A Novel, Intensive Home-Visiting Intervention for Runaway, Sexually Exploited Girls

Laurel D. Edinburgh and Elizabeth M. Saewyc

PURPOSE. *Few studies have examined interventions that help adolescents who run away. This study both describes a home-visiting intervention program for young, sexually assaulted runaways (10–14 years old) and provides preliminary outcomes from the first 20 female participants.*

DESIGN AND METHODS. *Using a strengths-based approach, advanced practice nurses provided frequent home and school visits and case management, and assisted girls to access an empowerment group over a 1-year period.*

RESULTS. *Teens' risk behaviors decreased, including truancy, runaway episodes, sexually transmitted infections, and substance use.*

CONCLUSIONS. *Preliminary results suggest that this is an effective intervention for reducing risk behaviors and helping younger runaways reconnect to school and family.*

PRACTICE IMPLICATIONS. *Client-centered interventions in community settings can address the complex health needs of vulnerable young runaways.*

Search terms: *Adolescents, community nursing interventions, home-visiting, runaways, sexual abuse, sexual assault, sexual exploitation, street-involved youth, strengths-based approach*

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Sexually exploited runaway teens are a unique and difficult population to reach using traditional models of health care (Unger et al., 1998). Advanced practice nurses (APNs) have specific educational preparation in providing population-based health care for vulnerable teens (Bensussen-Walls & Saewyc, 2001). APNs were chosen to lead this intervention because of their training in managing complex health problems, advanced case management skills, and ability to interpret and integrate research into clinical practice. This retrospective, descriptive pilot study explored the initial outcomes of a program where APNs provided home-visiting, health care, and case management to young, runaway, sexually exploited teens. This nurse-developed and staffed program became a component in a larger, multisectoral model of intervention, the Runaway Intervention Program (RIP). This paper describes a nursing model of care, the theoretical perspectives guiding this home-visiting and case-management program, and the preliminary outcomes of this intervention for the first 20 clients.

Review of the Literature

The early adolescent street youth (10–14 years old) is an overlooked, highly vulnerable population (Unger et al., 1998). The younger teens are when they first run away, the more likely they are to become involved in high-risk and health-compromising behavior, such as drug use, criminal activities, and violence (Tyler, Hoyt, Whitbeck, & Cauce, 2001). Teens who run away at an early age also are more likely than older teens to run away multiple times, to be sexually victimized, and to be involved in substance use (Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996).

Factors associated with running away include a previous history of intra-familial physical or sexual abuse, mental illness of a parent, domestic violence, teen–parent conflict, and social isolation (Sullivan & Knutson, 2000; Warf et al., in press).

Additionally, youth with behavior disorders, communication disorders, and learning disabilities are more likely to run away (Slesnick & Prestopnik, 2005). Previous sexual abuse is a unique risk factor, leading to poor psychosocial outcomes because of the degrading and stigmatizing effects of abuse for the adolescent (Tyler et al., 2001). Sexual abuse by a family member, someone outside the family, or both may be a precipitating factor to the first runaway event (Saewyc, Magee, & Pettingell, 2004).

The risks faced by the youngest runaways are similar to those of older runaways, yet they often have fewer cognitive resources to rely on for avoiding these risks, due to their developmental stage. Sexual exploitation, including gang rape, prostitution, and survival sex, is common among runaway and street-involved youth, affecting as many as 40% or more (Smith et al., 2007). The many health and social consequences of running away also include: untreated physical illnesses, depression, self-harming behaviors, suicide, substance abuse, experiences of violence, and high-risk sexual behavior leading to sexually transmitted infections (STIs) and teen pregnancy (Rotheram-Borus et al., 1996; Warf et al., in press). In a study of runaway teens in Maryland, many teens reported dysfunctional family relationships, abuse, neglect, learning disabilities, emotional issues, and parents with similar academic or emotional issues (Riley, Greif, Caplan, & MacAulay, 2004). The strongest predictor of sexual exploitation when a youth has run away is a history of prior sexual abuse (Smith et al.).

Early adolescent street youth, i.e., those under age 15, while far less common than their older peers, are still at high risk for violence, poor overall health status, STIs, and incarceration (Unger et al., 1998). They are also more likely than older street youth to have gang affiliations and involvement in illegal activities for survival, such as sexual exploitation, stealing, and drug dealing. Many persistently homeless and street-involved older youth began running away or were kicked out of their homes at early ages, becoming disconnected from family, school, and other supportive resources (Saewyc, 2003; Smith et al., 2007). Fortunately, younger street-involved adolescents are likely to still be attending school at least intermittently (Smith et al., 2007). Researchers have suggested that interventions focused early in the pattern of running away and street involvement may be more effective in restoring a normal developmental trajectory and reconnecting teens to important social supports (Auerswald & Eyre, 2002; Saewyc, 2003).

APNs in interdisciplinary teen clinics often provide services for high-risk and street-involved youth, but specific outcomes of teen-focused care by APNs have been studied infrequently. In one such study, Bensussen-Walls and Saewyc (2001) compared the outcomes when high-risk and homeless pregnant teens received care from teen clinics to similarly high-risk teens attending traditional, adult-focused obstetric centers. The teen clinics were staffed by APNs and offered both clinic and home-visiting services. They reported both perinatal and psychosocial outcomes were better for teen clinic patients, including better access to services, greater rates of vaginal versus cesarean births, higher infant birthweights, as well as high breastfeeding and postpartum contraception rates. APNs taking care of other subspecialty populations, such as geriatric surgical cancer patients, AIDS patients, and renal patients, have demonstrated that these nurses improve patient outcomes (Kleinpell-Nowell & Weiner, 1999; McCorkle et al., 2000). To date, however, there has been limited evaluation of how masters-prepared nurses caring for sexually exploited runaway youth can change their likely trajectory of poor health and psychosocial outcomes, and whether a community health model is an effective intervention to reduce risk behaviors among sexually exploited runaways.

A few studies have demonstrated that health promotion efforts with street youth can be effective in helping them improve their health and health-related decisions. More than a decade ago, Fors and Jarvis (1995) reported an effective peer-led program to reduce drug use among street youth, and more recently, Auerswald, Sugano, Ellen, and Klausner (2006) demonstrated that on-site street testing for STIs, including HIV, was a feasible and effective intervention for improving access to care and reducing STIs. A sexual health intervention among homeless youth in Texas improved self-efficacy around sexual health behaviors (Rew, Fouladi, & Yockey, 2002), but the intervention was predominantly among older homeless teens. There are almost no studies reporting health promotion interventions for younger runaways.

Methods

Conceptual Framework for the Intervention

The conceptual framework for this intervention is focused around two major theoretical perspectives: developmental traumatology to explain the health and behavioral effects of the running away and sexual exploitation, and resilience theory to guide the health promotion interventions.

Developmental traumatology, as summarized by DeBellis (2001), posits that trauma experienced during the key developmental stages of childhood and adolescence, especially maltreatment such as sexual abuse and exploitation, has profound physiological, cognitive, and social effects on the growing young person. Such trauma can affect a teen's ability to form emotional attachments, destroy trust in adults, and create cognitive distortions about sexuality and relationships. These can lead to risky sexual behaviors, including multiple sexual partners, unprotected intercourse, and teen pregnancy and parenthood (Saewyc et al., 2004). They can also lead to re-victimization (Grauerholz, 2000). The shame and pain from such trauma can cause depression and suicidal thoughts,

and trigger self-harm behaviors such as cutting. Teens may try to cope with their stress and depression through alcohol and other drug use, but neurological changes as a result of the trauma may actually increase the teen's susceptibility to chemical dependence (Teicher, 2002; Teicher et al., 2003).

Resilience theory, in contrast, focuses on the ways some children and youth exposed to stressors and trauma are able to successfully cope with adversity and develop into capable, healthy adolescents and adults, despite their traumatic exposures. The concept of resiliency has become important in working with all youth, but especially with high-risk youth. Although originally considered a trait, it has more often been described as a process or set of influences, and researchers have focused instead on the environmental or interpersonal protective factors that foster adaptive coping among those at risk (Blum, McNeely, & Nonnemaker, 2002). A number of protective factors in the diverse environments of young people —family, friends, school, and community—have been shown to influence positive youth development. These protective factors can also help buffer youth from the negative effects of trauma, and help return them to a normal developmental trajectory. Some of the most consistently identified protective factors have been supportive, caring relationships, especially connectedness to family, school, and other adults in the community. This program for runaway, sexually exploited youth, therefore, was based on helping to foster resilience by helping to reconnect participants to supportive environments and opportunities for positive youth development.

The RIP Intervention

In 2003–2004, young female adolescents between the ages of 10 and 14 years were eligible to participate in the RIP, an intensive home-visiting and case-management program, if they had run away from home at least once and also had a history of extra-familial sexual assault or sexual exploitation. The model of care in this intervention was based on the approach of the teen clinic services described by Bensussen-Walls and Saewyc (2001), although those services were primarily for pregnant and parenting teens; details of the intervention model are described below. During the first year, 20 teens participated in RIP. The majority of females involved in the intervention during that first year were Hmong (90%), while 5% were Native American, and 5% were Latina.

Outcomes were assessed for this program at 6 and 12 months, based on the goals of the program in reducing the psychological effects of the sexual abuse trauma, risky sexual behaviors and STIs, episodes of running away, and levels of substance use. All teens were located again at 1 year, even if they were no longer participating in all aspects of RIP. The core elements of the RIP program were a comprehensive initial assessment, intensive home and school visiting as well as case management by an APN, and a therapeutic empowerment group.

This research was approved by the Institutional Review Board of Children's Hospital and Clinics of Minnesota and by the Behavioral Research Ethics Board of the University of British Columbia. The guardian consent was obtained for both treatment and use of medical records for participation in research.

Initial assessment. Each teen enrolled in RIP had a thorough healthcare evaluation at a youth-friendly child maltreatment clinic. Information about the runaway event was gathered to assess the seriousness of the episode. The teen was asked, "Who provided you with shelter? Who provided your meals? How long were you gone? How many times have you run away in the past?" The teen was also asked the reasons for leaving home. Further information was gathered from family (if available): whether they reported their teen missing to the police, if they could identify reasons the teen was running away, and what other interventions have been tried within the family to stop the runaway behavior. Obtaining an extensive history about the running away can help identify risk factors for sexual exploitation, intra-familial abuse, and the teen's physical safety while away from home. The additional information from the teen's family helps assess whether the family understands the risks to their adolescent while away from home and how the family has already tried to cope with a difficult, emotionally laden event.

The initial RIP evaluation also included a thorough past medical history, family health history, social history, and questions assessing risk and protective factors for the youth. Additional questions were asked regarding both intra-familial and extra-familial abuse. If a teen acknowledged new abuse, a thorough history about the abuse event or events was obtained. This specific part of the history was videotaped with the teen's knowledge and permission, so that the intimate nature of the abuse events did not need to be reported by the teen directly to the police or child protection. Any teen disclosing abuse also had the option to meet with a sexual assault victim advocate who helped guide them through the issues in reporting abuse experiences. Mandated reporting occurred if the teen disclosed intra-familial abuse or abuse by extra-familial adults in positions of authority per state law, but even in these instances a teen could still meet separately with an advocate. The teen was also offered a physical exam, which included a video-colposcopic genital exam, screening for pregnancy and sexually transmitted infections, and collection of evidence when appropriate.

Home-Visiting and Case Management

The RIP intensive home-visiting intervention program was offered by APNs, and each adolescent was assigned one APN to provide his/her care. Adolescents who had run

away and had experienced recent intra-familial sexual abuse were excluded from enrollment, because these families qualify for established services from child protection. Eligible teens had to have their guardians' permission to participate, and the conference with the parents describing the service took place in the home or in the clinic, depending on the parents' wishes. Guardians signed a consent that permits the APN to make home or community visits, to discuss general health issues, substance use, and reproductive health with their teens, and acknowledges that if the APN finds out that the teen is not attending school, a report will be made to the countywide Truancy Intervention Program (TIP). Both the parents and the teens were provided information about confidentiality and what information, if disclosed, would not be kept confidential due to safety or mandated reporting laws.

A teen entering the intensive home-visiting intervention program received four individual APN visits at home or at school during the first month, and two visits per month for the next 2 months. Community visits then tapered off in frequency to once every 3 to 4 weeks. Visits continued for 1 year, and may have increased in frequency if there was a subsequent health or social crisis. By the time home visits ceased, the goals were for teens to no longer be running away from home, to be attending school regularly, and to have transitioned to a youth-development activity in the community, as well as be reporting improved relationships with family, reduced risk behaviors, more effective coping behaviors, and improved health decision-making.

The visits were client-centered and took a strengths-based or positive-development approach, focused on developing trusting relationships, identifying and supporting girls' goals, and helping to build skills and self-esteem. While the APN home visits were ongoing and served a variety of purposes, there was a clear health education component to each visit. The nurses used a harm reduction approach for all educational topics, geared to the developmental level of the teen. The teen chose the topics of the teaching session at each visit, but eventually all topics listed in Table 1 would be covered. The APN would start with general questions and move to more specific questions about an array of health topics, as recommended by Rew, Whittaker, Taylor-Seehafer, and Smith (2005).

The APNs also focused some time during every visit on issues related to school connectedness. This included asking the young teen about school, helping the teen negotiate conflicts they feel are occurring in school, and working with the school to identify resources that may be helpful to the teen within the school environment. This type of case management included meeting with a school counselor and identifying a plan to help the teen become better connected to school. In one instance, for example, this meant having a choir teacher agree to meet daily for 5 to 10 minutes to check in with the teen about how she was doing. In another situation, the teen's advisor was switched to a teacher the teen identified as someone who cared about her. Nurses have even fostered school connectedness by helping a teen with initial homework assignments upon returning to school or finding outside-of-school supports for homework help. While homework help might be considered out of the usual scope of nursing practice, educational attainment has been widely identified as one of the key social determinants of health (Marmot & Wilkinson, 1999), and in RIP it has clearly been an effective intervention for helping reconnect runaways to school.

Table 1. List of Nursing Assessments and Education Completed During Home Visits

Goal setting
Crisis intervention
Help reconnecting with school, including homework assistance
Mental health screening and referrals
Connections to community programs, i.e., summer day camp
Health education for:
Safe sex and contraception
Mental health issues
Substance use and abuse
Family conflict
Nutrition and physical fitness
Injury prevention
Skills for daily living, such as:
Making appointments
Riding the bus
Accessing health care
Parent education and support for positive parenting skills; how to access services

A unique aspect of the home-visiting program was the immediate access to health care the teen has within the home visit. The health care included ongoing screening for pregnancy and STIs, and a range of reproductive health care. For example, not only could an APN provide condoms during community visits but could also prescribe and initiate birth control or help the teen navigate changes in methods of contraceptives used. The young teens often expressed a lack of funds for purchasing condoms, embarrassment with purchasing them, or being without transportation. The community visits helped remove some of the key barriers a young teen may face in meeting her own reproductive healthcare needs, such as knowing where to get such care, transportation, and financial resources.

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During the early implementation of this program, it became quite clear that the youngest teens needed significant help in developing life skills that would help them to obtain health care on an ongoing basis. The teens needed to learn how to make healthcare appointments, access health insurance information, and even how to use public transportation to get to appointments. These life skills were helpful for the teens beyond healthcare access: the same skills could help a teen return home if stranded at a party or if taken to an unfamiliar location by peers or to get to school on her own after missing the school bus in order to avoid being truant. Teaching these life skills often required additional APN visits, and whenever possible, skills practice opportunities were delegated to a nursing student under the APN's direction.

The case management also included working with parents to increase their awareness of the risks faced by young runaways and to help them access support from the various legal, health, and social systems. Parents may be unprepared for their own emotional responses to the knowledge that their daughter has been sexually assaulted or exploited, and they may not know how to best help their teen cope with the aftermath or alter risky behaviors. In this program, the APNs offered parents reassurance about common reactions as well as suggestions for therapeutic ways to respond and help their daughters heal from their traumatic experiences.

Counseling Intervention

Many teens initially refused any attempt at connecting them to a counselor as a means to address substance abuse or mental health concerns. A traditional counseling intervention was also not culturally appropriate for many of the ethnic minority clients. We felt, however, that the teens' mental health issues should not be ignored and that significant health behavior change would be difficult without addressing these problems along with the physical and reproductive health issues. The solution was to offer all teens participation in a therapeutic empowerment group, which met after school weekly under the guidance of a skilled therapist. The group worked on problem-solving skills, family and peer conflicts, and addressing and labeling stigma and trauma when it arose in the group's discussion. Within the semistructured group setting, teens learned to be leaders and unofficial peer counselors. Over time, the group itself became a youth-development activity. A teen could attend for as long as she felt it was helpful; no one was terminated from the group by arbitrary time or age cutoffs. Transportation was also provided for the weekly group through a van service for those who needed it.

Costs Associated with the Intervention

The program was initially funded by a 1-year grant of $22,000. This translated to approximately $1,000 per client. Additional support was gained from billing Medicaid for reproductive healthcare services, such as STI and pregnancy tests, for teens who had insurance. In addition, because this service was provided within an existing clinic structure, none of the overhead costs of a stand-alone project were included. Even with subsequent increases in the numbers of cases in following years, and such costs as transportation to weekly groups, costs for the program have remained at less than $2,000 per client. Although there are no programs like this in the literature with reported costs, there are other home-visiting and case-management programs for high-risk teens. These are most commonly for pregnant and parenting girls, for example, the First Steps Maternity Support Services program in Washington State (Washington State Department of Social and Health Services, 2007), the maternity home-visiting program designed by Olds and colleagues (Olds, Henderson, Phelps, Kitzman, & Hanks, 1993), or the Ohio LEAP program to increase school attendance among teen-parent welfare recipients (Bos & Fellerath, 1997). The program cost per case for the RIP intervention compares favorably to these somewhat similar programs: the First Steps program cost as much as $2,920 per case in 2007, the maternity home-visiting by Olds et al. cost more than $3,000 per case in 1993 (Kearney, York, & Deatrick, 2000), and the Ohio LEAP program, which did not include goals for anything other than increased school attendance, still cost more than $1,400 per case (Bos & Fellerath).

Client Outcomes

In this preliminary phase, 21 teens were offered the service of RIP after their initial healthcare evaluations at the child maltreatment clinic, and 20 of the 21 sets of parents consented to their daughters' participation. These first 20 teens were followed for 1 year. At baseline, the majority of the teens had been involved in prostitution, using survival sex, or had been gang raped (75%). Most reported "too many partners to count." Ninety percent of the teens had run away from home at least once; the time away from home varied from a few days to several months. All the teens had been truant from school, as defined by missing 10 or more days of a school year. The teens were tested for STIs during their initial assessments, and chlamydia was diagnosed in 55% of the teens. None of the teens had knowingly been pregnant or were pregnant at baseline. Ninety percent of the teens reported at least some substance use, most commonly alcohol, but including other drugs such as marijuana, crystal methamphetamine, and crack cocaine. None of the teens were using hormonal birth control at entry to the program, and none had accessed a healthcare provider for reproductive health care prior to RIP's involvement.

Assessments at the 6-month mark showed improvements, including a decrease in the rate of chlamydia infections from

55% to 15%. At this point, none of the girls had become pregnant. All of the participants had re-enrolled in school and were attending. Running away episodes, as reported by parents, appeared to be decreasing, as did the risk behaviors reported by the teens when they left home without permission. The exact number of times a teen ran away from home preceding the RIP intervention as well as during the RIP intervention was difficult to assess. Adolescents and parents often had different definitions of what qualified as running away. Additionally, counting missing person reports to the police was an inaccurate method of assessment because many parents did not speak English and had difficulty making a police report or even knowing who to call. This marker of improvement was measured by asking the adolescent during nursing visits about runaway behavior and documenting the length of time and summary of events that occurred while the adolescent was away from home.

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At 12 months, the teens' knowledge about their health and their actual healthcare practices changed. There were still no pregnancies. All of the teens could state how to access a teen-based clinic as well as how to use hormonal contraceptives. The teens knew where to access free or reduced-fee condoms and knew the appropriate times when condom use was required. All the teens used at least some form of contraception during part of the RIP program. The teens most often choose to use ethinyl estradiol/norelgestromin patches (Orthoevra patches), or intramuscular medroxyprogesterone acetate (Depo-Provera). Education on all forms of hormonal contraception was done with each adolescent, and teens were guided in their decision-making process on how to use a type of hormonal birth control based on their medical history and risk behaviors. The rate of repeat chlamydia infections decreased to 5% by 12 months. The teens also reported less substance use; at 12 months, only 20% of the teens reported ongoing alcohol or illicit drug use. There were no suicide attempts during the first year, but one teen was hospitalized due to suicidal ideation, and one teen received inpatient chemical-dependency treatment.

There was a range in the number of home visits and case-management tasks each teen received. Participants received an average of 14.7 nursing visits, 11.75 case-management contacts, and 2.15 parent visits. The number of visits increased if there was a crisis and declined when the teens were stable, as evidenced by not running away, attending school, and having completed their health-education goals.

Discussion

This intensive home-visiting, case-management, and therapeutic-empowerment group intervention offered a flexible and strengths-based approach to the complex health needs of sexually exploited young runaways, for a modest cost. One-year outcomes among the first 20 participants were quite promising, demonstrating reductions in risky behaviors and health problems such as STIs, and improvements in health knowledge and health practices.

One-year outcomes among the first 20 participants were quite promising, demonstrating reductions in risky behaviors and health problems such as STIs, and improvements in health knowledge and health practices.

Initially, the thought of including the parents in this youth-centered, harm-reduction healthcare model seemed as though it would set the program up to fail. Surprisingly, very few parents who were approached about having this service offered to their teens turned it down. The parents clearly wanted help and services to keep their young teens healthy and at home. The one issue that emerged during parental consent meetings was that the parents did not want to be blamed for their teens' running away and subsequent risky health behaviors. Parents often initially wanted more help for their teens than the teens wanted themselves. It is not surprising the youth did not see the need for help; youth often have difficulty with trusting adults, and at their developmental stage, the youngest teens often cannot fathom the actual risks of runaway behavior. Over time, however, the teens usually developed trusting relationships with the nurses. This relationship modeled normal adult–teen interactions, serving as a counter model for the abusive or exploitive relationships with adults these teens had previously experienced. These relationships were built on trust and clearly defined issues of confidentiality. Several studies have identified the importance of confidential care for adolescents (Ford, English, & Sigman, 2004).

The program's emphasis on sexual-health education, reproductive health care, and STI prevention, and testing and treatment for such young teens may be disconcerting to some healthcare providers. However, it is a critical emphasis because so many of the girls were not using any method of contraception or safe sexual practices, and they had correspondingly high rates of STIs. One benefit of having APNs with prescriptive authority in the home-visiting role was this

allowed girls to choose and start a contraceptive method on the same day teaching was completed; condoms were also always available and were offered at each visit. This accessibility may account in part for the decrease in repeat STI rates and the lack of pregnancies in a population at high risk for unintended pregnancy (Saewyc et al., 2004).

The APN often assisted the adolescent and her family by addressing the cultural factors that created barriers in reunification and communication in the family after the teen had run away. As adolescent runaways were disproportionately from minority backgrounds, the APNs needed knowledge about cultural group norms and how the history of racism, oppression, and stigma affects families and youth. Hmong adolescents are in a difficult position because they are expected to meet traditional Hmong family roles while also adhering to the American peer culture (Ho, 1990). These roles become even more difficult after there is sexual abuse. The Hmong community gives women both support and recognition for being able to endure pain without speaking out (Scott, 2002). Girls are also given fewer freedoms than boys, and blame for sexual encounters lies with the females (Scott). The APNs were able to individualize education for parents about sexual abuse and normal adolescent development. Although none of the APNs were Hmong or spoke Hmong, their understanding of the cultural pressures for everyone in the family helped bridge conflicts. The APNs could then access culturally appropriate family-counseling resources in the community to begin therapy. While the majority of teens seen by the APNs were Hmong during the initial intervention, a comfortable knowledge about culture for all ethnic groups should be part of all APNs' continuing education.

An important strategy for effective home visits and health education was individualizing assessments and teaching curriculum. This meant teens with chemical-dependency concerns could receive immediate case management, teaching, and intervention, for example, and a teen with questions about the consequences of missing school could have those concerns addressed, while teens engaging in high-risk sexual behaviors received information about contraception, healthy relationships, and prompt STI testing and treatment. By responding to the teens' priorities, nurses were able to foster trust as well as convey information that was immediately relevant.

The results from the first 20 clients of the program are promising and suggest that for this high-risk population, similar to teen mothers and parents at risk of child maltreatment, home-visiting and intensive case management may be effective strategies for promoting a variety of positive health outcomes. Teen clinics alone may not address the issues of the youngest and most vulnerable populations, such as runaway and sexually exploited young teens, because these youth may not have the skills needed to access such settings. Equally, home-visiting and case management are often limited to pregnant and parenting teens in public health services, but this may be shortsighted. Runaway and sexually abused teens are at high risk of unintended pregnancy, and it would be more useful to offer these services to young teens before their trajectories are further complicated by early parenthood.

There are, however, limitations that should be considered in this description of the intervention. The initial results, while promising, are from a small number of cases and from only 1 year of follow-up. Furthermore, some of the goals of the intervention, such as improved connectedness to family, school, and other caring adults, and reduced trauma and improved self-esteem, were not directly measured among these first cases. Also, it is possible that the outcomes in this study may not have occurred solely due to the APN intervention. It should be noted that a larger, more rigorous, and longer-term evaluation of the intervention is underway that includes measures of these protective factors, and results should be available soon.

How Do I Apply These Findings to Nursing Practice?

Home-visiting, intensive case management, and youth-focused empowerment groups can be effective interventions for high-risk sexually exploited runaways. It is important to establish trusting relationships with these vulnerable girls and with their parents, offering confidential care within the boundaries of mandated reporting rules. Such interventions should include a flexible, individualized, teen-centered approach that focuses on developmental skill-building and addresses each teen's priorities. Teens need to be taught how to access health care, from making the appointment and managing transportation to asking questions within the clinic setting. Helping to reconnect runaway teens to supportive resources, such as school, should be considered part of the health goals. Health education within a caring, therapeutic relationship can be effective and empowering for this vulnerable population.

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