conducting mental-health research and treatment. Federal regulations and court decisions intended to outline ethical conduct for researchers and clinicians do not provide clear guidelines for working with runaway and homeless youth. Mental health researchers are hampered by issues of informed consent and reporting requirements when designing treatment and research projects. It is, perhaps, the ethical dilemmas related to consent and reporting requirements that explain the paucity of research examining treatment outcomes with runaway and homeless youth (Fisher, 1994). Such research is critical because few empirical evaluations to identify interventions that reduce problems associated with adolescent homelessness have been completed.

Another dilemma faced by runaway and homeless adolescents is the lack of access to community mental health treatment. Treatment providers often are not equipped to effectively intervene with this group (Rotheram-Borus et al., 1994), given a deficiency of treatment coordination, insufficient parental involvement, and providers' lack of knowledge about the issues that homeless youth face. This shortage of available and efficacious interventions raises the question of whether these youth are receiving treatment on a par with services provided to nonhomeless adolescents. If runaway and homeless adolescents are not receiving equitable treatment, then efforts should be made to remedy this problem.

In this article, we address issues of informed consent, reporting, and access to effective services in both research and treatment. It is our expectation that the delineation and discussion of these issues will facilitate the removal of barriers to research and treatment with this neglected group and that the suggestions for managing the ethical dilemmas will help guide researchers and clinicians in their work with these youth.

Informed Consent for Research

Obtaining informed consent to participate in research and treatment is a requirement of the U.S. Department of Health and Human Services (DHHS; Office for Protection from Research Risks [OPRR], 1979). To obtain a valid consent, a researcher must provide all information that would be relevant to a decision maker. The researcher must determine that the person possesses the cognitive capacity to analyze the risks and benefits of participation and to ensure that the participation is voluntary (Prout, DeMartino, & Prout, 1999).

The Belmont Report of the National Commission for the Protection of Human Subjects (OPRR, 1979) explicitely states that permission to participate in research must be obtained from the participant and, in the case of minor children, from a parent or authorized legal delegate. The mandates for informed consent are based on the individual's right to autonomous self-determination. Furthermore, the DHHS has instituted regulations to the effect that both *consent* from the parent and *assent* from the child must be obtained before minors can be

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included in research (OPRR, 1993). Assent refers to the child's agreeing to participate, rather than simply failing to refuse participation (Porter, 1999). The age requirements for obtaining assent as provided by the DHHS are vague, and it is up to each research institution's Institutional Review Board to determine a minimum age of assent.

Homeless and runaway youth present special problems for the researcher who is attempting to obtain a valid consent for participation. Perhaps the most difficult issue to resolve when working with this population involves interpreting the guidelines that specify when parents must provide consent and when it is appropriate to allow consent from the adolescent alone. Current DHHS guidelines allow the adolescent to consent alone in cases of abuse and neglect.

In many cases, obtaining valid consent from a caregiver is complicated by the youth's status as a runaway. A youth living on the streets may not wish for the researcher to contact his or her family, social worker, or other legal guardian. It is also possible that parents who are contacted to obtain consent may not return the consent forms, indicating a lack of interest or concern for their son or daughter. Given the difficulty with obtaining parental consent, the debate about adolescents' ability to consent alone to mental health research becomes relevant.

Adolescent Consenting for Research Alone

The decision as to whether the adolescent can consent alone becomes an issue involving the adolescent's autonomy to researchers working with runaway and homeless youth. According to the Belmont Report, individuals participating in research have the right to weigh the risks and benefits of participation to ensure that participation will not inhibit or disrupt their life plan. Mandates for parental consent, however, limit children's autonomy by giving parents the authority to grant or withhold permission for their child's participation in research (Attkisson, Rosenblatt, & Hoagwood, 1996; Prout et al., 1999). One can infer that these stipulations were intended to protect parents' rights to make autonomous decisions for their family as a whole, as well as to protect the safety of the child. Therefore, the issue of an adolescent's consenting alone involves the adolescent's readiness to make decisions in his or her own best interest, independent of parents or family.

Mental competency—The issue of mental competency is a cornerstone in the debate over whether homeless or runaway adolescents should be allowed to consent alone to research. Resolving the question of adolescent self-consent involves evaluating a youth's competence to understand that to which he or she is consenting (English, 1999) and to make the best choices for himself or herself (Blustein & Moreno, 1999).

In terms of cognitive development, children gain the ability to perform abstract reasoning and formal logic during adolescence. Adolescents learn to conceive of theoretical situations and to project multiple outcomes for behavior (Flavell, 1985; Inhelder & Piaget, 1958). Although not all adolescents mature at the same rate, it is generally true that reasoning and logic abilities develop during the middle school and high school years (Leffert & Petersen, 1999). Governmental guidelines regarding consent, however, do not recognize the advent of reasoning skills in adolescents. Although not expressly stated, federal regulations requiring parental consent imply that all minors lack the cognitive skills to make appropriate choices for themselves.

Many researchers do not acknowledge this lack of mental competency among adolescents. As reported by Melton (1981), a number of investigators have documented that adolescents fare as well as adults in terms of competency to make decisions (Grisso & Vierling, 1978; Weithorn, 1980). Leffert and Petersen (1999) described studies demonstrating that by age 14, youth have developed reasoning abilities commensurate with those of adults (Kuhn, Amsel, & O'Loughlin, 1988; Weithorn & Campbell, 1982).

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Still, some theorists argue that adolescents may be encumbered by environmental tensions or problems that affect their ability to consent to research. These theorists have suggested that normal development of cognitive abilities may be compromised by the youth's environment (Putnam, Liss, & Landverk, 1996). A lack of formal education, experience, or emotional regulation may disable adolescents' decision-making skills (Leffert & Petersen, 1999). Putnam et al. (1996) suggested that children already taxed psychologically by maltreatment or neglect may be too overwhelmed to offer valid consents. Certainly, runaway and homeless adolescents would fall under this description of maltreated youth. However, the question remains as to whether these youth are rendered incompetent by their negative experiences.

In response to those who have suggested that abused adolescents are unable to be autonomous, Blustein and Moreno (1999) remarked that not all children are compromised cognitively by abuse. Hence, we should not underestimate the resiliency of children who are able to cope successfully with adversity. Furthermore, it should be noted that traumatic experiences do not universally preclude mental competence. Valid consent is routinely obtained from adults who have experienced trauma, the implicit consensus being that traumatic experiences do not lead inevitably to mental incompetency.

Levine (1995) and others have suggested applying the concept of "mature minors" to adolescents older than age 14 who are able to consent for themselves to ideographic or epidemiological research that poses minimal risk. In the case of runaway or homeless adolescents who are separated from caregivers either voluntarily or by force, this idea of mature minors would allow these youth access to the resources of research (i.e., monetary, mental health referrals) that could be denied them if parental permission were required. Applying the mature minor criterion on an individual basis for adolescents who wish to consent alone to research is a legitimate consideration. Considering the evidence that demonstrates the advanced cognitive development of adolescents, refusal to recognize his or her autonomous decisions may not be in the youth's best interest.

Abuse and neglect—In some instances, adolescents always are granted the autonomy to consent alone to research. As previously stated, regulatory guidelines clearly specify that adolescents may consent alone in cases of abuse. For runaway and homeless adolescents, the incidence of abuse is well documented (Kurtz, Jarvis, & Kurtz, 1991; Kurtz, Kurtz, & Jarvis, 1991; Wolfe, Toro, & McCaskill, 1999). Reports of violence by parents range from 17% to 50% and reports of sexual abuse range from 5% to 30% (Kurtz, Jarvis, & Kurtz; Kurtz, Kurtz, & Jarvis; Whitbeck & Simons, 1990). Whitbeck and Simons further observed that 42% of the youth they sampled cited physical abuse as a reason for leaving home and 24% cited sexual abuse as a reason for running away. In their sample of shelter-bound youth, Slesnick and Meade (2001) found that 52% of system youth (youth with prior stays in group or foster homes) reported sexual abuse compared with 28% of nonsystem youth. Moreover, 53% of system youth and 51% of nonsystem youth reported physical abuse. Thus, although reports of abuse among runaway and homeless youth range between 25% and 50%, these adolescents constitute a large subgroup of this population. In cases of abuse, a researcher who informs parents of their child's wish to participate in a study may violate the youth's privacy or place the youth at risk for further mistreatment (Fisher, Hoagwood, & Jensen, 1999).

Runaway and homeless adolescents experience more subtle incidents of mistreatment through parental psychological abuse, which may include behavior that undermines the child's belief in his or her own worth, such as name-calling or hypercriticism. Psychological abuse is difficult to document in the literature because of the problems involved in measuring the severity of this form of abuse. However, as in cases of physical abuse, a youth may fear that contacting his or her parents for consent to participate in research will bring about further abuse.

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As with cases of physical abuse, the DHHS provides an exemption from parental consent in cases of neglect. Kurtz, Jarvis, and Kurtz (1991) found that homeless youth reported parental neglect more often than nonhomeless youth did. Homeless youth have reported that their parents are not available or willing to care for or support them and that, in essence, the adolescents are not wanted by their parents. In one study, 41% of youth cited parents' not caring about them as a reason for leaving home (Whitbeck & Simons, 1990). In cases in which the parent has abandoned the child, obtaining informed consent may be inappropriate because the parent is not fulfilling his or her role as caretaker of the child.

However, guidelines for informed consent as put forth in the Belmont Report do not adequately define abuse or neglect. In cases in which abuse or neglect of the child is more insidious, there are no clear guidelines for obtaining informed consent from parents or from adolescents alone. Examples of subtle neglect demonstrate the gray areas in which OPRR guidelines do not dictate a definite course of action for obtaining informed consent. Parents of runaway and homeless youth sometimes eject their child from the home as a form of retribution or as an attempt at behavior control. Similarly, parents can decline to visit or to pick up their child from a homeless shelter or they may refuse to provide their shelter-residing child with clothing or personal-hygiene products. In other cases, parents of homeless and runaway youth offer minimal care for their child because the child is abusing drugs or alcohol or has a mental illness (Kurtz, Jarvis, & Kurtz, 1991; Teare, Furst, Peterson, & Authier, 1992). When parents are unwilling or unable to care for their child, but custody has not been removed by the state, the youth may be better able than the parents to determine the risks and benefits of research participation and to make an informed decision.

High family conflict—Although not all homeless youth have been abused, the large majority of these adolescents report leaving home because of some type of conflict with their families (Crespi & Sabatelli, 1993; Kurtz, Jarvis, & Kurtz, 1991; Kurtz, Kurtz, & Jarvis, 1991; Teare et al., 1992). In their sample, Kurtz, Kurtz, & Jarvis found that runaway youth reported poor family communication and high levels of family conflict. These researchers viewed youths' running-away behavior as an attempt to cope with long-standing conditions of emotional strife in the home rather than as an impulsive reaction to a single conflictual family situation. Although a high level of conflict among family members does not provide evidence for abuse, frequent conflict in the home has been associated with substance use, delinquency, and depression (e.g., Hops et al., 1987; Mas, 1986). In this situation, it may again be in the adolescent's best interest to consent alone to research if he or she determines that parental consent may cause further strife at home.

Youth wants no family contact—Homeless street youth often are not in contact with their families and do not want or do not know how to contact their parents. Thus, requiring consent from a legal guardian for these youth to participate in research would likely preclude their participation in the project. In addition, excluding youth who spend lengthy periods living on the streets—whose experiences and conditions are likely to be most severe (Tyler, Tyler, Echeverry, & Zea, 1991)—would skew research on the development of effective treatment interventions toward those participants with more stable family environments.

Guardianship—When charges of abuse or neglect require the removal of the adolescent from the home, the youth often is placed in the state's custody. Decisions regarding research participation are then made by caseworkers, who sometimes have neither the time nor the knowledge of the child to evaluate the risks and benefits of research participation for him or her. To allow these youth to have access to requested research services, and given the tenuous role of caregivers in their lives, having them consent alone to research should be a legitimate consideration.

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Informed Consent for Treatment

Issues of informed consent also arise for mental health treatment with this population. In the field of research, legal and ethical practices regarding consent have been outlined by federal regulators, but consent in the area of treatment generally is governed by judicial precedent and state law. At the federal level, court decisions have tended to support adolescents' access to medical treatment without consent, as broadly applied from abortion decisions (Prout et al., 1999). However, in cases of psychological treatment, parental-consent requirements have been more stringent. For example, school counselors attempting to provide consultation to youth without substantiated abuse have been denied permission to offer services without parental consent (Reynolds, Gutkin, Elliot, & Witt, 1984). At the state level, laws governing the age of consent for adolescents to participate in treatment without parental consent vary by state (English, 1999), although generally the age of consent must be at least 14 years (Levine, 1995).

Melton (1981) observed the changes in mental-health-clinic services after Virginia state law allowed minors of all ages to have unlimited access to medical and mental health services. Outcome data indicated that after passage of the new legislation, there were no increases in the number of children seeking treatment independently of their parents, nor were there increases in the number of children younger than 14 seeking treatment alone. Evidence also indicated that clinics aware of the change in state law were more likely to seek consent for treatment from adolescents than clinics not aware of the new legislation. Clinics aware of the changes also were more likely to take measures to respect the privacy and treatment decisions of the adolescent patients. State laws allowing unlimited access to mental health services not only may increase a service provider's awareness of a youth's role in the consent process, but also would offer homeless youth an opportunity to access needed services without parental consent.

The fact that states vary in allowing adolescents to consent alone to treatment reflects the aforementioned controversy concerning adolescent competency to consent. The questions raised in the debate over adolescent consent to research apply in treatment settings as well. In cases in which parents are unavailable to provide consent, as is the case for many homeless and runaway youth, consent to treatment alone may be necessary to receive services. Otherwise, these youth likely will not receive needed medical or mental health intervention.

Treatment offers the potential to reduce imminent threats to homeless youths' safety. Requiring parental consent for psychological intervention may prevent mental health workers from providing such services. For example, service providers can facilitate youths' transition from the streets into more stable housing, reducing risks associated with living on the streets. Participating in psychotherapy also may reduce youths' symptoms of depression. The need for this is underscored by the high rates of attempted suicide in this population (McCarthy & Hagan, 1992; Shane, 1991; Smart & Walsh, 1993). Also, therapists can assist youth to reduce drug and alcohol problems as well as related dangers, including drug and alcohol overdose, street violence, and HIV exposure.

Responsibilities to Report

Once consent has been obtained, however, the ethical dilemmas in working with runaway and homeless youth continue. In fact, the Institutional Review Board requirements designed to protect these adolescents from harm—namely, the requirements to report suspected child abuse or neglect—often can prevent youth from participating in research or therapy (Kufeldt & Nimmo, 1987).

Fear of the consequences of reporting abuse may cause many homeless and runaway youth to avoid seeking help because they may face repercussions by already angry, rejecting parents.

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If protective services intervenes, these children may dread the interference of state officials in their family life. Garinger, Brant, and Brant (1976) discussed the social stigma and overintrusion of protective services in the home, where the interests of the individual child often are ignored by the bureaucratic system of the state. Hence, the evaluator's duty to report abuse by parents may prevent many youth from participating in research and treatment or cause them to underreport instances of abuse or neglect.

In addition to child abuse and neglect, issues involved in reporting instances of self-harm or endangerment must be considered. Homeless and runaway youth report high rates of risky sexual and criminal behavior (Deisher et al., 1989; McCarthy & Hagan, 1992). As Scarr (1994) remarked, instances of statutory sexual activity, smoking, drug and alcohol use, and petty theft are all examples of the adolescent placing himself or herself at risk of negative consequences. However, the duty to report these activities to parents or authorities encroaches upon standards of confidentiality. These behaviors may warrant reporting because they involve the endangering of a minor. When these actions do not involve immediate risk, but rather represent a pattern of problem behavior, the obligation to report harm becomes unclear. In addition, reporting all incidences of risk may alienate the youth from seeking help. Adolescents need to feel that it is safe to reveal their risky behavior if they are to be helped to reduce it.

How, then, do researchers and practitioners confront these reporting dilemmas? When working with a highly maltreated population, such as homeless and runaway youth, the evaluator must anticipate receiving information that will require reporting. The informed-consent process allows for explicit delineation of what actions will follow any discovery of abuse or intent to harm. Adolescents must be informed of the explicit limits of confidentiality using concrete examples with which they can identify. Rather than describing the limits as "abuse, neglect, or intent to harm self or other," the evaluator should provide specific examples of situations in which reporting is required and cite the individuals or organizations that will receive this information.

Once the adolescent has been informed of the outcome of divulging harm, the responsibility falls on the evaluator to balance the client's right to autonomy with a professional duty to nonmaleficence. Providing the youth with the precise guidelines for reporting confers on the adolescent the self-determination to decide whether he or she will reveal personal experiences. The evaluator maintains a duty to recognize harmful situations experienced by the client. When there is reason to suspect that the child is withholding information about abuse, it remains the evaluator's responsibility to continue to monitor the adolescent's safety.

Access to Services

Even after the ethical considerations for obtaining consent and reporting harm have been addressed, a lack of access to empirically validated services for these youth remains a problem. Evidence shows that these youth are not getting the help that they need (Fisher, 1994; Rotheram-Borus et al., 1994). In most cases, when runaway and homeless adolescents receive psychological counseling, it occurs at a shelter. Often, treatment is provided to youth only while they are residing at the shelter, which ranges from hours to several months (Grigsby, 1992). Some shelters for homeless children provide no psychological treatment (Fitzgerald, 1993). In certain cases, extended treatment is offered to youth and families, but unless it is mandated by the court, parents or youth can refuse treatment. Also, only 30% of homeless youth access shelter services (U.S. House of Representatives, 1992), indicating that the majority of runaway and homeless youth live on the streets and do not receive or seek care.

Research has documented very low service utilization among runaway and homeless youth (De Rosa et al., 1999; Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Robertson, 1989). One study showed that only 9% of runaway and homeless youth had ever accessed

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mental health services (De Rosa et al., 1999) and only 10% to 15% had ever received treatment for alcohol or drug problems (De Rosa et al., 1999; Robertson, 1989). Among shelter-residing youth, service utilization may be higher; Slesnick, Meade, and Tonigan (2001) found that 29% of their shelter-based sample had accessed psychological services, although rates of drug and alcohol service access were comparable to rates found by other researchers. These youth may avoid seeking services because they perceive them to be judgmental and inflexible. Marshall and Bhugra (1996) suggested that this was the case among homeless adults.

Low service utilization may be explained, however, by a lack of available treatment. This low availability of services represents a violation of several of the ethical principles on which the mental health professions are founded. First, the principle of beneficence bestows a duty to provide for the good of the client and to protect him or her from harm. The distressed condition of runaway and homeless youth points to a need for intervention. It is, therefore, the duty of mental-health-care providers to provide not only services to this underserved population but also treatment that will address their unique areas of need.

The principle of justice must also be considered in the relative lack of treatment services for these youth. In terms of justice and equity, these youth have the inherent right to receive services commensurate with those received by nonhomeless youth. Perhaps the foremost reason why runaway and homeless youth do not receive treatment is the lack of effective services tailored to their needs. To date, we have found no empirical validation of interventions for runaway or homeless youth other than an HIV (Rotheram-Borus et al., 1994) and case-management (Cauce et al., 1994) intervention. The general approach to the treatment of these youth involves applying treatments evaluated for use on related but dissimilar populations, such as nonhomeless youth and families or homeless adults. Empirical trials are necessary to address this void in the research.

Numerous barriers to treatment must be overcome in order to provide services to this population. Practical considerations must be addressed before treatment can commence. The very nature of being a runaway youth involves isolation from caretakers who could facilitate the procurement of treatment. Lack of insurance or transportation and the high cost of mental health services can prohibit these youth from receiving treatment. Adolescents covered by their family's managed care or private insurance provider may not be able to access those resources if contact with their parents is severed. Or, if they are avoiding detection by their parents, these youth may spurn using their family's insurance because it will notify parents as to their location. Although some adolescents are covered by Medicaid, many runaway and homeless youth residing at shelters come from families with earnings too high to qualify for Medicaid. And although runaways living on the streets do have access to Medicaid, they often do not access the coverage (English, 1999), presumably because they have no address to provide or they are unaware that coverage is available.

In addition to these practical issues, the disjointed system of care can impede the treatment of these youth. The institutions involved in the care of these children once they are off the streets include homeless shelters, the juvenile justice system, child-protective services, private insurance providers, hospitals, Job Corps, group-home facilities, foster-care services, and others. Each of these agencies is responsible for intervention in the interest of the adolescents, yet many organizations are driven by finances and seek to process high numbers of clients as expeditiously as possible. These agencies can also be territorial, vying for the opportunity to intervene (and bill) on behalf of the youth and refusing to coordinate care. For example, a southwestern youth agency that assists many homeless youth with job training discourages and sometimes refuses to admit into their program adolescents who receive outpatient psychotherapy. Others will not allow a youth to continue to see his or her current established therapist if the youth is admitted into their programs.

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Finally, but perhaps most relevant, alienation from society and family may preclude these youth from seeking and receiving treatment. Runaway or homeless adolescents can become discontented and resentful in a world that has yet to offer help or hope and, hence, these youth may be resistant to overtures of assistance. Considering the lack of empirically supported treatments offered to these youth, the mental-health field has not adequately served this population and may be deserving of mistrust.

Marshall and Bhugra (1996) noted that outpatient-therapy appointments are low priority for the homeless person who needs shelter and food. Discrepancies between needs perceived by the homeless and by mental health professionals can create a dichotomy that leads to a rejection of the services (Herman, Struening, & Barrow, 1993). Thus, those working with the homeless must provide case management when they provide treatment services. With a group that is residentially unstable, flexibility and accessibility have to be maintained. Practically, this means that service providers and researchers must be willing to work with youth on the street, in clinics, or wherever the youth may be located. Smart and Ogborne (1994) suggested that use of outreach workers may also increase attendance and follow-up among youth.

Conclusions

Runaway and homeless youth present several challenges to the interpretation of ethical guidelines for research and treatment. In this article, we addressed issues of informed consent and reporting requirements as well as ethical dilemmas associated with providing access to useful services. Many situations were presented in which requiring parental consent for a youth's participation may be inappropriate and may not be in the youth's best interest. We argued that in these situations, the youth should be allowed to consent alone, without parental approval. It is incumbent on service providers and researchers to address these dilemmas so that barriers to research and treatment with runaway and homeless youth may be removed. Few treatment-evaluation studies have been conducted with this population, and many youth do not access needed services, or services do not exist that adequately address their unique needs. Service providers may address problems of service access by identifying youths' needs, meeting them in nontraditional settings, and using outreach workers to locate and engage them. If efficacious treatments are to be developed for use with this population, then the issues associated with consent and reporting must be resolved so that researchers may conduct treatment evaluation studies and therapists may provide appropriate interventions.

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References

Attkisson, CC.; Rosenblatt, A.; Hoagwood, K. Research ethics and human subjects' protection in child mental-health services research and community studies. In: Hoagwood, K.; Jensen, PS.; Fisher, CB., editors. Ethical issues in mental health research with children and adolescents. Mahwah, NJ: Erlbaum; 1996. p. 43-57.

Blustein, J.; Moreno, JD. Valid consent to treatment and the unsupervised adolescent. In: Blustein, J.; Levine, C.; Dubler, NN., editors. The adolescent alone. Cambridge, UK: Cambridge University Press; 1999. p. 100-110.

Booth RE, Zhang Y. Conduct disorder and HIV risk behaviors among runaway and homeless adolescents. Drug and alcohol dependence 1997;48:69–76. [PubMed: 9363405]

Cauce AM, Morgan CJ, Wagner V, Moore E, Sy J, Wurzbacher K, et al. Effectiveness of intensive case management for homeless adolescents: Results of a 3-month follow-up. Special Series: Center for Mental Health Services Research Projects. Journal of Emotional and Behavioral Disorders 1994;2:219–227.

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Crespi TD, Sabatelli RM. Adolescent runaways and family strife: A conflict-induced differentiation framework. Adolescence 1993;28:865–878.

De Rosa CJ, Montgomery SB, Kipke MD, Iverson E, Ma JL, Unger JB. Service utilization among homeless and runaway youth in Los Angeles, California: Rates and reasons. Journal of Adolescent Health 1999;24:449–458. [PubMed: 10401975]

Deisher RW, Farrow JA, Hope K, Litchfield C. The pregnant adolescent prostitute. American Journal of Diseases of Children 1989;143:1162–1165.

English, A. Health care for the adolescent alone: A legal landscape. In: Blustein, J.; Levine, C.; Dubler, NN., editors. The adolescent alone. Cambridge, UK: Cambridge University Press; 1999. p. 78-99.

Fisher CB. Reporting and referring research participants: Ethical challenges for investigators studying children and youth. Ethics and Behavior 1994;4:87–95.

Fisher, CB.; Hoagwood, K.; Jensen, PS. Casebook on ethical issues in research with children and adolescents with mental disorders. In: Hoagwood, K.; Jensen, PS.; Fisher, CB., editors. Ethical issues in mental health research with children and adolescents. Mahwah, NJ: Erlbaum; 1999. p. 133-266.

Fitzgerald M. Residential care for homeless youth: Hopeful signs from an extensive service. Journal of Child and Youth Care 1993;8:61–67.

Flavell, JH. Cognitive development. 2. Englewood Cliffs, NJ: Prentice-Hall; 1985.

Forst ML, Crim D. A substance use profile of delinquent and homeless youths. Journal of Drug Education 1994;24:219–231. [PubMed: 7844695]

Garinger, T.; Brant, D.; Brant, V. Preserving parents' and childrens' rights. In: Koocher, GP., editor. Children's rights and the mental health professions. New York: Wiley; 1976. p. 53-81.

Grigsby RK. Mental health consultation at a youth shelter: An ethnographic approach. Child & Youth Care Forum 1992;21:247–261.

Grisso T, Vierling L. Minors' consent to treatment: A developmental perspective. Professional Psychology 1978;9:412–427. [PubMed: 11662545]

Herman DB, Struening EL, Barrow SM. Self-assessed need for mental health services among homeless adults. Hospital and Community Psychiatry 1993;44:1181–1183.

Hops H, Biglan A, Sherman L, Arthur J, Friedman L, Osteen V. Home observations of family interactions of depressed women. Journal of Consulting and Clinical Psychology 1987;55:341–346. [PubMed: 3597946]

Inhelder, B.; Piaget, J. The growth of logical thinking from childhood to adolescence. New York: Basic Books; 1958.

Kipke MD, Simon TR, Montgomery SB, Unger JB, Iversen EF. Homeless youth and their exposure to and involvement in violence while living on the streets. The Journal of Adolescent Health 1997;20 (5):360–367. [PubMed: 9168383]

Kufeldt K, Nimmo M. Youth on the street: Abuse and neglect in the eighties. Child Abuse & Neglect 1987;11:531–543. [PubMed: 3427514]

Kuhn, DE.; Amsel, E.; O'Loughlin, M. The development of scientific thinking skills. San Diego, CA: Academic Press; 1988.

Kurtz PD, Jarvis SV, Kurtz GL. Problems of homeless youths: Empirical findings and human services issues. Social Work 1991;36:309–314.

Kurtz PD, Kurtz GL, Jarvis SV. Problems of maltreated runaway youth. Adolescence 1991;26:543–555. [PubMed: 1962537]

Leffert, N.; Petersen, AC. Adolescent development: Implications for the adolescent alone. In: Blustein, J.; Levine, C.; Dubler, NN., editors. The adolescent alone. Cambridge, UK: Cambridge University Press; 1999. p. 31-49.

Levine RJ. Adolescents as research subjects without permission of their parents or guardians: Ethical considerations. Journal of Adolescent Health 1995;17:287–297. [PubMed: 8924433]

Marshall, EJ.; Bhugra, D. Services for the mentally ill homeless. In: Bhugra, D., et al., editors. Homelessness and mental health. Cambridge, UK: Cambridge University Press; 1996. p. 99-109.

Mas, CH. Attribution styles and communication patterns in families of juvenile delinquents. University of Utah; Salt Lake City: 1986. Unpublished doctoral dissertation

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McCarthy B, Hagan J. Surviving the street: The experiences of homeless youth. Journal of Adolescent Research 1992;7:412–430.

Melton GB. Effects of a state law permitting minors to consent to psychotherapy. Professional Psychology 1981;12:647–654. [PubMed: 11653686]

Mundy P, Robertson M, Robertson J, Greenblatt M. The prevalence of psychotic symptoms in homeless adolescents. Journal of the Academy of Child and Adolescent Psychiatry 1990;29:724–731.

Nye F, Edelbrock C. Some social characteristics of runaways. Journal of Family Issues 1980;1:147–150.

Office of Protection of Research Risks. Ethical principles and guidelines for the protection of human subjects of research, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Washington, DC: Author; 1979.

Office of Protection of Research Risks. OPRR protecting human research subjects institutional review board guidebook. Washington, DC: Author; 1993.

Porter, J. Regulatory considerations in research involving children and adolescents with mental disorders. In: Hoagwood, K.; Jensen, PS.; Fisher, CB., editors. Ethical issues in mental health research with children and adolescents. Mahwah, NJ: Erlbaum; 1999. p. 15-28.

Prout, SM.; DeMartino, RA.; Prout, HT. Ethical and legal issues in psychological interventions with children and adolescents. In: Prout, HT.; Brown, DT., editors. Counseling and psychotherapy with children and adolescents. New York: Wiley; 1999. p. 26-48.

Putnam, FW.; Liss, MB.; Landverk, J. Ethical issues in maltreatment research with children and adolescents. In: Hoagwood, K.; Jensen, PS.; Fisher, CB., editors. Ethical issues in mental health research with children and adolescents. Mahwah, NJ: Erlbaum; 1996. p. 103-132.

Reynolds, CR.; Gutkin, TB.; Elliot, SN.; Witt, JC. School psychology: Essentials of theory and practice. New York: Wiley; 1984.

Robertson, M. Homeless youth in Hollywood: Patterns of alcohol us (A report of the National Institute on Alcohol Abuse and Alcoholism). Berkeley, CA: Alcohol Research Group, School of Public Health, University of Southern California; 1989.

Rotheram-Borus, MJ.; Feldman, J.; Rosario, M.; Dunne, E. Preventing HIV among runaways: Victims and victimization. In: DiClemente, RJ.; Peterson, JL., editors. Preventing AIDS: Theories and methods of behavioral interventions. New York: Plenum Press; 1994.

Rotheram-Borus, MJ.; Selfridge, C.; Koopman, C.; Haignere, C.; Meyer-Bahlburg, HFL., et al. Abstracts: V International Conference on AIDS. Ottawa, Ontario, Canada: International Development Research Centre; 1989. The relationship of knowledge and attitudes toward AIDS to safe sex practices among runaway and gay adolescents; p. 728

Scarr S. Ethical problems in research on risky behaviors and risky populations. Ethics & Behavior 1994;4:147–155.

Shaffer, D.; Caton, CLM. Runaway and homeless youth in New York City. New York: Ittleson Foundation; 1984.

Shane PG. A sample of homeless and runaway youth in New Jersey and their health status. Journal of Health & Social Policy 1991;2:73–82.

Slesnick N, Meade M. System youth: A subgroup of runaway youth. Journal of Substance Abuse. 2001

Slesnick N, Meade M, Tonigan JS. Service utilization and runaway youth's functioning at pretreatment. Alcoholism Treatment Quarterly. 2001

Smart RG, Ogborne AC. Street youth in substance abuse treatment: Characteristics and treatment compliance. Adolescence 1994;29:733–745. [PubMed: 7832037]

Smart RG, Walsh GW. Predictors of depression in street youth. Adolescence 1993;28:41–53. [PubMed: 8456615]

Teare JF, Furst DW, Peterson RW, Authier K. Family reunification following shelter placement: Child, family, and program correlates. Orthopsychiatry 1992;62:142–146.

Tyler FB, Tyler SL, Echeverry JJ, Zea MC. Making it on the streets in Bogota: A psychosocial study of street youth. Genetic, Social, and General Psychology Monographs 1991;12:397–417.

Unger JB, Kipke MD, Simon TR, Montgomery SB, Johnson CJ. Homeless youths and young adults in Los Angeles: Prevalence of mental health problems and the relationship between mental health and

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substance abuse disorders. American Journal of Community Psychology 1997;25:371–394. [PubMed: 9332967]

U.S. House of Representatives, Education and Labor Committee. U. S. Code of Law and Administrative News. 1992. Legislative history, juvenile justice and delinquency amendments. House Report No. 102–756.

Weithorn, LA. Competency to render informed treatment decisions. A comparison of certain minors and adults. University of Pittsburgh.; 1980. Unpublished doctoral dissertation

Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. Child Development 1982;53:1589–1598. [PubMed: 7172783]

Whitbeck LB, Simons RL. Life on the streets: The victimization of runaway and homeless adolescents. Youth & Society 1990;22:108–125.

Wolfe SM, Toro PA, McCaskill PA. A comparison of homeless and matched housed adolescents on family environment variables. Journal of Research on Adolescence 1999;9:53–66.

Yates GL, MacKenzie R, Pennbridge J, Cohen E. A risk profile comparison of runaway and nonrunaway youth. American Journal of Public Health 1988;78:820–821. [PubMed: 3381958]