American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Runaway Youth: Caring for the Nation's Largest Segment of Missing Children

Thresia B. Gambon, MD, MPH, MBA, FAAP,[a] Janna R. Gewirtz O'Brien, MD, FAAP,[b] COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON COMMUNITY PEDIATRICS

The largest segment of missing children in the United States includes runaways, children who run away from home, and thrownaways, children who are told to leave or stay away from home by a household adult. Although estimates vary, as many as 1 in 20 youth run away from home annually. These unaccompanied youth have unique health needs, including high rates of trauma, mental illness, substance use, pregnancy, and sexually transmitted infections. While away, youth who run away are at high risk for additional trauma, victimization, and violence. Runaway and thrownaway youth have high unmet health care needs and limited access to care. Several populations are at particular high risk for runaway episodes, including victims of abuse and neglect; lesbian, gay, bisexual, transgender, and questioning youth; and youth in protective custody. Pediatricians and other health care professionals have a critical role to play in supporting runaway youth, addressing their unique health needs, fostering positive relationships within their families and with other supportive adults, and connecting them with available community resources. This report provides clinical guidance for pediatricians and other health care professionals regarding (1) the identification of adolescents who are at risk for running away or being thrown away and (2) the management of the unique medical, mental health, and social needs of these youth. In partnership with national, state, and local resources, pediatricians can significantly reduce risk and improve long-term outcomes for runaway youth.

INTRODUCTION

The largest segment of missing children in the United States includes runaways, children who run away from home, and thrownaways, children who are told to leave or stay away from home by a household adult.[1,2] This report aims to provide clinical guidance for pediatricians regarding (1) the identification of adolescents who are at risk for running away or being thrown away and (2) the management of the unique medical, mental health, and social needs of these youth.

abstract

[a]Citrus Health Network, Miami, Florida; and [b]Department of Pediatrics, University of Minnesota, Minneapolis, Minnesota

Clinical reports from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, clinical reports from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

Drs Gambon and Gewirtz O'Brien drafted, reviewed, and revised the manuscript, approved the final manuscript as submitted, and agree to be accountable for all aspects of the work.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

DOI: https://doi.org/10.1542/peds.2019-3752

Address correspondence to Thresia B. Gambon. E-mail: tbgambon@me.com

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2020 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

To cite: Gambon TB, Gewirtz O'Brien JR, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON COMMUNITY PEDIATRICS. Runaway Youth: Caring for the Nation's Largest Segment of Missing Children. *Pediatrics*. 2020;145(2):e20193752

Downloaded from www.aappublications.org/news by 113680 on April 13, 2020

There has been a considerable amount of research conducted in the area of runaway and thrownaway youth since the 2004 publication of the previous clinical report "The Pediatrician's Role in the Prevention of Missing Children."[3] This clinical report expands on the previous report's discussion of youth who run away in the United States. Although estimates of the prevalence of running away vary depending on definitions, methodology, and population, the 2013 National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART-3), released by the US Office of Juvenile Justice and Delinquency Prevention in 2017, estimated that 413 000 children ran away or were thrown away in 2013, at a rate of 5.3 per 1000 children, comparable to previous NISMART cycles.[2,4] Other studies have estimated that between 5% and 8% of adolescents run away every year.[5–8] It is important that pediatricians understand this population so they can better serve these youth and families in clinical practice and in the community setting.

Unaccompanied adolescents who run away or who are asked to leave home have unique health needs. Before running away, many have learning disabilities, struggle with mental illness, experience school failure, or engage with peer groups who participate in high-risk behaviors.[9] Many have experienced abuse or neglect before running away.[10–13] While away, these unaccompanied minors are at high risk for victimization and violence; substance use; risky sexual behavior, including survival sex; further absenteeism from school; and other associated negative health consequences.[9–11,14–19]

DEFINITIONS

According to the Office of Juvenile Justice and Delinquency Prevention, a runaway episode occurs when a child leaves home without permission and stays away overnight for at least 1 night (for children younger than 15 years) or 2 nights (for children 15 years or older). A thrownaway episode occurs when a child is asked or told to leave the home by a household adult or is prevented from returning home by a household adult for at least 1 night when no adequate alternative care is arranged.[2]

Runaway and thrownaway episodes are grouped together because youth often fall into both categories. Information varies depending on who is interviewed regarding the circumstances; youth do not always view the circumstances the same way as the guardians and/or parents do.[20] Twenty-two percent of youth described the episode as a combination of running away and being thrown out.[20] In this report, the term "runaway" is used to refer to both categories, although the term "thrownaway" is occasionally used to be consistent with the data.

Runaways may not always be classified as missing children, making it difficult to quantify the problem. Many runaways are not considered missing because guardians and/or parents know the whereabouts of the youth. Youth who run away may stay with friends or other family members.[1,20] In addition, some runaways may not be reported missing because the guardians and/or parents are not looking for them. There is a small category of children who are permanently abandoned and are often not included in data because they may not be reported as missing.[1]

DEMOGRAPHICS

The total number of youth who run away is difficult to measure for a number of reasons, including inconsistent definitions and difficulty with sampling.[4] The data regarding the incidence of running away vary by state and by study population. As noted previously, NISMART-3 estimated a prevalence of running away of 5.3 per 1000 children.[2] In another study, published in 2006 on the basis of data from the 1996 wave of the National Longitudinal Study of Adolescent Health, authors reported that 6.4% of youth (nearly 850 000) had run away in the 12 months before the 1996 survey.[6] By using the data from the National Longitudinal Survey of Youth (1997 cohort), it was found that nearly 1 in 5 youth ran away before age 18. A school-based survey of Minnesota youth in grades 8 through 11 revealed that between 4% and 7% of students had run away at least once in the previous year.[7,8]

Each report of a missing child made to law enforcement is required by federal law to be entered into the Federal Bureau of Investigation National Crime Information Center (National Center for Missing and Exploited Children [NCMEC]).[21] Some of the reports may be regarding the same child because a report can be made each time a child is missing. In 2017, 464 000 reports were made into this database. One role of the NCMEC, the national clearinghouse and resource center for missing and exploited children, is to help with finding these children. In 2017, the NCMEC assisted with more than 27 000 cases, including 25 000 runaways (missingkids.org).[21]

The Runaway Safeline, (1–800-RUNAWAY), formerly known as the National Runaway Switchboard, is a federally funded national resource that provides services to youth and their families (https://www.1800runaway.org/). The Safeline allows runaway and homeless youth or their parents to call for assistance or guidance; attain 24-hour referrals to community resources, including shelter, food banks, legal assistance, and social services agencies; and seek crisis intervention counseling.[20] The Safeline handled more than 70 000 calls and electronic contacts in

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

2017.[22] Of those contacts, 31% of contacts were about youth who were contemplating running away, 16% were about youth who had run away, 5% were about youth asked to leave home or prevented from returning home (thrownaway), and 9% were about youth experiencing homelessness. Approximately three-fourths of the calls came from the affected youth.[22] Research compiled by the National Opinion Research Center found that more than 70% of youth left home on the spur of the moment, 36% of youth planned to run in advance, and 23% of youth who were thrown out said they expected to be thrown out.[20] This information was compiled from calls to the National Runaway Switchboard from 2000 to 2009, a comprehensive review of research on runaways, and new research conducted on youth in the streets and shelters in Chicago and Los Angeles between October 2008 and January 2010.[20] More than half of the adolescents reported that friends knew where they were, and 26% said that their parents knew their whereabouts. Only 13% of youth interviewed said that no one knew where they were.[20]

The NISMART-3 response rate was not high enough to be able to break down the characteristics of the runaway episodes.[2] Data from NISMART-2, conducted in 1999, reveal that 68% of runaways were between 15 and 17 years of age, 28% were 12 to 14 years of age, and 4% were 7 to 11 years of age.[1] Runaway episodes are most likely to occur during the summer; runaways usually go between 10 and 50 miles from home. Twenty-three percent traveled more than 50 miles from home. Most were gone from 24 hours to 1 week. Seven percent of runaways were missing for 1 to 6 months.[9]

The data regarding the distribution of runaway youth from racial and ethnic minority backgrounds are inconsistent.[1] Although racial and ethnic distributions have not been reported for NISMART-3, NISMART-2 data suggest that youth of color may be slightly overrepresented among runaway youth.[1,2] Research published in 2006 exploring the demographic profile of runaway youth in the United States using data from the National Longitudinal Study of Adolescent Health did not reveal significant differences in running away among racial and ethnic groups.[6] However, more recent data from the National Runaway Safeline reveal that youth of color seem to be overrepresented among runaway youth in crisis who are connecting with the Safeline; 23% of those youth connecting identify as black or African American, compared with 14% of the general population.[22] Morton et al[23] found similar results in 2018, revealing that black or African American youth were more likely to be homeless (including runaway episodes) than their peers. Although data on American Indian/Alaska Native youth who have run away are limited, an estimated 1 in every 130 American Indian/Alaska Native children go missing each year.[24] The number missing is likely to be higher, but estimates of American Indian/Alaska Native youth are limited because there is no centralized reporting system in tribal communities.[24]

The data regarding the gender distribution of runaway youth are also mixed but consistently reveal that girls run away more often than boys.[6] Sanchez et al[6] reported that female-identifying youth were more likely to have runaway. Data from the National Runaway Safeline reveal a similar trend. Among those youth connecting with the National Runaway Safeline in 2017, 69% identified as female, 29% identified as male, and 3% identified as either transgender or gender nonconforming.[22]

More than a decade of data suggest that lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are disproportionately represented among runaway and thrownaway youth. An estimated 20% to 40% of teenagers who are homeless identify as LGBTQ, compared with 4% to 10% of nonhomeless peers.[25–28] In a 2015 study of 434 homeless youth in Texas, 25% of youth identified as lesbian, gay, bisexual, transgender, or something else.[25] The unique runaway experiences and health care needs of LGBTQ runaway youth are discussed in detail later in this report.

HEALTH IMPACTS

A generation of research reveals that runaways are at high risk for adverse health outcomes, including disease, crime (both as victims and perpetrators), injuries, alcohol use, illegal drug use and sales, and sexual contact including abuse and activity.[1,9,10,15–17,29] It is critical that pediatricians are aware of the health implications of runaway episodes so that they can better care for these children. Many, but not all, runaways are homeless while away. The American Academy of Pediatrics (AAP) policy statement "Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity" details the health risks associated with homelessness.[30] This section focuses on health risks associated with running away, although there is some overlap.

While away from home, youth are at high risk for poor sexual health outcomes, including pregnancy, sexually transmitted infections, and sexual exploitation and abuse.[17,31–35] Nearly half of female street youth and one-third of female youth living in emergency shelters report a history of pregnancy.[33,36] Although not the focus of this report, runaways may become involved in sex trafficking or exploitation, including survival sex, which is sex in exchange for food, clothing, or housing.[1,15] Readers are referred to the AAP policy "Child Sex

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims" and other publications for additional information on this critical topic.[37,38] For youth who have been victims of abuse or neglect before running away or while away from home, pediatricians are mandated reporters. In states where sex trafficking is considered a form of abuse, pediatricians must make a formal report of suspected exploitation to law enforcement and to child protective services as well, if indicated.

Youth who run away are more likely to engage in substance use.[1,9] In addition to the health consequences associated with substance use alone, substance use increases the risk of sexual assault and mental health consequences dramatically for runaway adolescents.[38] In urban areas, these youth often join gangs or are involved in violent and/or drug-related criminal activity.[1,39] They have a high likelihood of being affected by violence while away from home.[1,11]

Youth who run away experience higher rates of mental illness, including anxiety, depression, and suicidality.[1,9,14,40] Edinburgh et al[14] showed that among runaway youth presenting to a child advocacy center, nearly a quarter had a history of a suicide attempt, compared with 13.7% of youth who had not run away. Older data from NISMART-2 revealed that 4% of endangered runaway and thrownaway youth had attempted suicide previously, but these data were not updated in NISMART-3.[1] A 2004 study measuring the prevalence of mental health disorders among runaway and homeless youth in small- to midsized cities in 4 Midwestern states revealed significantly higher rates of mental health disorders when compared with age-matched peers.[41]

Unfortunately, runaways frequently risk further trauma while away, including physical or sexual assault.[1,14,15,42] Poor mental health is believed to be associated with street victimization among homeless and runaway youth.[38] Running away puts youth at risk for exposure to additional trauma, further limits their social supports, and makes it difficult to access the necessary medical help for these disorders.[38]

There is a strong association between substance use and runaway episodes, although a causal link has not been established.[9,14,43] It is unclear whether the use of drugs and/or alcohol precipitates running away or being asked to leave home or whether the circumstances associated with the episodes lead to increased substance use, although longitudinal studies suggest that the association is likely bidirectional.[9] A 2013 study by Edinburgh et al[14] of youth presenting at a child advocacy center revealed that 1 in 3 runaway youth met criteria for problem substance use, whereas 1 in 10 nonrunaway youth met criteria. NISMART-2 data revealed that 17% of runaway youth reported using "hard drugs"; 18% were in the company of someone known to be using drugs while away, and 19% of runaway and thrownaway youth surveyed were substance dependent.[1]

Running away also has long-term effects on educational success. Youth who run away multiple times are 18% more likely to drop out of high school.[44] Youth who run away from home are less likely to graduate from high school. Seventy-five percent of runaway or homeless youth drop out of school.[19]

IDENTIFYING YOUTH WHO ARE AT RISK FOR RUNNING AWAY

There is no current, validated screening tool for runaway episodes, but practices should consider assessing for previous runaway episodes and risk factors for running away using a trauma-informed approach, which involves being aware of trauma and adverse childhood experiences that can affect health. "A trauma informed practice is defined as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma."[45] The AAP Trauma Toolbox for Primary Care contains resources on implementation for a primary care practice to become trauma informed.[45]

Many factors drive adolescents to run away or to be asked to leave home. The most common reason youth give for running away is fleeing a negative home environment.[9] In a study conducted by Tucker et al[9], several factors were found to be common in the runaway population. These factors included a perception of low parental support in the ninth grade, school disengagement, substance use, and depressive affect.[9] Disruption of the family structure and dysfunction and disorganization of homes are known risk factors for running away.[9,10]

Runaway behavior is more common in youth who have been exposed to violence, had a poor parent-child relationship, and/or had a history of delinquent behavior or depressive symptoms. Some studies have shown that economic problems in the home may lead to more youth running away.[19] Tyler and Bersani[46] noted that youth living in disadvantaged neighborhoods were also more likely to run away.

Disengagement from school is a significant risk factor for a child running away or becoming homeless. Tucker et al[9] reviewed an analysis of more than 15 000 youth in crisis shelters or transitional living programs and found that 47% had irregular school attendance and 22% had dropped out or been expelled.

Youth who are asked to leave home may include youth who are pushed out of their homes for different

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

reasons, some because the family cannot provide for their specific mental health or disability needs, some because parents cannot afford to provide care, and many because of poor relationships between parents and youth.[1,19]

Implementation of various screens during health care visits can assist to identify family stressors, school problems, and other social determinants of health that may increase the risk of running away. Screening tools such as the Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education survey instrument (WE CARE) and Safe Environment for Every Kid (SEEK) parent screening questionnaire screen families for problems related to education, housing, child maltreatment, domestic violence, and more. More information is available on the AAP Poverty and Child Health Web site.[47] For, adolescents, pediatricians should conduct a thorough, confidential psychosocial assessment, such as the HEEADSSS assessment (home environment, education and employment, eating, peer-related activities, drugs, sexuality, suicide/depression and safety).[48] Routine depression screening is also recommended for teenagers. Pediatricians should also assess for protective factors, including whether adolescents consider themselves to have several sources of support at home, at school, and in the community.[14]

When an adolescent at high risk for running away is identified, early intervention to prevent runaway episodes is recommended. Use of practice- and community-based resources to address any modifiable risk factors, support the psychological and behavioral health needs of the child and family, and ensure safety can be helpful. Pediatricians can share information regarding national resources for runaways and their families, including the National Runaway Safeline and the NCMEC (see Resources). Pediatricians can ask adolescents where they would go if they were to run away or be forced out, specifically assessing for other safe, supportive adults who might be able and willing to provide shelter and support in a crisis. Pediatricians can refer families to local resources for behavioral health, family therapy, and support and assistance with other issues.

Several high-risk populations deserve additional attention, including victims of abuse and neglect, LGBTQ youth, and youth in protective custody. Each of these populations is discussed in further detail in the sections that follow. Adolescents in these subgroups are at high risk for running away and may experience significant health effects while away.

VICTIMS OF ABUSE AND NEGLECT

Among runaway and thrownaway youth surveyed as part of NISMART-2, 21% (estimated 350 400) reported being physically or sexually abused at home in the year before the episode or were afraid of abuse if they returned.[1] Across multiple studies of homeless youth, rates of sexual abuse ranged from 17% to 35% and physical abuse ranged from 40% to 60%.[19,26] Approximately 20% of street youth have, at some point, been removed from their homes by authorities because of neglect or abuse.[32] Runaway youth consistently report family conflict as a primary reason for leaving the home.[32,49] Thrane et al[10] studied the impact of family abuse on running away, deviance, and street victimization and found that adolescents who had been exposed to neglect and sexual abuse ran away sooner and were more likely to be victimized on the street. Although most runaway youth are missing for less than 1 week and remain close to home, those who go missing for longer periods of time and who travel farther from home are more likely to have been abused previously.[10] As previously noted, while youth are away, they are at risk for further victimization.[14,38]

LGBTQ YOUTH

As noted previously, a decade of research suggests that an estimated 20% to 40% of teenagers who are homeless identify as LGBTQ, compared with 4% to 10% of nonhomeless peers.[25–28] In a 2012 survey of service providers for homeless youth and youth at risk for homelessness, Durso and Gates[50] explored reasons for homelessness among LGBTQ youth and found that nearly half (46%) of LGBTQ youth reported running away because of rejection relating to sexual orientation or gender identity, and 43% reported being forced out by parents because of sexual orientation or gender identity. Nearly one-third of these youth (32%) attributed their homelessness to physical, sexual, or verbal abuse at home.[50] To the authors' knowledge, there are no specific data that are focused on LGBTQ runaway youth; thus, the literature on LGBTQ homeless youth is used more generally in this discussion given the significant overlap in this population.

LGBTQ youth are more likely to be affected by the many health risks associated with homelessness.[41,50,51] LGBTQ youth who are homeless report higher rates of survival sex, substance use, and victimization when compared with non-LGBTQ homeless youth.[41,51–53] A survey by Cochran et al[51] comparing LGBT homeless youth and heterosexual homeless youth revealed that LGBT youth reported, on average, 7.4 more acts of sexual victimization than their heterosexual counterparts and had significantly higher rates of psychopathology.[50] LGBTQ youth also experience higher rates of depression and suicidality.[41,53,54] In a multistate single-day survey of homeless youth

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

by Van Leeuwen et al,[54] 62% of LGBTQ homeless youth reported a previous suicide attempt, compared with 29% of non-LGBTQ homeless youth.[54] In the same study, homeless LGBTQ youth had higher rates of sexually transmitted infections, including HIV, than heterosexual homeless youth.[54]

YOUTH IN PROTECTIVE CUSTODY

Data on runaway youth living in protective custody, including foster care, vary depending on the source of the data.[55–57] In 2017, 4734 (1.1%) of the 442 995 children in foster care in the United States ran away from their foster care placements, consistent with data reported by the US Department of Health and Human Services in 2016. Data from 2010 include all runaways in foster care from birth to 18 years of age, but because young children do not have the capability to run away, the estimate of children who run away increases with age, with approximately 30% of youth 12 years or older in out-of-home care placements having run away.[58,59] In 2013, Benoit-Bryan[59] reported that older youth in foster care were more than 2.5 times more likely to run away than youth who do not live in foster care. Lin[58] found that most foster youth who run away run to their family of origin and/or their friends out of a desire to maintain relationships with their community of origin.

One study from 2015 reported that youth in foster care who run away have often experienced emotional or psychological problems that began before entering foster care.[55] Experiences such as parental incarceration and personal history of substance use were associated with a higher number of runaway episodes.[55]

While in out-of-home care, children with developmental and cognitive disabilities were less likely to run away, whereas children with mental and behavioral health problems were more likely to run away.[57] Courtney and Zinn[57] found that some mental and/or behavioral disorders, such as schizophrenia and other psychoses, were associated with lower risk of running away, but alcohol- and other substance-related disorders were associated with increased risk. Data from the 2009 Adoption and Foster Care Analysis and Reporting System (AFCARS), a federally mandated data collection system that includes case-level information on (1) all children in foster care for whom child welfare agencies have responsibility for placement, care, and supervision and (2) children adopted through child welfare agencies, found that autism spectrum disorder was associated with a decreased incidence of running away.[55]

Child welfare system–related characteristics, including the type of placement, permanency plan while in care, reason for placement, number of placements, and the quality of care received in placements were also found to be factors associated with runaway behaviors.[58] The instability of foster care placements is a predictor of youth running away behavior, and multiple placements are related with an increased risk of running away.[58] Children who ran away experienced an average of 6 placement settings.[58] Stabilization of foster care placement is associated with fewer runaway episodes.[58] Placement type is also important; youth in foster homes, especially if placed with a relative, are less likely to run away than those placed in residential care.[57] In addition, children who are placed in the same foster home as a sibling are less likely to run away.[57] Youth who know they are unlikely to be reunified with family or relatives and/or be adopted are more likely to run away.[55] Of note, youth with a history of running away are 92% more likely to run away again.[58]

Children who run away from out-of-home care are at increased risk of negative consequences similar to all runaway youth, such as criminal victimization, sexual exploitation, and substance or alcohol use.[55]

For youth in protective custody, pediatricians should discuss stability of placement with the foster parent, case manager, and/or child, and a confidential discussion with the child should take place about how the child feels about where he or she is living and any concerns. For all children in foster care, it is critical that pediatricians recommend that their behavioral health needs be met. Pediatricians and other health care providers for youth in out-of-home custody can refer to the multiple resources available through the AAP on the Healthy Foster Care America Web page (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/default.aspx).

ROLE OF TECHNOLOGY AND SOCIAL MEDIA

The rapid expansion of social media has influenced the experiences of runaway youth in several ways. Early data exploring the nature of Internet-initiated crimes suggest that online relationships may increase the risk of running away.[60] However, the evolving social media landscape makes the effects difficult to measure, and available follow-up data are limited. A study conducted from October 2001 to July 2002 of a random sample of law enforcement agencies described the characteristics of episodes in which juveniles became victims of sex crimes committed by people they met through the Internet.[61] This study revealed that victims in these crimes were primarily 13- to 15-year-old girls who met adult male offenders and developed romantic relationships with them for 1 month or longer. In most cases, offenders did not deceive victims regarding their age or sexual

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

motives. Of 129 cases studied, 5% involved violent offenses and 3% involved brief abductions in the setting of sexual assaults. Notably, 29% of the victims who attended face-to-face meetings were reported missing to police, with 24% being runaways and 5% who had misinformed parents regarding where they were going.[61] In a 2014 study of law enforcement perspectives on the role of technology in child sexual exploitation, investigators working on child sexual exploitation cases report that technology has played a significant role in the majority of cases.[62]

Recognizing the potential links between runaway youth, sexual exploitation, and technology, in April 2018, the Family and Youth Services Bureau added a tool titled "Online Recruitment of Youth Via Social Media and the Internet" to its "Human Trafficking and Runaway and Homeless Youth: Practical Tools for Grantees." This tool explores the role of social media trafficking recruitment, lists red flags, and recommends prevention strategies for youth-serving agencies.[63]

Innovative work has also emerged exploring the potential use of technology to improve health and access to services for homeless youth.[64–68] A 2016 study by Harpin et al[69] of homeless youth in Denver, Colorado, revealed that 71.9% of youth consistently used social media. Tyler and Schmitz[68] reported on using texting technology for data collection and explored potential opportunities for interventions leveraging technology. Buccieri and Molleson[64] explored the use of a youth-developed application for homeless youth. In their study of law enforcement, Mitchell and Boyd[62] discussed the potential opportunity for technology to be used to connect with difficult-to-reach populations that may be at risk for commercial sexual exploitation, including homeless and runway youth. Although much of this work has focused on homeless youth specifically, it has potential implications for runaway youth and requires further study.

MANAGEMENT OF RUNAWAY EPISODES

For children who have run away, pediatricians can conduct a thorough assessment of mental health concerns; substance use; previous history of abuse, violence, or victimization while away; exposure to trauma; and sexual and reproductive health needs and treat accordingly. Pediatricians should provide comprehensive care, including psychological and social support, to families who have a child or adolescent who has recently returned home after running away. Often, these children are targeted for punishment for the act of running away or for the associated misdeeds of substance use, theft, or prostitution when what is needed is medical and psychological treatment, family realignment, or placement in protective custody.[3]

Pediatricians can support and maintain awareness of programs that serve runaway youth and build connections with these programs through the medical home. Pediatricians may also consider sharing information regarding national resources for runaways and their families listed below, including the National Runaway Safeline and the NCMEC (see Resources).

OPPORTUNITIES FOR FUTURE RESEARCH AND ACTION

Additional research on the recognition, management, and prevention of runaway episodes is critical. Specifically, the development of well-validated screening tools for identifying children who are at high risk for running away or being thrown away would help pediatricians and other health care providers better identify this high-risk population of adolescents. Innovative, evidence-based interventions aimed at the prevention of runaway and thrownaway episodes in the clinical and community setting should also be developed and studied to guide practice- and community-based intervention.

Another potential area of study is the role of the Internet and social media in episodes of runaway youth, including further exploration of safe media use and applications of social media and technology to better support youth who have run away.

Finally, policies and programs that improve health care access for runaway youth are essential. Federal legislation supporting the Runaway and Homeless Youth Program, initially passed in the 1970s and revised as recently as 2017, recognizes this need and provides funding for services that support runaway and homeless youth. This legislation includes grant funding for programs that target mental and physical health among runaway youth and integrate health care into existing services for youth.[70,71] Shelter-based clinics, clinics for runaway youth, health care services for street youth, and free youth clinics all may serve as options to meet the health care needs of this population but must provide readily accessible, culturally competent, trauma-informed, and confidential care.[72–75] The Runaway Intervention Program in Minnesota represents an innovative nursing-led intervention targeting runaway youth with promising outcomes.[73,76,77] Community-based interventions that improve health care access and outcomes in a cost-effective manner should be studied and supported. Policy strategies are needed that improve access to health insurance and health care for runaway youth.

CONCLUSIONS

Runaway and thrownaway youth, the largest category of missing children, require ongoing support and

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

continued engagement with pediatricians and other health care providers and community resources to prevent recurrence and address their unique health needs.

RECOMMENDATIONS FOR CLINICAL PRACTICE

- Identify youth who are at high risk for running away or being thrown away.
  - Conduct a thorough, confidential social history and home environment, education and employment, eating, peer-related activities, drugs, sexuality, suicide and/or depression, and safety (HEEADSSS) assessment for all adolescents, including surveillance for risk factors known to be associated with running away.[48] Routine depression screening is recommended for children 12 and up by using standardized tools such as the Patient Health Questionnaire for Adolescents (PHQ-A) and the primary care version of the Beck Depression Inventory (BDI).[78]
  - Assess whether adolescents consider themselves to have sources of support, including the pediatrician, so that they do not need to resort to running away. Ask them to identify an adult they feel comfortable confiding in and recommend they go to that adult if they are having any issues.
- Consider posting and sharing information regarding national resources for runaways and their families in waiting or examination rooms.
- If an adolescent is believed to be at high risk for running away or has run away before, discuss a safety plan for future runaway episodes, including a plan for accessing safe housing. Review potential health and behavioral risks associated with running away and provide necessary health care to mitigate risk, such as reliable contraception and access to mental health care.
- If risk factors are identified, intervene early to prevent runaway episodes by using practice- and community-based resources to address any modifiable risk factors, support the psychological and behavioral health needs of the child and family, and ensure safety.
- Consider counseling special populations as follows:
  - Victims of abuse and neglect: For children with a known or suspected history of abuse or neglect, confirm that they feel safe in their current living situation.
  - LGBTQ youth: Help support sexual minority children and youth and their families, particularly about the process of coming out regarding nonconforming gender expression or sexual orientation.
  - Youth in protective custody: For youth in protective custody, discuss stability of placement with the foster parent, case manager, and/or child. Discuss with the child how he or she feels about where he or she is living and any concerns.
  - Youth with mental health and/or substance use issues: Recommend appropriate ongoing mental health support and services. For substance use, consider using the screening, brief intervention, and referral to treatment (SBIRT) outlined in the AAP policy statement and clinical report.[79,80]
- Support and maintain awareness of programs that serve youth who have run away or are homeless, including hotlines, shelters, and other resources to provide for basic needs while youth are away (see Resources).
- For youth who have run away, conduct a thorough assessment of mental health concerns; substance use; previous history of abuse, violence, or victimization while away; exposure to trauma; and sexual and reproductive health needs and treat accordingly. Youth who have run away may run away again. Refer at-risk youth to programs that are focused on self-empowerment, healthy sexuality, and relationships and safety planning with the goal of increasing youth resilience.
- Provide comprehensive care through a trauma-informed lens, including psychological and social support, to families who have a child or adolescent who has recently returned home after running away.
- Although the prevention of runaway episodes has not been well studied, prevention likely depends on the development of strong, nurturing, reciprocal relationships from early childhood. Building on existing approaches within Bright Futures for health supervision visits and validated community programs, the AAP supports efforts to promote positive relationships and positive parenting strategies early on.
- In states where sex trafficking is considered a form of abuse, pediatricians must make a formal report of suspected exploitation to law enforcement and to child protective services as well, if indicated.

RESOURCES

- The National Runaway Safeline, formerly known as the National Runaway Switchboard (1–800-RUNAWAY; https://www.1800runaway.org/), serves as a hotline for children considering running away and those who have run away.
- NCMEC (www.missingkids.com): If a child runs away, the parent or

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

guardian should contact the NCMEC at 1-800-THE-LOST in addition to reporting the incident to law enforcement. Any information about a missing child or suspected sexual exploitation should be reported to NCMEC.

- Strengthening Families (www.strengtheningfamilies.net) provides resources for building resilience in parents and children.
- National Network for Youth (www.nn4youth.org) is a public education and policy advocacy organization dedicated to the prevention and eradication of youth homelessness.

LEAD AUTHORS

Thresia B. Gambon, MD, MPH, MBA, FAAP
Janna R. Gewirtz O'Brien, MD, FAAP

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, 2019–2020

Arthur Lavin, MD, FAAP, Chairperson
George LaMonte Askew, MD, FAAP
Rebecca Baum, MD, FAAP
Evelyn Berger-Jenkins, MD, FAAP
Tiffani Johnson, MD, FAAP
Douglas Jutte, MD, MPH, FAAP
Arwa Nasir, MBBS, MSc, MPH, FAAP

FORMER COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH MEMBERS

Michael W. Yogman, MD, FAAP, Former Chairperson
Nerissa S. Bauer, MD, MPH, FAAP
Thresia B. Gambon, MD, FAAP
Keith M. Lemmon, MD, FAAP
Jason Richard Rafferty, MD, MPH, EdM, FAAP
Lawrence Sagin Wissow, MD, MPH, FAAP

LIAISONS

Sharon Berry, PhD, ABPP, LP – *Society of Pediatric Psychology*
Edward R. Christophersen, PhD, ABPP, FAAP – *Society of Pediatric Psychology*
Kathleen Davis, LSW – *Family Liaison*
Norah L. Johnson, PhD, RN, CPNP-BC – *National Association of Pediatric Nurse Practitioners*
Rachel Shana Segal, MD – *Section on Pediatric Trainees*
Abigail Boden Schlesinger, MD – *American Academy of Child and Adolescent Psychiatry*
Amy Starin, PhD, LCSW – *National Association of Social Workers*

STAFF

Carolyn McCarty, PhD

COUNCIL ON COMMUNITY PEDIATRICS, 2019–2020

James Duffee, MD, MPH, FAAP, Chairperson
Kimberley J. Dilley, MD, MPH, FAAP
Andrea E. Green, MD, FAAP
Joyce Javier, MD, MPH, MS, FAAP
Madhulika Mathur, MD, MPH, FAAP
Gerri Mattson, MD, FAAP
Kimberly G. Montez, MD, MPH, FAAP
Jacqueline L. Nelson, MD, FAAP
Christopher B. Peltier, MD, FAAP

FORMER COUNCIL ON COMMUNITY PEDIATRICS MEMBERS

Benjamin A. Gitterman, MD, FAAP
Thresia B. Gambon, MD, MPH, MBA, FAAP
Janna R. Gewirtz O'Brien, MD, FAAP
Virginia Keane, MD, FAAP

LIAISONS

Donene Feist
Zheyi Teoh, MD

STAFF

Dana Bennett-Tejes, MA
Jean Davis, MPP

ABBREVIATIONS

AAP: American Academy of Pediatrics
LGBT: lesbian, gay, bisexual, and transgender
LGBTQ: lesbian, gay, bisexual, transgender, and questioning
NCMEC: National Center for Missing and Exploited Children
NISMART-2: 1999 National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children
NISMART-3: 2013 National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

REFERENCES

1. Hammer H, Finkelhor D, Sedlak AJ. *Runaway/Thrownaway Children: National Estimates and Characteristics*. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; 2002. Available at: https://www.ncjrs.gov/pdffiles1/ojjdp/196469.pdf. Accessed March 1, 2017
2. Sedlak AJ, Finkelhor D, Brick JM; Office of Juvenile Justice and Delinquency Prevention. National estimates of missing children: updated findings from a survey of parents and other primary caretakers. 2017. Available at: https://www.ojjdp.gov/pubs/250089.pdf. Accessed June 11, 2019
3. Howard BJ, Broughton DD; American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. The pediatrician's role in the prevention of missing children. *Pediatrics*. 2004;114(4):1100–1105. Reaffirmed January 2015
4. Greene JM, Sanchez R, Harris J, Cignetti C, Akin D, Wheeless S. Incidence and

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

prevalence of homeless and runaway youth. 2003. Available at: https://www.acf.hhs.gov/sites/default/files/opre/incidence.pdf. Accessed March 2017

5. Ringwalt CL, Greene JM, Robertson M, McPheeters M. The prevalence of homelessness among adolescents in the United States. *Am J Public Health*. 1998;88(9):1325–1329

6. Sanchez RP, Waller MW, Greene JM. Who runs? A demographic profile of runaway youth in the United States. *J Adolesc Health*. 2006;39(5):778–781

7. Minnesota Student Survey Interagency Team. Minnesota Student Survey 2013. Roseville, MN: Minnesota Department of Education; 2013. Available at: http://w20.education.state.mn.us/MDEAnalytics/DataTopic.jsp?TOPICID=242. Accessed January 21, 2019

8. Minnesota Student Survey Interagency Team. Minnesota Student Survey 2016. Roseville, MN: Minnesota Department of Education; 2016. Available at: http://w20.education.state.mn.us/MDEAnalytics/DataTopic.jsp?TOPICID=242. Accessed January 21, 2019

9. Tucker JS, Edelen MO, Ellickson PL, Klein DJ. Running away from home: a longitudinal study of adolescent risk factors and young adult outcomes. *J Youth Adolesc*. 2011;40(5):507–518

10. Thrane LE, Hoyt DR, Whitbeck LB, Yoder KA. Impact of family abuse on running away, deviance, and street victimization among homeless rural and urban youth. *Child Abuse Negl*. 2006;30(10):1117–1128

11. Tyler KA, Gervais SJ, Davidson MM. The relationship between victimization and substance use among homeless and runaway female adolescents. *J Interpers Violence*. 2013;28(3):474–493

12. Tyler KA, Johnson KA. A longitudinal study of the effects of early abuse on later victimization among high-risk adolescents [published correction appears in *Violence Vict*. 2006;21(4): preceding 403]. *Violence Vict*. 2006;21(3):287–306

13. Whitbeck LB, Hoyt DR, Ackley KA. Families of homeless and runaway adolescents: a comparison of parent/caretaker and adolescent perspectives on parenting, family violence, and adolescent conduct. *Child Abuse Negl*. 1997;21(6):517–528

14. Edinburgh LD, Harpin SB, Garcia CM, Saewyc EM. Differences in abuse and related risk and protective factors by runaway status for adolescents seen at a U.S. Child Advocacy Centre. *Int J Child Adolesc Resil*. 2013;1(1):4–16

15. Edinburgh L, Pape-Blabolil J, Harpin SB, Saewyc E. Assessing exploitation experiences of girls and boys seen at a Child Advocacy Center. *Child Abuse Negl*. 2015;46:47–59

16. Edinburgh L, Saewyc E, Thao T, Levitt C. Sexual exploitation of very young Hmong girls. *J Adolesc Health*. 2006;39(1):111–118

17. Lacoursiere T, Fontenot HB. The impact of running away on teen girls' sexual health. *Nurs Womens Health*. 2012;16(5):411–417

18. Meltzer H, Ford T, Bebbington P, Vostanis P. Children who run away from home: risks for suicidal behavior and substance misuse. *J Adolesc Health*. 2012;51(5):415–421

19. National Conference of State Legislatures. Homeless and runaway youth. Available at: http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx. Accessed March 20, 2017

20. Pergamit M, Ernst M, Benoit-Bryan J, Kessel J; National Runaway Switchboard. Why they run: an in-depth look at America's runaway youth. 2010. Available at: http://www.missingkids.org/footer/media/keyfacts. Accessed February 3, 2018

21. The National Center for Missing and Exploited Children. Key facts. Available at: www.missingkids.com. Accessed March 17, 2018

22. National Runaway Safeline; US Department of Health and Human Services. National trends on youth in crisis in the United States: an analysis of trends in crisis connections to the National Runaway Safeline over the past decade (2007–2017). 2018. Available at: https://www.1800runaway.org/wp-content/uploads/2018/11/NRS-2018-Trend-Report_Final.pdf. Accessed January 21, 2019

23. Morton MH, Dworsky A, Matjasko JL, et al. Prevalence and correlates of youth homelessness in the United States. *J Adolesc Health*. 2018;62(1):14–21

24. US Department of Justice. National vs. native missing youth statistics. Available at: https://amber-ic.org/wp-content/uploads/2017/11/NationalvsNativeMissingYouth.pdf. Accessed August 2, 2019

25. Narendorf SC, Santa Maria DM, Cooper JA. Youth Count 2.0!: full report of findings 2015. Available at: https://www.uh.edu/socialwork/_docs/Research/FINAL%20REPORT%20YOUTH%20COUNT%202.0.pdf. Accessed April 28, 2019

26. Cray A, Miller K, Durso LE; Center for American Progress. Seeking shelter: the experiences and unmet needs of LGBT homeless youth. 2013. Available at: https://www.americanprogress.org/issues/lgbt/reports/2013/09/26/75746/seeking-shelter-the-experiences-and-unmet-needs-of-lgbt-homeless-youth/. Accessed April 28, 2019

27. Corliss HL, Goodenow CS, Nichols L, Austin SB. High burden of homelessness among sexual-minority adolescents: findings from a representative Massachusetts high school sample. *Am J Public Health*. 2011;101(9):1683–1689

28. Cunningham M, Pergamit M, Astone N, Luna J; Urban Institute. Homeless LGBTQ youth. 2014. Available at: www.urban.org/research/publication/homeless-lgbtq-youth. Accessed April 28, 2019

29. Yates GL, MacKenzie R, Pennbridge J, Cohen E. A risk profile comparison of runaway and non-runaway youth. *Am J Public Health*. 1988;78(7):820–821

30. Council on Community Pediatrics. Providing care for children and adolescents facing homelessness and housing insecurity. *Pediatrics*. 2013;131(6):1206–1210. Reaffirmed October 2016

31. Thrane LE, Chen X. Impact of running away on girls' pregnancy. *J Adolesc*. 2012;35(2):443–449

32. Robertson MJ, Toro PA. Homeless youth: research, intervention, and policy. In: Fosburg LB, Dennis DL, eds. *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Washington, DC: US Department of

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

Housing and Urban Development, US Department of Health and Human Services; 1999:77–108

33. Thompson SJ, Bender KA, Lewis CM, Watkins R. Runaway and pregnant: risk factors associated with pregnancy in a national sample of runaway/homeless female adolescents. *J Adolesc Health*. 2008;43(2):125–132

34. Thompson SJ, Pillai VK. Determinants of runaway episodes among adolescents using crisis shelter services. *Int J Soc Welf*. 2006;15(2):142–149

35. Thompson SJ. Risk/protective factors associated with substance use among runaway/homeless youth utilizing emergency shelter services nationwide. *Subst Abus*. 2004;25(3):13–26

36. Greene JM, Ringwalt CL. Pregnancy among three national samples of runaway and homeless youth. *J Adolesc Health*. 1998;23(6):370–377

37. Greenbaum J, Crawford-Jukubiak JE; Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3): 566–574

38. Thrane LE, Yoder KA, Chen X. The influence of running away on the risk of female sexual assault in the subsequent year. *Violence Vict*. 2011; 26(6):816–829

39. Crawford DM, Whitbeck LB, Hoyt DR. Propensity for violence among homeless and runaway adolescents: an event history analysis. *Crime Delinq*. 2011;57(6):950–968

40. Lim C, Rice E, Rhoades H. Depressive symptoms and their association with adverse environmental factors and substance use in runaway and homeless youths. *J Res Adolesc*. 2016; 26(3):403–417

41. Whitbeck LB, Johnson KD, Hoyt DR, Cauce AM. Mental disorder and comorbidity among runaway and homeless adolescents. *J Adolesc Health*. 2004;35(2):132–140

42. Bender K, Brown SM, Thompson SJ, Ferguson KM, Langenderfer L. Multiple victimizations before and after leaving home associated with PTSD, depression, and substance use disorder among homeless youth. *Child Maltreat*. 2015;20(2):115–124

43. Holliday SB, Edelen MO, Tucker JS. Family functioning and predictors of runaway behavior among at-risk youth. *Child Adolesc Social Work J*. 2017;34(3): 247–258

44. Aratani Y, Cooper JL. The effects of runaway-homeless episodes on high school dropout. *Youth Soc*. 2015;47(2): 173–198

45. American Academy of Pediatrics. Trauma toolbox for primary care. Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Becoming-a-Trauma-Informed-Practice.aspx. Accessed October 3, 2019

46. Tyler KA, Bersani BE. A longitudinal study of early adolescent precursors to running away. *J Early Adolesc*. 2008; 28(2):230–251

47. American Academy of Pediatrics. Poverty and child health toolkit. Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/home.aspx. Accessed June 27, 2019

48. American Academy of Pediatrics. Bright Futures. Performing preventative services: a bright futures handbook. Available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/History,%200bservation,%20and%20Surveillance.pdf. Accessed July 23, 2019

49. National Runaway Safeline. NRS call statistics. Available at: https://www.1800runaway.org/trendreport2017/. Accessed November 15, 2018

50. Durso LE, Gates GJ. *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund, The Palette Fund; 2012. Available at: https://williamsinstitute.law.ucla.edu/research/safe-schools-and-youth/serving-our-youth-july-2012/. Accessed January 31, 2019

51. Cochran BN, Stewart AJ, Ginzler JA, Cauce AM. Challenges faced by homeless sexual minorities: comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *Am J Public Health*. 2002;92(5):773–777

52. Rice E, Barman-Adhikari A, Rhoades H, et al. Homelessness experiences, sexual orientation, and sexual risk taking among high school students in Los Angeles. *J Adolesc Health*. 2013;52(6): 773–778

53. Keuroghlian AS, Shtasel D, Bassuk EL. Out on the street: a public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *Am J Orthopsychiatry*. 2014; 84(1):66–72

54. Van Leeuwen JM, Boyle S, Salomonsen-Sautel S, et al. Lesbian, gay, and bisexual homeless youth: an eight-city public health perspective. *Child Welfare*. 2006;85(2):151–170

55. Kim H, Chenot D, Lee S. Running away from out-of-home care: a multilevel analysis. *Child Soc*. 2015;29(2):109–121

56. Finkelstein M, Wamsley M, Currie D, Miranda D; Vera Institute of Justice. Youth who chronically AWOL from foster care. 2004. Available at: https://www.vera.org/publications/youth-who-chronically-awol-from-foster-care-why-they-run-where-they-go-and-what-can-be-done. Accessed February 4, 2018

57. Courtney ME, Zinn A. Predictors of running away from out-of-home care. *Child Youth Serv Rev*. 2009;31(12): 1298–1306

58. Lin C-H. Children who run away from foster care: who are the children and what are the risk factors? *Child Youth Serv Rev*. 2012;34(4):807–813

59. Benoit-Bryan J. Family characteristics and runaway youth. 2013. Available at: https://www.1800runaway.org/wp-content/uploads/2015/05/Family-Characteristics-and-Runaway-Behavior-final2.pdf. Accessed July 22, 2019

60. Wolak J, Finkelhor D, Mitchell KJ, Ybarra ML. Online "predators" and their victims: myths, realities, and implications for prevention and treatment. *Am Psychol*. 2008;63(2): 111–128

61. Wolak J, Finkelhor D, Mitchell K. Internet-initiated sex crimes against minors: implications for prevention based on findings from a national study. *J Adolesc Health*. 2004;35(5): 424.e11-424.e20

62. Mitchell KJ, Boyd D. *Understanding the Role of Technology in the Commercial*

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

Sexual Exploitation of Children: The Perspective of Law Enforcement. Durham, NH: Crimes Against Children Research Center, University of New Hampshire; 2014. Available at: https://scholars.unh.edu/ccrc/37/. Accessed April 28, 2019

63. Family and Youth Services Bureau. *Human Trafficking and Runaway and Homeless Youth: Practical Tools for Grantees. Online Recruitment of Youth Via Social Media and the Internet Youth Social Media Use*. Washington, DC: Family and Youth Services Bureau; 2018. Available at: https://rhyttac.memberclicks.net/assets/docs/Resources/RHY%20HT%20Social%20Media.pdf. Accessed April 28, 2019

64. Buccieri K, Molleson G. Empowering homeless youth: building capacity through the development of mobile technology. *J Community Pract*. 2015;23(2):238–254

65. Rice E, Barman-Adhikari A. Internet and social media use as a resource among homeless youth. *J Comput Mediat Commun*. 2014;19(2):232–247

66. Stott TC, MacEachron A, Gustavsson N. Social media and child welfare: policy, training, and the risks and benefits from the administrator's perspective. *Adv Soc Work*. 2017;17(2):221–234

67. Tyler KA, Olson K. Examining the feasibility of ecological momentary assessment using short message service surveying with homeless youth. *Field Methods*. 2018;30(2):91–104

68. Tyler KA, Schmitz RM. Using cell phones for data collection: benefits, outcomes, and intervention possibilities with homeless youth. *Child Youth Serv Rev*. 2017;76:59–64

69. Harpin S, Davis J, Low H, Gilroy C. Mobile phone and social media use of homeless youth in Denver, Colorado. *J Community Health Nurs*. 2016;33(2):90–97

70. Family and Youth Services Bureau. Runaway and Homeless Youth Program authorizing legislation. 2018. Available at: https://www.acf.hhs.gov/fysb/resource/rhy-act. Accessed January 21, 2019

71. Cooper EF; Congressional Research Service. The Runaway and Homeless Youth Program: administration, funding, and legislative actions. 2006. Available at: https://digital.library.unt.edu/ark:/67531/metacrs9962/m1/1/high_res_d/RL31933_2006Mar23.pdf. Accessed April 5, 2019

72. Klein JD, Woods AH, Wilson KM, Prospero M, Greene J, Ringwalt C. Homeless and runaway youths' access to health care. *J Adolesc Health*. 2000;27(5):331–339

73. Edinburgh LD, Saewyc EM. A novel, intensive home-visiting intervention for runaway, sexually exploited girls. *J Spec Pediatr Nurs*. 2009;14(1):41–48

74. English A. Runaway and street youth at risk for HIV infection: legal and ethical issues in access to care. *J Adolesc Health*. 1991;12(7):504–510

75. Hudson AL, Nyamathi A, Greengold B, et al. Health-seeking challenges among homeless youth. *Nurs Res*. 2010;59(3):212–218

76. Bounds D, Edinburgh L, Fogg L, Saewyc E. The Minnesota Runaway Intervention Program's influence on sexually exploited youth's trauma responses. *J Adolesc Health*. 2017;60(2):S22–S23

77. Saewyc EM, Edinburgh LD. Restoring healthy developmental trajectories for sexually exploited young runaway girls: fostering protective factors and reducing risk behaviors. *J Adolesc Health*. 2010;46(2):180–188

78. Siu AL; US Preventive Services Task Force. Screening for depression in children and adolescents: US Preventive Services Task Force recommendation statement. *Pediatrics*. 2016;137(3):e20154467

79. Levy SJ, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211

80. Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161210

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

Runaway Youth: Caring for the Nation's Largest Segment of Missing Children

Thresia B. Gambon, Janna R. Gewirtz O'Brien and COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON COMMUNITY PEDIATRICS

Pediatrics 2020;145;
DOI: 10.1542/peds.2019-3752 originally published online January 21, 2020;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/145/2/e20193752
References	This article cites 55 articles, 8 of which you can access for free at: http://pediatrics.aappublications.org/content/145/2/e20193752#BIBL
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): **Community Pediatrics** http://www.aappublications.org/cgi/collection/community_pediatrics_sub **Current Policy** http://www.aappublications.org/cgi/collection/current_policy **Committee on Psychosocial Aspects of Child and Family Health** http://www.aappublications.org/cgi/collection/committee_on_psychosocial_aspects_of_child_and_family_health **Council on Community Pediatrics** http://www.aappublications.org/cgi/collection/council_on_community_pediatrics **Psychiatry/Psychology** http://www.aappublications.org/cgi/collection/psychiatry_psychology_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.aappublications.org/site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: http://www.aappublications.org/site/misc/reprints.xhtml

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Runaway Youth: Caring for the Nation's Largest Segment of Missing Children

Thresia B. Gambon, Janna R. Gewirtz O'Brien and COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON COMMUNITY PEDIATRICS

Pediatrics 2020;145;
DOI: 10.1542/peds.2019-3752 originally published online January 21, 2020;

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/145/2/e20193752

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2020 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by 113690 on April 13, 2020