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Facilitators and Barriers to Implementing Church-Based Adolescent Sexual Health Programs in Baltimore City

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Abstract

Purpose: Black churches are an important community resource and a potentially powerful actor in adolescent health promotion. However, limited research exists describing the factors that may influence the successful implementation of evidence-based adolescent sexual health programs in churches. In the present study, a multi-informant approach was used to identify facilitators and barriers to implementing adolescent sexual health programs in black churches.

Methods: Nine Black churches located in Baltimore, MD, were recruited to participate in this study. The senior pastor and youth minister from each congregation participated in an in-depth interview (N = 18). A total of 45 youth (ages 13–19 years) and 38 parents participated in 15 focus groups. Qualitative data were transcribed verbatim and analyzed using a qualitative content analytic approach.

Results: Participants agreed that comprehensive adolescent sexual health education should be available for youth in black churches. They also believed that abstaining from sex should be discussed in all adolescent sexual health programs. Three facilitators were discussed: widespread endorsement of church-based adolescent sexual health education, positive influence of youth ministers on youth, and life lessons as teaching tools. Four barriers are described: perceived resistance from congregants, discomfort among youth, lack of financial resources, and competing messages at home about sexual health.

Conclusions: Our findings suggest that churches are a preferred place for adolescent sexual health education among some parents and youth. Study findings also reinforce the feasibility and desirability of church-based adolescent sexual health programs.

Keywords

Church based; Adolescents; Sexual health; Qualitative

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Reducing incidences of pregnancy and HIV among adolescents are two of the goals outlined by the Healthy People 2020 initiative [1]. Resources must be allocated toward prevention efforts targeting those who have the highest risk of becoming pregnant and/or contracting HIV. In Maryland, African-Americans have the highest HIV rate of any group and account for 76% of living cases of HIV among adults and adolescents [2]. In Baltimore, MD, 52% of African-American high school students have had sexual intercourse at least once, and 13% have had sexual intercourse before the age of 13 years [3]. In 2014, 38% of African-American high school students reported current sexual activity; 37.7% of this group did not use a condom at the last sex, and 16.6% did not use any other method to prevent pregnancy [3].

Tremendous potential exists to involve black churches in adolescent sexual health promotion. First, the strong social infrastructure of churches makes them a feasible and desirable context for the implementation of sexual health programs [4–6]. Second, African-American families believe that churches can and should be a resource for sexual health [7]. Third, some faith leaders are willing to be trained and believe that addressing sexual health is consistent with their congregation's mission [8,9]. Fourth, some black church leaders and families believe that much of the content in existing evidence-based adolescent sexual health programs should be offered to their youth in a church setting [10]. Finally, black churches that are physically located in African-American neighborhoods share knowledge and experience of the challenges residents face [11].

Still, few evidence-based adolescent sexual health programs have been implemented in churches because of persistent barriers [12]. For example, there continues to be considerable stigma around sexual health topics in some faith settings [13–15]. In addition, many faith leaders lack the skills and knowledge to effectively address these issues in their congregations, especially for youth [8,16]. Funding and coordinating change among multiple constituencies also limit the ability of some churches to implement HIV prevention interventions [17,18].

Previous studies describing the facilitators and barriers to addressing adolescent sexual health programs in churches have been limited in their scope [4,6,19]. In particular, they have largely focused on the perspectives of church leadership. Other studies have solicited youth and parents' perspectives on faith-based sexual education, but not faith leaders [20,21]. To be successful, a program should have buy-in from the entire church community. The goal of the present study was to use a multi-informant approach to identify the facilitators and barriers to implementing adolescent sexual health programming in black churches. We engaged a range of the stakeholders within the same church communities to garner a more holistic picture of the community landscape and feasibility of faith-based sexual education.

Methods

Data analyzed for this study were drawn from the Faith-based Adolescents Involved in Total Health (FAITH) project, an exploratory qualitative study that sought to understand the influence of youth ministers on adolescent sexual health. The Johns Hopkins Urban Health

Institute and Sisters Together and Reaching, Inc. partnered to conduct the FAITH project. All components of the project adhered to the principles of community-based participatory research. [22] The university and community partners jointly identified this need, secured funding, developed instruments, collected and analyzed data, and generated manuscripts. Regular meetings were scheduled for all partners to discuss updates, lessons learned, and dissemination of findings. Adolescent sexual health programs were defined as activities tailored to the developmental needs of adolescents and explicitly discussed sexual and reproductive health topics (e.g., relationships, sexual intercourse, sexually transmitted diseases, and pregnancy). Faith leaders were defined as senior pastors and youth ministers.

Congregation recruitment

Nine churches (eight Baptist and one African Methodist Episcopal) located in Baltimore communities with high teen birth and sexually transmitted infection rates participated in the FAITH project. Each congregation received a \$1,000 stipend. Faith leaders were not individually compensated for study involvement. Faith leaders were responsible for selecting dates for the focus groups to be held and recruiting focus group participants. They announced the project at Sunday morning worship services and within ministry meetings. Research team members also created fliers to distribute and post in the congregations.

Participants

Four groups of participants were included in the study: senior pastors, youth ministers, parents of youth aged 13–19 years, and adolescents aged 13–19 years. Two faith leaders from each congregation ($n = 18$) participated in an in-depth interview. Forty-five adolescents participated in seven focus groups. Thirty-eight parents participated in eight focus groups. All participants identified as black/African-American. No identifying information was collected from focus group participants.

Interview and focus group guides

Semistructured, in-depth interview and focus group guides were collaboratively developed by university and community partners. The guides were designed to facilitate a discussion on the church's potential influence on its youths' sexual and reproductive health. All participants were asked similar questions to ensure comparability across participant type. However, follow-up probes were used to allow for completeness of participant responses. Table 1 lists the contents of the interview and focus group guides and sample codes from each section.

Procedures

In-depth interviews were scheduled at a time, date, and location convenient for faith leaders. Focus groups were held at the individual churches on different days determined by the senior pastor. Repeated scheduling conflicts prevented one church from hosting parent and adolescent focus groups. Equipment failure prevented the recording of an adolescent focus group at another church. Parent and adolescent focus groups were held at the same time, but in separate rooms at each church. The focus groups ranged from 3 to 11 participants in size and included both male and female participants. Each adult participant was provided written,

informed consent before participation. In addition to obtaining parental permission for participants who were under 18 years of age, a written informed assent was obtained from all youth participants. Participants were assigned a unique study identification number to protect their privacy.

All data were collected by five members of the research team (three university partners and two community partners). Table 2 provides demographics and roles of each data collector. All interviews and focus groups were digitally recorded. In-depth interviews ranged from 67 to 145 minutes in duration; focus groups ranged from 46 to 125 minutes in duration. At the conclusion of each interview, pastors and youth ministers were thanked for their participation and given information about the next steps of the broader research project. At the end of each focus group, parents and youth participants were given \$25 for their time. All research protocols were approved by the university's institutional review board.

Data analysis

All data were transcribed by an online professional transcription company. Each recording was verified by a study team member, who corrected any discrepancies or omissions. Verified transcripts were imported into ATLAS.ti qualitative data analysis software to assist with data management and analysis.

Both community and university partners assisted in developing the project's codebook. Nine in-depth interview transcripts were independently read and coded by four members of the study team, all of whom were also data collectors. The codes were then discussed and refined as a group. There were 45 codes in the final codebook. This codebook was applied to the full data set. Each transcript was coded by two team members. After independently coding all transcripts, the two coders met to review and compare codes. Discrepancies were discussed and resolved by consensus. Through this iterative process, the coding scheme was refined, and subsequent in-depth interview and focus group transcripts were coded independently by the four study team members. Once all transcripts were coded, we used a content analytic approach [23] to compare codes across documents and identify commonalities. Themes were developed based on patterns that persisted throughout the interviews and focus groups. Peer debriefings were used to enhance the credibility and trustworthiness of our findings [24,25].

Results

We identified six facilitators and seven barriers identified to providing and sustaining adolescent sexual health programs in churches. Three of the facilitators (i.e., consistency with church mission, church as a trusted community resource, and willingness among faith leaders) and three barriers (i.e., taboo nature of discussing sexual health in church, negative influence of peers, and lack of training for faith leaders) have already been extensively discussed by previous researchers [4–6,26,27]. In the following sections, we describe the three facilitators (Table 3) and four barriers (Table 4) to church-based adolescent sexual health programming that have not yet been reported in the literature.

Facilitators

Widespread endorsement of church-based adolescent sexual health

education.—Participants agreed that comprehensive adolescent sexual health education should be available for youth in black churches. They also believed that abstaining from sex should be discussed in all adolescent sexual health programs. Participants also proposed using scriptures to introduce relevant topics such as sex, sexual expectations, and relationships. However, youth, parents, and faith leaders underestimated each other's motivation to address sexual health within congregations (Table 3, Quote 1). For example, some youth believed that anything in the Bible, including sex, could be a viable topic in a church discussion (Table 3, Quote 2). Youth and faith leaders were skeptical about how supportive parents would be toward a sexual health program. However, parent participants identified several benefits of church-based sexual health programs and highlighted the church as a positive place for adolescents to learn about sex and (Table 3, Quotes 3–5). Coupled with youth perspectives, their ideas can be used to build support for sexual education by helping pastors frame the message in a way that is palatable for all congregants.

Positive influence of youth ministers on youth.—Parents and youth commented on the strong and supportive relationships the youth had with youth ministers. These relationships were characterized by the honesty and realness of youth ministers. Many of the youth ministers were young adults who had built a rapport with the youth who attend activities. Parents remarked that relationships between youth and youth ministers made the church a comfortable place for youth, where they enjoy spending time. These qualities led families to rank youth ministers and ministry leaders as some of the most influential people within the congregation (Table 3, Quote 6). Youth ministers were seen as the ideal candidates to facilitate sexual health discussions with church-going youth because they were both trusted and familiar (Table 3, Quote 7). Youth agreed by saying that their relationships with youth ministers have influenced their decisions, especially around sex (Table 3, Quote 8). Thus, youth ministers are in a unique position to educate and influence youth and their behaviors.

Life lessons as teaching tools.—Several adult participants noted that churches often miss the opportunity to help congregants learn lessons through other people's experiences. Hearing about the experiences of familiar and respected congregants can help youth understand the possible consequences of their actions and encourage better decision making (Table 3, Quote 9). Participants felt that messages of redemption were a positive message for youth. The motivation was not to scare youth or provide a cautionary tale. Instead, adult participants believed that these genuine, heartfelt messages might bring them closer to God and encourage better decision-making (Table 3, Quote 10).

Barriers

Perceived resistance from congregants.—Youth, parents, and faith leaders all worried that older church members would react negatively to the idea of teaching about sexual health in the church (Table 4, Quotes 1–2). Faith leaders were also concerned that some parents would be opposed to the church teaching their children about sexual health. As

a result, faith leaders were reluctant to have sexual health programming for adolescents because they did not want to overstep their boundaries (Table 4, Quote 3). Participants also noted that parents might perceive teaching about sexual health as equivalent to giving youth permission to have sex, which they might oppose (Table 4, Quote 4). The concerns voiced by faith leaders stress the importance of getting parental buy-in for adolescent sexual health programming. Understanding the concerns of all congregants and framing the message in a way that respects their household values would likely lessen the negative perceptions they have about church-based sexual health programs.

Discomfort among youth.—A few youth did not believe that the church was a place where they would be most willing to talk about sexual health (Table 4, Quote 5). Youth and youth ministers were skeptical that boys would participate in a church-based sexual health program. When youth were asked directly about whether youth would participate in a church-based sexual health program, one youth responded, “I think maybe the girls might.” This assessment was a reflection of the overall patterns of participation in other church activities among youth. Parents believed that the boys who do participate may be doing so unwillingly. A youth minister also noted that including boys would be difficult and might change the nature of the program (Table 4, Quote 6). Thus, high male participation in a voluntary, church-based sexual health program seemed unlikely to participants.

Lack of financial resources.—Churches have limited and fluctuating financial resources, which makes implementing programs, especially new or additional ones, a challenge (Table 4, Quote 7). The financial burden may be higher among those churches that could benefit from such a program the most. Knowledge of the churches’ financial realities led participants to discuss alternative funding strategies for adolescent sexual health programming in their congregations. For example, one parent proposed partnering with outside organizations to support the implementation of a sexual health program within her church (Table 4, Quote 8). This parent and others noted that partnering with other organizations might both provide resources the church does not have itself and build relationships with others who are interested in the well-being of their youth.

Competing messages at home about sexual health.—Most participants believed that churches should serve as a sexual health resource for adolescents. However, faith leaders worried that their efforts would not significantly influence youth behaviors if the messages are inconsistent across settings (e.g., home, school, and church). Several pastors asserted that parents contributed to the incongruence in messaging by not monitoring their adolescents (Table 4, Quote 9). Other pastors believed that home environments actually create situations that encourage youth to make unhealthy decisions. Hence, a few hours of sexual health programming within the church could not counteract the environment in which youth live every day (Table 4, Quote 10).

Discussion

This study is one of the first to consider the perspectives of faith leaders, parents, and youth in the context of adolescent sexual health programs in churches. Our findings suggest that some African-American religious families prefer their churches to have sexual health

programs for adolescents to counteract the sexually permissive messages they receive from other sources. Participants also believed such programs could integrate spiritual themes and secular content. By doing so, church-based adolescent sexual health programs can support other efforts to reduce sexual health disparities among adolescents.

Our results reinforce previous findings that identify churches as a trusted community resource and a primary vehicle through which urban youth are protected [28]. Black churches offer African-American youth living in low-resource communities the opportunity to establish and maintain meaningful connections with adults outside their families [29]. The strong relationships between youth ministers and youth created a positive environment in which youth were more willing to learn and share about topics related to sexual health. Incorporating themes of forgiveness and the humanness of sin foster frank discussion about sexual health and facilitate relationship-building. Inviting youth ministers and other church leaders to share their experiences may also help create linkages to support services and provide social support [30].

Engaging in preparation and groundwork before the implementation of adolescent sexual health programs in churches may reduce the barriers identified. For example, inviting older congregants and parents to participate in program planning may increase their acceptability of such programs. A participatory approach to developing a church-based sexual health program necessitates full respect of partners' values and boundaries [4,31]. Having the support expressed by faith leaders indicates that pastors are willing to participate in generating community support. Furthermore, partnerships with other churches and organizations may facilitate the realization of such programs, even in the absence of internal funding.

Previous researchers have failed to consider the interest and desirability of the youth, especially males, as a barrier for church-based adolescent sexual health programs. Adolescent males are often not the target of health care services and education activities [32,33]. Participants mentioned difficulty with getting adolescent boys to participate in already-existing church activities and expressed doubt that boys would be any more willing to participate in a sexual health program. The challenge of engaging males in sexual health programming is not unique to the church setting [33,34]. These findings highlight the need for churches and other organizations to develop more creative strategies to engage and retain adolescent males in sexual health programming and research. Researchers have found the following strategies to be effective in recruiting and retaining teen boys in sexual health programs: creating positive environments for males, getting to know males and their communities, involving parents and guardians, and incorporating mentoring opportunities [35,36]. These tools, along with the already established networks within churches, will be assets to engaging and retaining young men in church-based adolescent health programs.

Participants also expressed concerns about the level of influence a church-based sexual health program can have on youth who receive contradictory messages in other settings. These concerns highlight a common threat to intervention efforts: unpredictable external factors. Many adolescents receive some form of sexual health education in school and from their families. The socioecological framework highlights the bidirectional influence that the

social and physical environment can have on behaviors and outcomes [37,38]. Health education must work within the context of these other factors. Consistently, family- and community-based interventions meant to improve sexual health outcomes have been shown to be effective despite challenging social circumstances [39,40]. Future researchers might consider examining the unique contribution that school-, faith-, and family-based sexual health messages have on youth sexual risk behaviors.

Strengths and limitations

This study is not without limitations. There was an overwhelmingly positive response to providing adolescent sexual health programs in churches among our participants. It is possible that this positive response was due to selection bias. The small sample size also limits the generalizability of the study to other communities in Baltimore and outside Maryland. We did not collect demographic data on participants, which limited our ability to contextualize the responses. We did not obtain detailed information on pubertal experiences; this omission limits our understanding of how developmental changes should be incorporated into church-based adolescent sexual health programs. Finally, it is possible that those who did not participate differ from participants in some characteristics, which would have resulted in differing feedback of facilitators and barriers that were not included in our analysis.

Despite these limitations, this study makes several important contributions to the literature. First, this study incorporated input from a variety of stakeholders, all of whom expressed support for offering adolescent sexual health programs in churches. These diverse perspectives reinforced the feasibility of faith-based adolescent sexual health programs and provided directions for future research. This study highlighted barriers to offering sexual health programs to adolescents, including the limited engagement of adolescent boys, which had not been identified in previous studies. Previous research suggests that religious families and leaders would welcome implementing evidence-based adolescent sexual health programs that (1) provide straightforward, comprehensive sexual health information, (2) align with the daily lives and social contexts of their youth, and (3) offer youth skills to build and maintain health relationships. [10] However, additional research is still needed to determine the essential components of effective faith-based adolescent sexual health interventions. Future researchers might explore how a church-based sexual health curriculum would differ from secular education and how parents might participate in the program to maximize effectiveness.

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IMPLICATIONS AND CONTRIBUTION

Black churches can play an important role in reducing racial disparities in sexual health among adolescents in the United States. This study considers the perspectives of faith leaders, parents, and youth in the context of adolescent sexual health programs in churches.

Table 1

Contents of interview/focus group guides

Topic	Questions	Sample codes
Characteristics of adolescents in church	Describe the kinds of adolescents you have at your church. What are the levels of spiritual commitment among the young people at your church? What can you tell us about the young people who live in this community, but do not attend church here?	<ul style="list-style-type: none"> •AC_ages •AC_gender •AC_spirit commit •AC_community
Programs and activities offered	What kinds of programs and activities currently are offered at your church for teenagers? What programs and activities do you participate in and why? ^a What kinds of programs and activities would you like to see at your church that are not currently being offered?	<ul style="list-style-type: none"> •PO_educational •PO_sports •PO_performing arts •PO_participation •PO_wanted
Teen issues	What do you think the big issues are for teens in your church?	<ul style="list-style-type: none"> •TI_bullying •TI_peer pressure •TI_crime & violence
Influence of youth ministry	When you hear the word “influence,” what comes to mind? What kind of influence would you say the youth ministry has on young people at your church? What would be helpful for people who are not part of your church to know when thinking about the level of influence the youth ministry has on adolescents? Who are the people at your church that you would describe as “most influential” in the lives of adolescents? What are some concrete examples of the people you mentioned having influence that stand out in your mind? What are some areas where the church has less influence on young people who are part of the youth ministry?	<ul style="list-style-type: none"> •IN_definition •IN_youth ministry •IN_outside •IN_most influential •IN_jacking •IN_examples •IN_church mission
Addressing total health in churches	What are your ideas for how your church could address additional issues in the lives of adolescents?	<ul style="list-style-type: none"> •TH_mental health •TH_sex abuse •TH_relationships •TH_gender related
Adolescent sexual health programs in churches	What can you tell me about sexual health programs at your church? Who led the sessions? How did the young people receive it? What are some reasons why churches may not address adolescent sexual health as part of your youth ministry?	<ul style="list-style-type: none"> •SP_description •SP_leaders •SP_youth reception •SP_reason none
Church-based adolescent sexual health curriculum development	In your minds, what is an appropriate age to begin discussions about adolescent sexual health with young people in general? Why did you pick that age? What would a curriculum need to look like for you to be comfortable discussing sexual health with adolescents in a church setting? How would you want the curriculum to address the following topics? 1) Human sexual anatomy 2) Reproductive health 3) Healthy relationships and teen dating violence 4) Contraception and birth control 5) Sexually transmitted diseases 6) What else should or could a faith-based adolescent health curriculum include? Who do you think might be uncomfortable with discussing sexual health with young people in a church setting?	<ul style="list-style-type: none"> •CD_age •CD_characteristics •CD_topics •CD_discomfort •CD_bible based
Implementing a church-based adolescent sexual health program	What would we need to say to convince the youth and adults in your church to develop a sexual health education or health education program here at the church? What kinds of questions do you think they would have? Who all would need to be involved in developing the program and what role would they play? Who do you think would have the hardest time accepting that the church might be involved in addressing sexual health education with young people? How might we address any concerns among diverse groups of church-goers?	<ul style="list-style-type: none"> •IM_discussion •IM_questions •IM_involvement •IM_acceptance •IM_concerns •IM_strengths

^a Asked in adolescent focus groups only.

Sample codes	Questions	Topic
In the end, what are the strengths of a faith-based approach to adolescent health development in your opinion?		

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Table 2

Description of data collectors

Characteristic	DC 1	DC 2	DC 3	DC 4	DC 5
Partner type	University	University	Community	University	Community
Age, years	<35	<35	>35	>35	>35
Gender	Female	Female	Male	Male	Female
Race ^a	Black	Southeast Asian	Black	White	Black
Relation to Baltimore	SPH faculty	SPH faculty	STAR employee	SOE faculty	Young adult from partner church
Years in Baltimore	<10	<10	>10	>10	>10
Responsibilities	<ul style="list-style-type: none"> • Interview senior pastors • Conduct focus groups 	<ul style="list-style-type: none"> • Conduct focus groups • Take notes during focus groups 	<ul style="list-style-type: none"> • Take notes during in-depth interviews and focus groups 	<ul style="list-style-type: none"> • Interview youth ministers 	<ul style="list-style-type: none"> • Conduct focus groups

SOE = Johns Hopkins School of Education; SPH = Johns Hopkins Bloomberg School of Public Health; STAR = Sisters Together and Reaching, Inc.

^aNo data collectors were of Hispanic descent.

Table 3**Representative quotes of facilitators of adolescent sexual health programs in churches**

Facilitators	#	Participant type	Quotes
Widespread endorsement	1	Senior pastor	There is one thing that I am suspicious about sometimes I think the parishioners in the church might be further down the road than the pastors, sometimes they are. Sometimes they are ready to hear what pastor's may not be ready to say. They may be more ready for it than we are. And that's a possibility. I may be the one holding the folk back
	2	Youth	Some people may think if [talking about sex] is inappropriate for the church, but I mean, it's in the Bible, so why not talk about it
	3	Parent	What better place for them to learn... Then they can get the biblical part.
	4	Parent	They talk about it [sexual health] in schools. They may as well get the spiritual part.
	5	Parent	It's [the church] the right place before they learn it on the street anyway
Positive influence of youth ministers	6	Parent	The youth minister I believe has a big impact and a great influence... He is very approachable and he can talk to them, where they will listen to him and he is a mentor and a friend.
	7	Parent	I would say the youth ministry causes other young people to say, "It's OK to do that in church. I want to be a part of that. That looks like that's fun." I think it makes them want to join in. It's important that that is in place so that it would draw in other young people.
Life lessons as teaching tools	8	Youth	Suddenly, a decision that you thought that you could've went one way, but you think about the ministries you're in, and how could that affect. You try to make the best decision and the more healthy decisions.
	9	Youth Minister	I believe that if we give them some of our life experiences, instead of hiding them, that will help. My first child was out of wedlock. You talk about, not to say the damages, but how hard things have been because now the child's split between two homes some days
	10	Parent	We all have had choices, bad choices, but God has gotten us through it, and our youth need to know that. This is the real world that we live in, you know.

Table 4

Representative quotes of barriers to adolescent sexual health programs in churches

Barriers	#	Participant type	Quotes
Perceived resistance from congregants	1	Parent	Some of the older people may not be able to deal with that type of information because they think it might be too much.
	2	Senior pastor	My average member, you have not asked but I'll share this, is 59 years old with 33 years here. So changes in the approach to ministry are faced with resistance.
	3	Youth minister	You'll get those two spectrums. Parents, "No, I do not want you talking to my kids. That is not your responsibility, that's mine." Or just those that think we should not be talking about it at all.
	4	Youth minister	Often times a lot of parents do not want us to talk to their kids about those kinds of situations. Because they think that instead of that pulling them away from it, it may push them to it.
Discomfort among youth	5	Youth	I feel like the church is a place for holy talks about like God, not about like sex and diseases and other things like that. I do not really feel comfortable talking about it inside the church.
	6	Youth minister	Boys are not as mature as girls and so we would have to keep that in mind if we have any training that, you know, we may have to corral the boys, if they come.
Lack of Financial resources	7	Senior pastor	I think one of the struggles, at least for us anyway, is financial resources for youth ministry, no matter what the church. The vast majority of the income or the revenue for the church is tithes and offerings, and especially in hard economic times, they diminish
	8	Parent	We're not strong financially, so we would need to know are there any handouts or giveaways that someone would be able to fund or sow into our church ministry to help us out.
Competing messages at home	9	Senior pastor	Sometimes the setting is not all that healthy... Some of them are just left to roam up and down the sidewalks on their own without having any kind of structured activities for them to be engaged in
	10	Senior pastor	Whatever good may happen here, they are going home and as much as we might want to believe it, two or three hours here is not going to trump 100 hours at home. It's not. No way, under no circumstances. If it did, we would be fine, but it is just not going to happen no matter how good we paint the picture here, no matter how much information we may give them, no matter how much counseling we may give them here, when that kid leaves my office that kid is going home, back to the atmosphere that created the situation."