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A Review of Services and Interventions for Runaway and Homeless Youth: Moving Forward

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Abstract

Research focused on the impact of community-based services and treatment interventions designed to intervene in the lives of runaway and homeless youth has increased in the last two decades in the U.S. and internationally. In light of the tremendous need for identifying effective strategies to end homelessness and its associated problems among youth, this paper summarizes and critiques the findings of the extant literature including U.S., international, and qualitative studies. Thirty-two papers met criteria for inclusion in the review. Among the conclusions are that comprehensive interventions which target the varied and interconnected needs of these youth and families may be worthy of more study than studies that isolate the intervention focus on one problem. Also, more research incorporating design strategies that increase the reliability and validity of study findings is needed. Other preliminary conclusions and future directions are offered.

Keywords

runaway and homeless youth; interventions; service evaluation; review

The first controlled evaluation of an intervention for runaway/homeless youth was conducted in 1991 and focused on HIV prevention among shelter residing adolescents (Rotheram-Borus, Koopman, Haignere, & Davies, 1991). In the 18 years since that trial, other investigators have sought to identify methods to improve the lives of runaway and homeless youth and their families. Thus, treatment development and evaluation efforts for this population are relatively recent. Early studies focused on understanding the population, their struggles, needs, experiences and etiology of homelessness. These important studies provided the requisite groundwork to develop and target intervention efforts. The primary goal of this paper is to review and summarize the findings of community-based service and intervention efforts directed towards runaway and homeless youth. A summary of the impact of such efforts is provided as well as recommendations for future research. First, current conceptualizations of runaway and homeless youth are offered.

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Current Conceptualizations

It is difficult to know how many runaway and homeless youth exist – with various estimates putting the number between 500,000 and 2.8 million in the U.S. (Cooper, 2006) and 100 million worldwide including 40 million in Latin America, 30 million in Asia, and 10 million in Africa (Ensign & Gittelsohn, 1998; UNESCO, 2007). Youth report leaving home, or being asked to leave home because of family conflict, physical or sexual abuse and/or parental unwillingness or inability to care for them (MacLean, Embry, & Cauce, 1999; Mallett, Rosenthal, & Keys, 2005). While abuse is an oft-cited reason for leaving home, some evidence suggests that neglect may not be significantly associated with leaving home but rather the trauma of physical and/or sexual abuse is of primary significance (Sullivan & Knutson, 2000).

Housing options for runaway youth are limited to residing at a runaway shelter, living directly on the streets, squatting in abandoned buildings, or couch surfing among friends' homes. Minors have the option of seeking services through runaway shelters though research suggests that only 30% of those in need utilize shelters (Kipke, O'Connor, Palmer, & MacKenzie, 1995). Most street living youth, however, do not reach the shelter system and do not tolerate the possibility of reuniting with their families (Robertson, 1991).

Early conceptualizations of runaway and homeless youth were often synonymous with delinquency, but more recent definitions focus on family, behavioral, and systemic issues (Riley, Greif, Caplan, & MacAulay, 2004). In 1983, the Inter-nongovernmental Organizations defined a "street child" as any child for whom the streets is either an abode or critical source of income/survival (UNICEF, 2001). The Stewart B. McKinney Act (1987) defined a homeless youth as any youth who lacks parental, foster, or institutional care. This includes youth who have left home voluntarily, were thrown out of the home (throwaways or push-outs) or were removed from the home by the state (system kids). The McKinney-Vento Act (2002) further defines homeless individuals as those who lack a fixed, regular, and adequate nighttime residence; and an individual who has a primary nighttime residence that is: a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter and transitional housing for the mentally ill); b) an institution that provides a temporary residence for individuals intended to be institutionalized; or c) a public or private place not designed for, or ordinarily used as regular sleeping accommodations for human beings.

Shelter Recruited Youth

Youth that access runaway shelters tend to be younger than street living youth and often have never spent a night on the streets (Robertson & Toro, 1999). One study showed that only 8% of shelter recruited youth ever slept overnight on the streets and only 34% of street recruited youth ever stayed overnight at a runaway shelter (Kang, Slesnick, Glassman, & Bonomi, 2008). It appears that the majority of youth, between 72–87%, who seek services from a runaway shelter return home, providing support for the need of family based intervention in this setting (Peled, Spiro, & Dekel, 2005; Thompson, Pollio, & Bitner, 2000; Thompson, Safyer, & Pollio, 2001).

Street Living Youth

Some evidence suggests that street living youth fare worse than shelter youth. Street living youth can be exposed to street crime and violence that shelter youth may never experience (Patel & Greydanus, 2002) and report higher levels of drug use and risk behaviors (Clements, Gleghorn, Garcia, Katz, & Marx, 1997; Van Leeuwen et al., 2004). Clements and colleagues (1997) note the importance of examining street based youth as separate from more stable runaway youth given the higher levels of risk behaviors reported by these youth.

Those who provide guidance for intervening in the homeless trajectory of youth who are cut-off from family and the system, recommend community based programs and funding to link these youth back to school, housing and employment (Chamberlain & MacKenzie, 2004). Many note the need for outreach, drop-in centers and reintegration services for street living youth (Robertson, 1991; Slesnick, Kang, Bonomi, & Prestopnik, 2008; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). Integration into the mainstream is especially important as health risks and poor health outcomes increase with the duration of homelessness (Bailey, Camlin, & Ennett, 1998; Greenblatt & Robertson, 1993). However, as noted by several researchers, when youths' needs and goals do not match those of service providers, the likelihood of youth rejecting services increases (Hyde, 2005; Marshall & Bhugra, 1996). The development of trust and fears regarding violations of confidentiality and being retuned home or to foster care prevent many from seeking services (Ensign & Bell, 2004).

Current Study

In summary, the goal of this paper is to review and summarize those evaluations of stand alone, community-based service interventions (those offered by shelters and drop-in centers) and evaluations of add-on treatment interventions (e.g., case management, substance abuse treatment and HIV and STD intervention) which focus on assisting shelter, street or drop-in center recruited youth. Since reasons for homelessness and response to the problem vary around the world (Toro, 2007), international research was reviewed separately. Furthermore, qualitative research offers unique insight into youths' experiences of services and interventions received, thus these studies were included. Since no comprehensive review of service and intervention research was found in the literature, this paper sought to address that gap. Also, because of the potential differences in experiences among street- and shelter-recruited youth as described above, these samples were discussed separately throughout. In particular, the effectiveness of service and intervention approaches in improving the life situation of shelter and street/drop-in center recruited youth was of interest.

Search procedure

A search of the databases that included Academic Search Premier, Psych Info, Medline, Eric, and Social Work Abstracts was conducted with combinations of the following keywords: homeless youth, runaway, adolescent, shelter, intervention, drop-in, outreach, international, qualitative, treatment and services. The reference section of selected articles was then searched for relevant studies. Additionally, the National Institutes of Health CRISP database was searched for similar keywords and research papers from principal investigators who conduct intervention research with this population were identified.

Inclusion criteria

In order for a study to be included several criteria had to be met: 1) the sample needed to be either runaway, shelter, street or drop-in center recruited youth who met one of the standard definitions as noted above. Youth was defined as between the ages of 12 to 24, 2) the focus of the study was on improving the life situation, through reducing identified problem behaviors such as HIV, substance use, homelessness as well as medical and mental health problems of youth and/or their families, 3) unpublished master's theses or dissertations and articles were included if they were published in English-language journals. The requirement for a randomized design was not used because to date, few such studies have been completed.

Article selection

Based on these criteria, 32 articles met criteria for inclusion in this review. Upon examination of the articles chosen for review, four categories of evaluations emerged: studies assessing youth outcomes after shelter or drop-in utilization (i.e., service evaluations) (n = 16), those

assessing treatment outcomes (i.e., intervention evaluations) (n = 6), qualitative research (including international studies) that focused on youths' experiences of services developed for their care (n = 7), and international studies (n = 5). Each section includes a summary of the literature followed by methodological strengths and limitations.

Service Evaluations

Legislative and Policy Efforts

In the U.S., the runaway and homeless youth programs are authorized by the Runaway and Homeless Youth Act (Juvenile Justice and Delinquency Prevention Act, Pub. L. 93–415, Sept. 7, 1974, 88 Stat. 1109 (Title 42, Sec. 5601 et seq.), as amended by the Runaway, Homeless and Missing Children Protection Act of 2003 (Public Law 108–96). Three programs were funded by Congress to prevent the victimization of homeless youth and ensure their access to education, employment training, health care, drug and alcohol treatment and other social services. The first program is the Basic Center program that provides grants to support emergency shelter for youth under age 18. The second program is the John H. Chafee Foster Care Independence Program under the Foster Care Independence Act (HR 3443 and 1802HR 3443 and 1999), formerly referred to as the independent living program, which has the overarching goal to help adolescents in foster care (ages 16–21) make the transition to living self-sufficiently once they graduate from the foster care system (USGAO, 1999). Unless a street living youth has graduated from the foster care system (usually at age 18) or receives federal foster care payments, he or she is not eligible for these services which include longer-term residential support (up to 18 months) as well as life skills support. The Street Outreach Program (also named the Sexual Abuse Prevention Program or the Runaway Prevention program) was written to support street-based outreach and education to runaway, homeless and street youth many of whom have been sexually abused or are at risk of sexual abuse. While current service interventions for homeless youth are directed by legislative action with funds dedicated to emergency shelter, housing, and outreach, long-term evaluation of these service interventions is lacking with few studies tracking the success of these programs. The following section briefly describes the typical services offered by drop-in centers and emergency shelters and is followed by a review of the research documenting the outcomes among youth receiving these services.

Youth drop-in centers

The National Survey of Homeless Assistance Providers and Clients in 1999 (Burt et al., 1999) report that only 14 youth drop-in centers and 22 outreach programs exist in the U.S., which compares to 1,790 drop-in centers and 3,310 outreach programs for homeless adults. Drop-in centers offer a bridge to the mainstream (Baron, 1999) beyond outreach alone. These centers are unstructured and provide immediate services, such as food, clothing, showers, laundry, and bus tokens (Joniak, 2005). Some provide case management, which is determined by their level of funding. These centers offer a place for youth to build trust, and if the youth deems the drop-in center staff trustworthy he or she might request more intensive services (Slesnick et al., 2008). While evaluations of the impact of drop-in centers are lacking, one study showed that drop-in center services can provide a step towards reducing homelessness and problem behaviors among homeless youth (Slesnick, Kang, Bonomi, & Prestopnik, 2008). The study indicated that although homeless youth were successfully engaged into the services offered by the drop-in center, greater focus on increasing access to housing among homeless youth is needed, especially for minors who refuse to return home or enter foster care. Even though the literature is characterized by a dearth of data detailing the efficacy of drop-in centers, preliminary data suggests that drop-in centers might ease the challenge of meeting engagement and ultimately, reintegration goals. The near complete lack of research, but potential for easing

re-contact with disenfranchised youth, underscores the importance of further evaluation of drop-in centers.

Runaway shelters

Runaway shelters offer emergency services for runaway youth. If the shelter is funded by the Runaway and Homeless Youth Act's Basic Centers Program, then the shelter is supposed to focus its efforts towards reunification with the family. Teare and colleagues (1994) detailed the treatment activities received by 100 adolescents accessing a runaway shelter in Nebraska. The primary intervention that youth received while in the shelter was social skills training, though since the majority of youth in that shelter returned home, the authors called for a focus on family interventions. Some studies indicate that youth reunited with parents following a shelter stay show improved outcomes (e.g. less hopelessness, depression and suicide ideation) compared to youth discharged to other locations (Teare et al., 1992; Thompson et al., 2000). However, regardless of location, once discharged, many youth return to the shelter. Baker, McKay, Lynn, Schlange and Auville (2003) examined the correlates of recidivism, defined as returning to a northeastern runaway shelter after being discharged, for first time and repeat runaways. In general, the authors found that 34% of repeat runaways and 18% of first time runaways returned to the shelter within a year after discharge. Few predictors of recidivism were found suggesting that the factors that predict running away from home may not also predict repeated running away or return to the shelter system.

Four studies evaluated the effectiveness of shelters in alleviating symptoms associated with the youth's stay at the shelter (Barber, Fonagy, Fultz, Simulinas, & Yates, 2005; Pollio, Thompson, Tobias, Reid, & Spitznagel, 2006; Steele & O'Keefe, 2001; Thompson, Pollio, Constantine, Reid, & Nebbitt, 2002). Adolescents who received shelter services reported reduced days on the run, school and employment problems at six weeks post-discharge (Thompson et al., 2002; Pollio et al., 2006), reduced behavioral and emotional problems at six months (Barber et al., 2005), and reduced substance use at discharge (Steele & O'Keefe, 2001). These authors also reported a lack of improvement in several realms. The observed positive outcomes were relatively short-lived as the improvements observed among youth post-discharge dissipated over time (Pollio et al., 2006). Although only one of these studies assessed the long-term impact of a shelter stay among runaway youth (Pollio et al., 2006), these studies suggest that shelters have at least a short-term positive impact in some domains. In addition, one study determined that length of shelter stay was not associated with future episodes of running away or re-arrests (McMahon, 1994), suggesting that shorter stays (3–5 days) may be just as effective as longer stays (10–30 days), at least for these outcomes.

Methodological Issues

One goal of community based programs (shelters and drop-ins) is to meet the basic, immediate needs of the youth and family, often within a limited amount of time. However, some youths' and families' goals require longer term intervention (e.g., to address social stability or family functioning). While the community based programs can also serve as gateways to longer-term or more intensive services, the extent to which they successfully connect youth to these services needs further evaluation.

Among the reviewed studies, the program evaluation assessment interviews were most often conducted immediately post-intervention. Since previous research suggests that treatment outcomes may diminish over time among the homeless (Pollio et al., 2006; Toro, 1999), the positive impact reported by these studies on employment, sexual risk taking, and drug use may be temporary, underscoring the need for more distal follow-up evaluation.

In addition, the studies reviewed here utilized a pre-post test design without the use of a control group or randomization to treatment condition. Therefore, valid and reliable causal interpretations about the effectiveness of these programs cannot be concluded. One exception was Thompson et al.'s (2002) study for which day treatment users were recruited to serve as a control group for the shelter-recruited runaways. Other reasonable comparison groups for use in future studies might include runaway/homeless adolescents who do not seek services, or potentially, foster care youth. In addition, some studies utilized composite samples drawn from multiple agencies (e.g., Pollio et al., 2006) and did not report differences between these agencies, which would require a nested data analytic method.

For many of the studies reviewed, even though a detailed description and rationale for the interventions were provided (e.g., Barber et al., 2005), no scientific background information (empirical support) was reported to justify implementation of the intervention. Agencies offered a variety of services targeting sexual risk taking, vocational training, mental health or substance abuse counseling, and medical care but availability of services among programs varied. This might be due to funding limitations, but it is unclear how or why the chosen services were selected. Similarly, there does not appear to be a consensus regarding what constitutes a clinically significant or valid measure of outcome. For example, some studies reported drug abstinence and recovery as the targeted outcome (e.g., Steele & O'Keefe, 2001) while others reported reduced drug use and focused on improvements over baseline (e.g., Slesnick et al., 2008). This diversity among studies and agencies further complicates the interpretation of findings.

Finally, except for Slesnick and her colleagues' study (2008) –studies reported that one case worker managed the youth's care but also conducted the research interviews. This approach has the potential to contaminate the results by inflating positive outcomes. That is, youth may be unwilling to report negative outcomes to their case worker which threatens the study's internal validity. In summary, despite the moderately promising findings of these service evaluations, future studies should strive to improve the research designs with the goal to achieve more reliable and valid findings.

Intervention Studies

Case Management and Vocational Training Interventions

Sosin and Durkin (2007) note that case management programs are worthy of study not only because they are commonly employed by community mental health organizations but because case management is considered essential among homeless service providers. Cauce and colleagues (1994) provides the only formally assessed case management intervention for drop-in center recruited youth. Project Passage, an intensive case management program was evaluated against a drop-in center's treatment as usual, or 'regular' case management. Few outcome differences were found, suggesting that a time-limited case management intervention may be as effective with homeless youth as longer term, costly case management with unlimited funds. The feasibility of a vocational training intervention was tested with a small sample of drop-in center recruited homeless youth (Ferguson & Xie, 2008). Vocational outcomes at post-intervention were not reported; however, youth who received the intervention reported greater life satisfaction (quantitative and qualitative reports), higher family contact but also higher sexual risk behaviors than those that did not receive the intervention.

Substance Abuse Treatment Interventions

Shelter youth—Two studies evaluated family therapy for substance abusing adolescents recruited from emergency runaway shelters (Slesnick & Prestopnik, 2005; Slesnick & Prestopnik, in press) as compared to treatment as usual through the shelter In both studies,

adolescents who received family therapy showed dramatic declines in alcohol and drug use up to 15 months post-baseline. Adolescents, regardless of experimental condition, showed improvements in many other areas including family (conflict and cohesion) and individual functioning. Together, these two studies suggest that family therapy can have a strong impact on alcohol and drug use compared to services provided through the shelter. Furthermore, runaway adolescents and their parents have been described as difficult to engage and maintain in treatment (Morrissette, 1992; Smart & Ogbourne, 1994); yet, these studies show that these families, similar to non-runaway families, can be effectively engaged and maintained in family treatment.

Street living youth—Three randomized controlled trials focused on intervening among substance abusing drop-in center and street recruited youth (Baer, Peterson, & Wells, 2004; Peterson et al., 2006; Slesnick, Pretopnik, Meyers, & Glassman, 2007). Baer, Peterson and colleagues provide some rationale for utilizing brief feedback and motivational intervention (MET) with street living youth - the intervention is less costly and demands much less of a hard-to-reach population than more intensive interventions. As such, two controlled evaluations of MET with homeless youth were conducted by this group (Baer et al., 2004; Peterson et al., 2006) but limited support for the utility of MET was found since youth assigned to MET showed few improvements compared to treatment as usual. Slesnick and colleagues (2007) reported that a more intensive intervention which included 16 individual sessions of the Community Reinforcement Approach combined with HIV prevention (CRA, Meyers & Smith, 1995; Godley et al., 2001) was significantly more effective than treatment as usual in reducing substance use and internalizing problems and increasing social stability up to the six month follow-up. Further analysis (see Slesnick & Kang, 2008) showed that youth assigned to the integrated treatment (CRA+HIV prevention) reported greater condom usage than youth assigned to treatment as usual. While this study examined the integration of the CRA approach with HIV prevention, other studies have focused solely on HIV prevention and are briefly described below.

HIV Prevention/Sexual Health Interventions

Shelter youth—Two studies report findings of a randomized trial examining the impact of Street Smart, a 10 session, group-based HIV prevention intervention (Rotheram-Borus et al., 1991; Rotheram-Borus, Song, Gwadz, Lee, Van Rossem, & Koopman, 2003). At six-months, the intervention was associated with an increase in condom use and a decrease in high-risk behavior (Rotheram-Borus et al., 1991) and at 2-years, females reported reduced unprotected sexual behavior, but no other differences were found (Rotheram-Borus et al., 2003).

Street living youth—Three studies examined the impact of an HIV prevention and sexual health intervention among drop-in center recruited youth (Booth, Zhang, & Kwiatokowsi, 1999; Rew, Fouladi, Land, & Wong, 2007; Tenner, Trevithick, Wagner, & Burch, 1998) and two studies reported findings from street recruited youth (Auerswald, Sugano, Ellen, & Klausner, 2006; Gleghorn et al., 1997). Among drop-in center recruited youth, neither a group-based sexual health intervention (Rew et al., 2007), a group-based peer helper intervention (Booth et al., 1999), nor a program that offered HIV testing, counseling and case management improved behavioral, cognitive or sexual risk outcomes among youth. Similar findings were reported among street recruited youths in San Francisco (Auerswald et al., 2006; Gleghorn et al., 1997). Gleghorn et al. (1997) approached 1,210 homeless youth on the streets, offering service listings/referrals, condoms and bleach. No relationship was found between the street outreach and condom use six months later, however, youth approached at six-months were more likely to report using a new needle at last injection. Auerswald et al. (2006) urine-tested street recruited youth for chlamydia and gonorrhea, offered treatment, and tracked a sub-sample of these youth six months later. While youth accepted this treatment, suggesting that street

based sexual health interventions may be viable, the intervention did not appear to significantly reduce the incidence of future infection. Taken together, these studies highlight the challenge of impacting sexual risk behaviors among homeless youth. HIV prevention and sexual health interventions offered in isolation of other areas relevant to the youth's life appear to have limited utility among shelter, drop-in and street recruited youth. Findings suggest that interventions which target risk behavior in addition to other life areas (substance use, mental health and housing) may be necessary in order to significantly reduce high risk behaviors.

Methodological Issues—Most of the intervention studies were designed, conducted, and evaluated by researchers from universities and/or research institutes. The extent to which researchers are aware of available programs and services for the youth and have strong alliances with service providers might determine their success in engaging, recruiting, and tracking homeless youth in their projects. For instance, those who had strong relationships with the community and outreach workers had more effective interventions and positive outcomes (Auerswald et al., 2006) and lower attrition rates than those who did not (Peterson et al., 2006). Since collaboration among the agencies and researchers might impact study outcomes, this effect should be considered or assessed.

In addition, convenience sampling through drop-in centers, shelters and the streets was common across studies. The intervention studies might have mixed findings and outcomes due to the recruitment procedures they employed. That is, homeless youth comprise a heterogeneous population of youth with differing characteristics (Kidd, 2003); a youth recruited from the streets may be different motivationally, emotionally and socially than a youth recruited from a service center and might respond differently to intervention efforts. Combining these youth within samples can significantly increase the variability in outcomes and lower the internal validity of the study. However, there are alternative approaches for recruiting samples of youth, similar to stratified random sampling (e.g., Gleghorn et al., 1997), and the feasibility and effectiveness of this method needs to be further explored.

Notwithstanding the above limitations, one of the strengths of the intervention research reviewed here was that preliminary pilot studies were conducted to construct study measures (Auerswald et al., 2006), revise clinical manuals (Baer et al., 2007), and test the clinical interventions (Ferguson & Xie, 2008). Significant attempts were made to match the characteristics and needs of the youth in the intervention. However, some interventions were very brief and specific. Several studies aimed to treat only drug abuse (Baer et al., 2007; Peterson et al., 2006) or prevent sexually transmitted diseases (Auerswald et al., 2006; Gleghorn et al., 1997). However, research suggests that drug abuse and sexual risk behavior are not primary concerns of the homeless (Baer et al., 2007) and to what extent these intervention efforts address the "real" needs of youth are questionable. In addition, few studies report the percent of eligible youth, the percent of youth who agreed to participate, or the percent who were actually engaged in the intervention. One possible interpretation could be that nonparticipation of some of the eligible youth was due to the lack of perceived relevance of the intervention project to their needs. Therefore, findings should be interpreted cautiously due to potential self-selection bias, especially for those studies that prioritize drug use and HIV prevention over more enduring problems such as housing and employment.

Finally, the intervention research focused on 'outcomes' rather than the 'process' of the intervention. For instance, research staff or clinicians provided a variety of services including mental health counseling, case management, and vocational training. This multifaceted approach of the intervention might facilitate the development of a unique relationship between the youth and the clinician. However, this alliance was not explored or controlled in these studies – making it possible that positive outcomes might be contaminated with the relationship and/or therapists' effects rather than the intervention procedures themselves.

Qualitative Studies

The majority of U.S. studies utilize quantitative methods of analysis while qualitative studies are more common among international studies (Toro, 2007). As noted by Kidd (2003), the experiences and ideas of street youth themselves have been neglected in the literature, but their perspectives and active involvement in service development are likely crucial for developing and improving intervention services. Karabanow and Rains (1997) note that obtaining the perspective of the youth is especially important since services for runaway and homeless youth are largely voluntary and consultation with youth is critical to the development of appropriate, engaging services. To that end, four international studies (two Australian, two Canadian) and three U.S. studies were identified that used a qualitative design for understanding youths' treatment or service experiences. Regardless of the country of origin or shelter versus street youth, these studies reported similar themes. In nearly every study, youth reported having negative experiences with helping agencies and professionals (Darbyshire, Muir-Cochrane, Feredy, Jureidini, & Drummond, 2006; Ensign & Gittesohn, 1998; Kidd, 2003; Thompson et al., 2006). The studies recommended that interventions be designed which consider the strengths (versus the weaknesses) of homeless youth, that needs differ significantly among individuals, and that services must be tailored to the life context and the desires of the youth (Ensign & Gittelsohn, 1998; French, Reardon, & Smith, 2003; Kidd, 2003; Nebbitt, House, Thompson, & Pollio, 2006; Thompson, McManus, Lantry, Windsor, & Flynn, 2006). In particular, youth in several studies reported that trusting the service provider (Ensign & Gittelsohn, 1998; French et al., 2003; Kidd, 2003; Thompson et al., 2006), feeling cared for (Karabanow & Rains, 1997), not feeling judged (French et al., 2003), and inclusionary rather than exclusionary practices (such as not being punitive for missed appointments) (Darbyshire et al., 2006) were prerequisites for successful engagement in services and for positive outcomes.

Methodological Issues

Qualitative research offers rich information regarding the perceptions and experiences of the youth themselves, which is less easily garnered from survey reports. While many of the conclusions in the qualitative studies also reflect some of those from quantitative research, unique information especially regarding individual differences was also provided. The studies reviewed here varied significantly in their methods with data being collected through individual interviews and focus groups with widely varying sample sizes of between 10 and 80 youth. It is not clear that information obtained from focus groups would be comparable to that obtained through individual interviews since it is possible that the interpersonal dynamics of the two interview contexts elicit different kinds of information depending upon perceived pressure, support or comfort with the situation.

Only two studies explicitly stated inclusion criteria (Darbyshire et al., 2006; Kidd, 2003) with the other studies broadly including samples that accessed a drop-in center (French et al., 2003; Thompson et al., 2006) or shelter (Ensign & Gittelsohn, 1998; Karabanow & Rains, 1997; Nebbitt et al., 2007). Some studies focused solely on youth who were considered 'success stories' (Nebbitt et al., 2007), or were engaged into services (Darbyshire et al., 2006; French et al., 2003; Karabanow & Rains, 1997; Thompson et al., 2006) which is useful for elucidating those factors associated with successful engagement or outcomes. Interviews with those not considered 'success stories' can be equally informative in that this information can elucidate factors that service providers and agencies can improve.

Age ranges of youth varied significantly with one study including adolescents only (e.g., 12 to 17 years) (Ensign & Gittelsohn, 1998) but with most including both adolescents and adults in their sample (e.g., 15 to 24 years). Inasmuch as age is associated with different developmental needs and access to different social resources, consideration of age in future qualitative studies

could be useful for identifying such potential differences and for enhancing program services. While balance between internal and external validity is always a struggle, regardless of a qualitative or quantitative research design, given the diversity of homeless and runaway youth, different themes are likely to appear based upon their prior experiences, resources, and demographics, therefore, these variables should be more fully considered in future studies. All of the studies interviewed youth at one point in time, often while services were being offered; interviewing youth at various points in time might offer an even richer perspective of attitudes and experiences as the impact of treatment is known to change over time (e.g., Pollio et al., 2006) and experiences with treatment, likely also change.

International Research

Several studies indicate that the number of street youth is increasing worldwide (Booth, 2006; Dekel, Peled, & Spiro, 2003; West, 2003). Toro (2007) notes that research on homelessness began to appear in the late 1990's outside of the U.S. and that the majority of this research focuses on single homeless adults. Even so, intervention evaluation studies with runaway and homeless youth from five countries (Israel, United Kingdom, China, South Korea and Uganda) were identified.

The government of Uganda implemented a program to resettle street youth from the capital city to family or local agencies (Jacob et al., 2004). It was noted that at the end of the first year, 700 children had been removed from the streets of the city and resettled by police. Systematic follow-up of resettled children was not conducted by researchers, but a nongovernmental organization (NGO) noted that 50% of the children that the NGO visited were no longer resettled in their villages. Moreover, the authors reported that of those children interviewed regarding the program, every child reported that they had been beaten or had seen others beaten, caned or cut during the round-up in the capital city or at the holding facility. The authors reported that this intervention has created an underworld in which children hide on the streets and avoid the police. On the positive side, this effort brought awareness to the problem of street children from which further efforts can be developed.

The central government of China also sought to intervene in the growing problem of runaway and homeless youth. The government established Protection and Education Centers for Street Children which offer basic needs, shelter and emergency medical care and arranges for the children to be returned to their family (Lam & Cheng, 2008). Determination of the effectiveness of this program included a 7-month ethnographic study of 50 street children interviewed by the authors in Shanghai. The authors concluded that most of the street children interviewed avoid these centers because of the behavioral restrictions associated with them and because the children did not wish to return home. Furthermore, most of the informants returned to the streets following their stay at the center. The authors conclude that more appropriate services that consider the needs and desires of the children are needed. A similar conclusion was reached by Dekel et al. (2003) in their evaluation of Israeli runaway shelters. The authors tracked 345 Israeli adolescents who resided in one of two runaway shelters at six to 12 weeks after their discharge from the shelter. While the majority of adolescents were discharged to their family's home, at follow-up, only 54% were staying with their family, 18% were in an out-of-home placement and 28% were on the streets or with friends. The authors note that placement options once leaving the shelter are limited, and because of this, many youth are placed or returned home when it is not the best or most appropriate solution.

Two studies examined outcomes of 'add-on' services to a shelter program. Taylor, Stuttaford, and Vostanis (2007) sought to examine the clinical outcomes of homeless youth (ages 16–29) who received mental health services from 18 homeless shelters in different regions of the United Kingdom. Overall, half of the youth (n = 76) who sought services (which included

cognitive-behavioral therapy, substance use treatment and psychoeducation) discontinued after the first session. Although the lack of an intent to treat analysis and lack of control group limit conclusions that can be drawn, significant improvements in aggressive behavior, self-injury, drug/alcohol use, depression, and other mental health problems were observed from pre- to post-treatment among youth. Similarly, Hyun, Chung, and Lee (2005) tested the effectiveness of a cognitive behavioral group therapy on clinical outcomes among a small sample of shelter-residing adolescents in Seoul, South Korea. Differences between the CBT group and the no-treatment control group were not reported, although adolescents who participated in the CBT group reported increased self-efficacy and decreased symptoms of depression from pre- to post-treatment.

Methodological Issues

Evaluations of governmental reaction to youth homelessness are imperative so that modifications to those interventions can be made to maximize the success of the interventions. In order to increase confidence in the conclusions drawn from the program evaluation designs, multiple post-intervention assessments obtained longitudinally, identification of valid indicators of success, the use of psychometrically sound measures, and tracking of all youth (regardless of their engagement in services) should be used. With programs struggling to maintain funding, such evaluation has been limited internationally and within the U.S.

Discussion

Even though only a small number of studies have examined the impact of shelters, drop-in centers and intervention approaches, the literature to date offers several preliminary conclusions regarding service and intervention effectiveness, as well as future directions. First, runaway shelters show some short term benefits to youth, but long-term benefits have not yet been demonstrated. Possibly, the services provided by the shelters are not effectively targeting the underlying causes of the presenting symptoms, or are not comprehensively addressing the range of needs of the families. Limited research suggests that the predictors of homelessness or residing in a shelter differ from the predictors of exiting homelessness or returning home (Baker et al., 2003; Slesnick, Bartle-Haring, Dashora, Kang, & Aukward, 2008). More research is needed to determine if the shelters' intervention targets are those that predict long-term resolution of problem behaviors. For example, given that the family of shelter-residing adolescents often has not yet disintegrated beyond intervention, and because of its role in the runaway crisis, targeting the family in intervention efforts might have great potential to prevent future homelessness and stays at a runaway shelter. While researchers have called for the development and evaluation of family-based interventions for shelter based youth (e.g., Chamberlain & MacKenzie, 2004; Teare et al., 1992), little such research has been conducted. Also, too few studies are available to determine the effectiveness of drop-in centers, with only one study tracking outcomes among youth (Slesnick et al., 2008). While that study indicated that youth accessing intervention services through a drop-in appear to show positive outcomes across a range of outcomes up to one year post-baseline, clearly more evaluation research is needed.

Second, case management is a widely utilized intervention approach for homeless individuals (Zerger, 2002) but little research is available to guide conclusions regarding its utility with homeless youth. Controlled evaluations of case management for use with homeless adults are sparse as well, but, to date, only one study has evaluated case management with homeless youth (Cauce et al., 1994). As noted above, that study showed that enhanced case management was not more effective than less intensive case management. Two studies using adult samples showed similar outcomes when an intensive case management intervention was compared to a less intensive intervention (Hurlburt, Hough, Wood, 1996; Toro et al., 1997). Possibly, case

management alone may be insufficient to address the issues of individuals experiencing homelessness, and psychosocial treatment combined with case management may have better potential. Research that further evaluates the potential of case management and its essential elements, including duration and intensity is needed.

Third, two trials indicate that brief, motivational interventions are not effective with street/drop-in recruited youth. One outcome of Motivational Interviewing (Miller & Rollnick, 2002) sessions is to increase access and/or attendance in other treatment services. Motivational approaches have shown positive effects for this outcome among some non-homeless samples including substance abusers (e.g., Miller & Wilbourne, 2002). Since homeless youth are known to have difficulty developing trust with service providers, early intervention success likely depends upon the development of a trusting relationship. Trust builds with time, and possibly with more frequent contact than offered through a very brief intervention such as Motivational Interviewing. Zerger (2002) concludes that while elements of Motivational Interviewing might be effective for engaging homeless individuals, the consensus is that the homeless population cannot benefit from such short-term interventions given the multitude and complexity of their problems.

Fourth, interventions that focus on HIV prevention and sexual risk alone do not appear effective in reducing risk behaviors among shelter and street/drop-in recruited youth. Possibly, individual problems or risk behaviors among individuals experiencing homelessness cannot be treated apart from the needs of the whole person (Kraybill & Zerger, 2003). That is, many runaway and homeless youth need assistance accessing food, education, transportation, clothing, shelter/housing, identification, financial assistance, legal aid, medical and dental care and job training, and for some, improving family relations. Addressing one area in isolation of the other areas is not likely to be as effective as an intervention that addresses multiple and overlapping areas of need (Bronfenbrenner, 1979). Fragmented service provision is a frequently cited barrier among these youth and suggests that integrated interventions which address the range of needs through one service provider might be better than those that link youth to various systems of care that work in a parallel fashion (Zerger, 2002). For adolescents who have fewer resources and power by nature of their younger age and developmental status compared to adults, integrated interventions might be especially potent. At least, comprehensive intervention approaches are worthy of future study, even if their primary target, or funding source, is HIV, substance abuse or mental health.

Fifth, the qualitative studies converged on similar conclusions even though a variety of samples were obtained, and the methods used for collecting and reducing the data differed across studies. This suggests that at least some of the experiences of youth are relatively similar, regardless of age, gender, ethnicity, shelter versus street recruited, or location. Most youth described the importance of trust, confidentiality, not feeling judged, with the authors of the studies concluding that flexible, caring and tailored services that meet the needs of the youth are essential for successful engagement and maintenance into services. In general, the international studies reported similar outcomes of shelter-based efforts to reunite adolescents with their families as found in the U.S. That is, although viable for some, interventions that unilaterally return adolescents home (or to the available alternative living situations) are not viable for a certain proportion of runaway and homeless youth who may be unwilling or not welcome to return home.

Finally, runaway and homeless youth are diverse, and flexible treatment is needed to address this diversity. For example, studies report wide age ranges in research samples. Also, among non-homeless samples, research suggests that childhood abuse, substance use and traumatic brain injury can contribute to developmental struggles and impact treatment response (DeBellis et al., 2001; Glasser, 2000). Interventions need to consider the cognitive and emotional

developmental stage of youth, but also, the specific content or targets of intervention will vary based upon the youths' reasons for running away or homelessness. Additionally, little mention of minority youth is offered within the literature. Among adults, being non-white is associated with a lower likelihood of receiving independent housing or exiting homelessness (Shinn et al., 1998). Thus, minority youth likely face more hurdles in their efforts towards stabilization than non-minority youth. And lastly, since youth are at different points in the homeless trajectory, any intervention chosen should be tailored to accentuating the potential resources and protective factors available to the youth and/or family.

Future directions

While intervention research is increasing in both quantity and quality, methodological challenges characterize research efforts. For example, to understand the impact of interventions, longer term follow-up is needed. Because many of these youth and families have unstable living situations, or are literally homeless, tracking requires significant time and expense, as well as creative problem solving and trust building between the research staff and client. Also, while facilitator blindness to participant's treatment intervention reduces observer-expectancy effects, in order to successfully track clients for follow-up assessments, facilitators might need the guidance from therapists who might know the location of their client.

As noted, many intervention efforts consider return of the adolescent to the family as primary (as mandated by the Runaway and Homeless Youth Act) while services for street living youth focus on achieving re-integration and independence among youth. In Action Research (Argyris, 1994), the social participants who are dealing with the actual problem are brought into the research process. Action research suggests that these participants have knowledge and understanding of the problem that cannot be accessed by an outsider no matter how strong their research techniques. Rather than imposing legislators', service providers' or researchers' priorities on youth, more action-based research may be needed so that services are developed in accordance with the needs and desires of the youth.

Finally, future studies should utilize intent to treat designs and report session attrition and overall treatment attendance rates. Such information can assist with future treatment development and refinement efforts. Also, given that youth report the importance of trust, confidentiality and not being judged, training of service providers to be especially focused on these aspects of relationship building may be critical for successfully engaging and maintaining runaway and homeless youth in interventions. While strict rules, structured service settings and disciplinary efforts may not function to engage these youth, short-term intervention efforts with caring, non-judgmental staff appear beneficial.

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Table 1

Summary of reviewed studies.

Study	Treatment Groups		Sample Characteristics	Follow-Up Points (Rates)	Findings
Service Evaluations:					
Barber et al., 2005	**1**	Shelter service evaluation examining immediate and short term outcomes (n=202); single group design	Youth age 18–21, 59% female, 55% African American, 19% Latino, 3% White, 14% Multiethnic, 8% other	2 weeks (81%), 3 months (70%), 6 months (91%) post-treatment	At 6 month follow-up: 82% of youth established stable housing and over one third were employed. Significant decreases in behavioral and emotional problems were reported between baseline and 6 months
Pollio et al., 2006	**1**	Shelter service evaluation examining outcomes and use of services (n=371); single group design	Shelter youth, average age 14.7 years, 61% female, 73% White	6 weeks, 3 months, 6 months post-baseline (approximately 25–30% attrition at each point)	Number of days on the run significantly decreased at each follow-up compared to baseline data. Significant increases in family contact and perception of family support were found at all three follow-up points. Negative school events and employment status showed mix results with positive changes between 6 weeks and 3 months, but negative changes by the 6 month follow-up.
Slesnick et al., 2008	**1**	Drop-in center service evaluation: CRA[a] and case management service (n=172); 32 sessions offered; single group design	Drop-in youth age 14–24, 59% male, 37.2% White, 31.4% Hispanic, 12.2% Native American, 7.6% African American, 11.6% Multiethnic	6 months (73%), 12 months (76%) post-baseline	Among youth who had used alcohol or drugs at baseline, average substance use significantly decreased. Gender, percent days in school, and percent days being housed predicted alcohol and drug use. Psychological distress significantly decreased. Females reported a greater increase in percent

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				days housed over time.
Steele and O'Keefe, 2001	**1** Shelter service evaluation including broad-spectrum health intervention: STD screening and treatment, weekly counseling sessions, case mgmt. (n=106); single group design	Shelter-residing youth age 16–21, 72% female, ethnicity distribution not reported	9 months post-baseline (follow-up rates not reported)	Youth reduced drug dependence by 38%, and STD rates fell from 60% at baseline to 7% at program completion. Forty-two percent had obtained employment at follow-up compared to 0% at baseline.
Thompson et al., 2002	**1** Short-term shelter services: temporary housing, skills training, referral services (n=368) **2** Long-term day treatment: longer term rehabilitation and education services in addition to ST services (n=54); nonrandom design	**1** ST shelter youth, average age 14.7 years, 60% female, 73% White **2** LT shelter youth, average age 15.3 years, 11% female, 60% White	**1** 6 weeks (71%) post-discharge **2** 6 weeks (87%) post-baseline	Youth in ST treatment showed significant improvement in days on the run, family support, suspension and detention rates, employment status, sexual activity, and self esteem. No significant differences were found in outcome variables between the ST and LT groups.
McMahon, 1994	**1** 3–5 day treatment intervention (n=44) **2** 10–30 day treatment intervention (n=44); Random assignment	Shelter youth, average age 14 years, 76% female, 26% African American, 42% Anglo, 30% Hispanic, 1% Other	Not applicable (post-test only design)	Recidivism rates were the same for both treatment groups: 50% of youth in each group committed at least one other offense. Recidivism rates in the 3–5 day treatment group decreased significantly when youth and their families participated in aftercare counseling post-discharge.
Intervention Studies				
Auerswald et al., 2006	Field-based STD screening and PDPT[b] intervention (n=216, 157 randomly chosen for 6 month follow-up); random assignment design	Street youth age 15–24, 66% male, 57% White, 21% African American, 6% Native American, 3% Latino, 1% Pacific Islander, 8% Multiethnic	6 months (70%) post-baseline	All follow-up youth who initially tested positive for an STD, tested negative at the 6 month follow-up. New instances of infection did occur

Study	Treatment Groups		Sample Characteristics	Follow-Up Points (Rates)	Findings
					for some youth at follow-up who tested negative at baseline.
Baer et al., 2007	**1**	BMI[C] (n=75); 4 sessions offered	Drop-in center youth age 14–19, 56% male, 58% White, 19% Multiethnic, 9% Native American, 8% African American, 4% Hispanic, 2% Asian or Pacific Islander	1 month (82.9%), 3 months (76.1%) post-baseline	Overall, youth significantly increased (drug) abstinence rates and decreased drop-in service utilization from baseline to 3 month follow-up. Alcohol use significantly dropped by the 3 month, but not 1 month follow-up. Marijuana use decreased at all time points. No significant differences in abstinence rates or substance use were found between conditions. An increase in drop-in service utilization in BMI youth was the only significant difference between treatment conditions.
	2	Treatment as usual (n=52); random assignment			
Booth et al., 1999	**1**	Peer-based, health risk intervention: youth trained to administer HIV prevention program to peers (n=72), 4 sessions provided	Youth age 12–19 recruited from a drop-in center, 51% male, 73% White, 125 Hispanic, 8% African American, 5% Native American, 3% other	2 days (no rate reported), 3 months (60%) post-baseline	Youth in the treatment condition significantly increased HIV/AIDS knowledge compared to the control group. Youth in both conditions decreased sexual risk behavior; treatment youth decreased heroin/ cocaine use while control youth remained the same. An increase in AIDS knowledge was associated with a greater likelihood of high risk sex. Youth who perceived their chance of being infected with HIV as 50% or greater were more likely to use heroin or cocaine.
	2	Control group: no training (n=75); nonrandom design			

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
Cauce et al., 1994	**1** Project Passage: intensive case mgmt. (n=55) **2** Treatment as usual: regular case mgmt. (n=60); random assignment	Homeless youth age 13–21, 57% male, 59% White, 22% African American, 8% Hispanic, 7% Native American, 4% other	3 months post-baseline (results based on the first 115 to complete the 3 month follow-up)	At the 3 month follow-up, significant decreases in problem behavior, substance use, and depressive symptoms, plus increases in self-esteem were found in both treatment and control groups. Slightly greater improvement in aggression, externalizing behaviors, and life satisfaction were found in the Project Passage sample.
Ferguson and Xie, 2008	**1** SEI *f*: vocational training and mental health intervention (n=16) **2** Treatment as usual (n=12); nonrandom design	Drop-in center youth age 18–24, 71% male, 39% African American, 21% Hispanic, 28% Caucasian, 14% mixed or other, 3% Asian	Immediately following intervention (69% SEI group, 67% treatment as usual group)	SEI youth significantly increased total life satisfaction in comparison to the control group. A significant difference in the number of sexual partners was also found with SEI youth increasing and control youth decreasing their number of partners. Youth in the treatment condition increased contact with family while youth in the control group decreased contact.
Gleghorn et al., 1997	Time 1: 1. HIV intervention (n=246) 2. Comparison group (n=183) Time 2: 1.HIV intervention (n=392) 2. Comparison group (n=325); nonrandom design	Youth age 12–23, currently or recurrently homeless, involved in the street economy, 83% male, 81.5% White	Before (T1)and during (T2) intervention (rates not applicable; T1 and T2 youth different)	Treatment and recent intravenous drug use significantly predicted contact with outreach workers. Treatment also predicted number of referrals in the past 6 months. Youth identified as punk/squatter were more than twice as likely to have used a condom with their last partner. White

Study	Treatment Groups		Sample Characteristics	Follow-Up Points (Rates)	Findings
					youth were half as likely as non-White youth to have used a condom with their last partner. Females and those using drugs intravenously were more likely to follow up with HIV-referrals.
Peterson et al., 2006	**1**	Motivational Enhancement (n=92), 4 sessions offered	Youth age 14–19 recruited from drop-in centers, 54.7% male, 72.3% White, 15.9% Multiethnic, 3.2% African American, 3.2% Native American, 3.2% Hispanic, 1% Asian/Pacific Islander or other	1 month (82%), 3 months (80%) post-baseline	Intervention participation did not affect alcohol or marijuana use. The treatment group showed a greater reduction in illicit drug use compared to the assessment only group. Youth in a later stage of change (contemplation or action-maintenance) had less drug use. Youth highly engaged in the intervention showed a significantly greater reduction in drug use compared to those with low engagement and those in the control groups.
	2	Assessment only (n=99)			
	3	Assessment at follow-up only (n=94); random assignment			
Rew et al., 2007	**1**	Gender-based intervention (n=285), 8 sessions offered	Street youth age 16–23, 61% male, 58% White, 11% Hispanic, 9% African American, 8% Multiethnic, 6% Native American, 1% Asian, 3% other	Immediately before (T1) and after (T2) the intervention, up to 6 weeks (T3) post-intervention (no rates reported)	Treatment youth had greater HIV/AIDS knowledge at T2 than control youth, but knowledge decreased by T3. Overall, knowledge decreased between baseline and the final follow-up for both conditions. No effect on condom self efficacy or intent to use condoms was found. Youth in the control condition significantly decreased safe sex behavior between baseline and T3.Females in the treatment condition
	2	Control group (n=196)			
	3	Youth who participated in both intervention and control groups (n=89); nonrandom design			

Study	Treatment Groups		Sample Characteristics	Follow-Up Points (Rates)	Findings
					significantly increased self-efficacy for breast self exams, and had greater HIV/AIDS knowledge by T3 compared to intervention males and control males and females.
Rotheram-Borus et al., 1991	**1** **2**	HIV intervention (n=78), 20 sessions offered Control group (n=67); nonrandom design	Shelter youth age 11–18, 64% female, 63% African American, 22% Hispanic, 8% White, 7% other	3 months, 6 months post-baseline (77% completed a 3 and/or 6 month follow-up assessment)	The intervention did not affect abstinence rates. The number of intervention sessions attended was significantly related to consistent condom use and sexual risk patterns. Those attending 15 or more sessions increased condom use by 30% between baseline and 6 month follow-up, and reduced sexual risk behavior from 20% at baseline to zero by the 3 and 6 month follow-up.
Rotheram-Borus et al., 2003	**1** **2**	Street Smart HIV intervention (n=101), 10 group sessions offered] Control group (n=86); nonrandom design	Shelter youth age 11–18, 50.8% male, 54% African American, 30% Hispanic, 16% White or other	3 (57%), 6 (62%), 12 (50%), 18 (49%), and 24 (70%) months post-baseline	Females in the intervention group reduced their number of recent sexual partners and rates of unprotected sex, and increased their rate of abstinence. Older females tended to have more sexual partners and participate in unprotected sex. Higher number of sexual partners, unprotected sex, and abstinence rates at baseline predicted higher rates at follow-ups for males and females. Marijuana use at baseline was a significant predictor of marijuana use at follow-up for both

Study	Treatment Groups		Sample Characteristics	Follow-Up Points (Rates)	Findings
					males and females. Females in the intervention group reduced alcohol use and number of drugs used.
Slesnick and Prestopnik, 2005	**1**	EBFT[d] (n=65), 15 sessions offered 2. Treatment as usual (n=59); random assignment	Youth age 12 to 17, 59% female, 41% Hispanic, 37% White, 7% African American, 4% Native American, 10% other	3 (87%), 9 (86%), 15 (89%) months post-baseline	Females reported higher family conflict, aggression, internalizing behavior, and depression than males. Males reported significantly more sexual abuse. Youth reporting both physical and sexual abuse reduced substance use at a greater rate when assigned to EBFT. Adolescents in both conditions showed significant improvement in other non-substance related domains (i.e., family functioning and mental health).
Slesnick and Prestopnik, In press	**1** **2** **3**	EBFT (n=37), 16, home based, sessions offered FFT[e] (n=40), 16, office based, sessions offered Treatment as usual (n=42); random assignment	Shelter youth, age 12–17 years, 55% female, 29% White, 44% Hispanic, 11% Native American, 5% African American, 11% other or mixed ethnicity	3 (82%), 9 (79%), 15 (73%) months post-baseline	EBFT participants showed higher engagement and session completion than FFT participants. Higher externalizing behavior and history of sexual abuse significantly predicted youth engagement in EBFT. EBFT and FFT youth significantly reduced percent days of drug and alcohol use while TAU youth remained steady. Males and females in EBFT significantly reduced drug and alcohol use over time, while only males reduced use in FFT. TAU showed no significant decreases

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				in substance use. Younger youth in EBFT and FFT reduced internalizing behavior; TAU youth did not.
Slesnick et al., 2007	**1** CRA (n=96), 16 sessions offered **2** Treatment as usual (n=84); random assignment	Drop-in center youth age 14–22, 66% male, 41% White, 30% Hispanic, 13% Native American, 3% African American, 1% Asian, and 12% Multiethnic	6 months (86%) post-baseline	CRA youth had a greater reduction in drug use, depression, and internalizing behavior. CRA youth improved social stability in comparison to the control group. All youth in the CRA condition significantly reduced depression scores, while only younger youth (age 19 and under) decreased depression. Youth in both conditions reduced drug use, and improved coping skills, internalizing and externalizing problems and delinquent behaviors.
Tenner et al., 1998	Individual interviews regarding an HIV intervention (n=272)	Street-involved, homeless and sexual minority youth; 37% gay, lesbian, or bisexual	Not applicable	HIV testing among street-involved, homeless, and sexual minority youth increased. Program awareness also increased, but no change was found in HIV risk behavior. HIV-positive youth were not referred to medical services more often than youth without HIV.
International Studies				
Dekel et al., 2003	Individual interviews with youth, parents, and/or social workers (information about youth collected from at least one source: n=345)	Homeless youth age 13–19; 80% born in Israel	6–12 weeks after leaving the shelter (70%)	Fifty-four percent of youth had returned home at follow-up while 18% moved to another home situation, and 28% were living in an unconventional place

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				such as the streets. Youth who went back to unconventional environments were older than youth who returned home or to a home-like environment. At follow-up, 66% of youth were still living at their intended destination upon departure from the shelter. Youth living at home at follow-up had frequent contact with family while at the shelter, had a relatively short shelter stay, and usually left the shelter for home. Youth in unconventional living arrangements had little contact with family while at the shelter, had short shelter stays, and left the shelter in unplanned ways for unstable environments.
Hyun et al., 2005	**1** Cognitive-behavioral therapy (n=14) **2** Control group (n=13); random assignment	Shelter youth, all male sample	8 weeks post-baseline (100%)	Self-efficacy scores significantly increased for the treatment group at follow-up. Depression scores significantly decreased for the treatment group. No changes in self-efficacy or depression were found for the control group. Self-esteem scores did not change in either group.
Jacob et al., 2004	Program evaluation of Model for Orphan Resettlement and Education (MORE) (n=402)	Orphans and street youth age 5–17; 91.8% male; youth from Uganda	Not applicable	Street youth and orphans virtually disappeared from the streets after program implementation. Strengths of the

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				program include government action and taking responsibility for homeless youth and decreased incentives for youth to live on the streets. Weaknesses include an increasing fear of police, substandard conditions at the shelter, rising costs, and lack of educational opportunities for youth inside the shelter. The lack of structure and increasing costs of the program threaten its sustainability.
Lam and Cheng, 2008	Unstructured and semi-structured interviews, and observations (n=11)	Street youth age 13–16; 72.7% male; 100% from China	Not applicable	Youth felt trapped and imprisoned inside the highly restrictive shelter. Complaints about boredom and lack of freedom were also common. The “prison”-like environment discouraged youth from seeking shelter services. Only two youth expressed appreciation for the family reintegration policy of the center; most tried to escape from being forced back into abusive homes.
Taylor et al., 2007	Mental health service intervention (n=150)	Homeless youth age 16–29, 53.3% male, 86.6% White British, 4% mixed, 1.3% Black Caribbean, 1.3% Black African, 2% Black British, 4.7% other	Follow-up completed at discharge (45%)	No change was found between the initial assessment and discharge for physical illness or disability problems, and living conditions. The risk of self harm significantly decreased at post-intervention. Youth who had previous

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				mental health problems, were at risk of drug abuse, attended many sessions, had a planned discharge interview, and had attended a satisfactory number of sessions with their counselor were more likely to improve on the mental health measure.
Qualitative Studies				
Darbyshire et al., 2006	Individual interviews (n=10)	Homeless youth age 16–24, 70% female	Not applicable	Youth resented being labeled and further marginalized by service providers. Quick, impersonal assessments and vague medical explanations added to feelings of discomfort. Positive experiences with service providers resulted from trust, respect and kindness.
Ensign and Gittelsohn, 1998	**1** Individual interviews (n=6) **2** Focus groups (n=31) **3** Free listing and pile sorting activities (n=15)	Shelter youth age 12–17, 98% from Baltimore City, MD	Not applicable	The most frequently listed health problems for shelter youth were STD's, HIV/AIDS, pregnancy, depression, drug use, and injuries. Youth were willing to seek medical assistance if care was confidential, teen-friendly, and non-judgmental.
French et al., 2003	Individual interviews (n=16)	Homeless, or at-risk for homelessness youth age 14–21	Not applicable	Four themes regarding successful program engagement emerged: personal characteristics, attractiveness of the services, accessibility of the services, and assertiveness of the follow-up procedure. Youth needed service providers to be

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				understanding, trustworthy, and non-judgmental. Engagement strategies needed to be tailored to the individual because of the heterogeneity of at-risk youths' situations.
Karabanow and Rains, 1997	Case study of residents (n=44) and staff (n=18)	Street youth age 16–21, 30 current residents, 9 former residents, 5 street kids who were never residents of this shelter	Not applicable	Youth reported feeling alienated by the rigidly enforced structure of the shelter. Feeling cared for by staff and viewing the shelter as a safe, second home were the main reasons youth chose to remain and/or return to the shelter.
Kidd, 2003	Individual interviews (n=80)	Street youth age 15–24, 61% male; 85% Caucasian, 9% Native Canadian, 6% other	Not applicable	Making friends on the street is essential for setting up a support system and learning the culture of the streets. Youth learn to value themselves in order to block out negative comments and actions from others. Surviving such hard times gives youth a sense of pride, and they were hopeful for a better future. Youth coped with stress by socializing with friends, using drugs or alcohol, doing a hobby, finding a place to think, and sleeping. Developing useful skills to produce self worth was also important.
Nebbitt et al., 2007	Focus groups and interviews with shelter providers (n=25) and former shelter youth (n=21)	White and African American sample: 23% youth, 24% providers were African American; Female: 76% youth, 64% providers	Not applicable	Family support and outreach was associated with youth successfully returning home after a shelter stay. Youth

Study	Treatment Groups	Sample Characteristics	Follow-Up Points (Rates)	Findings
				who returned home were engaged in treatment at the shelter and developed caring relationships with staff.
Thompson et al., 2006	7 focus groups (n=60, average of 8 youth per group)	Homeless youth age 16–24, 47% female; 65% Caucasian, 23.3% Latino/a, 9.7% African American	Not applicable	Youth utilized services in environments which they felt were safe and clean from service providers who were respectful, trustworthy, and kept information confidential. Although most youth had health problems, few used medical services. Youth sought independence and resented rigid rules and providers who treated them like children. Additionally, they did not want to be viewed as victims.

[a] Community Reinforcement Approach

[b] Patient-Delivered Partner Therapy

[c] Brief Motivational Intervention

[d] Emotion-Based Family Therapy

[e] Functional Family Therapy

[f] Social Enterprise Intervention