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Interventions that Address Safety Concerns Among Youth Experiencing Homelessness: A Systematic Review

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

In this systematic review, literature regarding youth experiencing homelessness and the clinical interventions focused on safety towards youth experiencing homelessness were synthesized. Using two databases SocINDEX, and PsychINFO; 10 studies regarding clinical interventions met criteria for the review. Each study was analyzed in population, intervention, and findings; while contrasting and comparing the definition of safety and the safety concerns between the clinical interventions. The findings identified focus areas of safety which include chemical health reduction, promoting harm reduction, psychological health, resilience, and service utilization. The primary safety focus areas were reduced to chemical health reduction, promoting harm reduction, and psychological health. Implications for future research should focus on following through clinical intervention with youth who are experiencing homelessness as well as having larger randomized populations.

.

Keywords: clinical, homelessness, intervention, safety, youth

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Interventions that Address Safety Concerns Among Homeless Youth: A Systematic Review

Introduction

Safety among youth experiencing homelessness in the United States is a focus area that needs attention due to the population growth, unavailable shelter space, high-risk activity, and the psychological development of youth. Out of the three major subgroups regarding the homeless population (homeless adults, families and youth) youth are the most at risk age group of becoming homeless, yet they are the least studied (Toro, Teagan, Lesperance, & Braciszewski, 2011). Homeless youth are spotted in many places because of the lack of available shelter space and because some youth choose not to access shelters due to the absence of feeling safe (Heinze & Hernandez Jozefowicz-Simbeni, 2009). Youth experience many changes when transitioning through puberty such as mental and physical development, and the firing of constant hormones; when adding homelessness to the puberty formula it increases the chances for a mental illness to develop due to increased chances of trauma, stress, anxiety and lack of access to medical help (Strike, Vanermorris, Rudzinski, Mozygemba, Wekerle, & Erickson, 2014). Youth experiencing homelessness may be difficult to identify, support, and treat due to their lack of stable housing and desire to blend in.

This target population represents a diverse group of individuals, including those who have left home (usually to escape abusive or dysfunctional situations), been encouraged or forced to leave, or have been removed from their parents' home and put into foster or institutional care (Kennedy, 2007; Rhule-Louie, Bowen, Baer, & Peterson, 2008).

These categories of youth experiencing homelessness are not mutually exclusive; rather, youth often move in and out of these categories dependent upon their particular

situation. Youth who experienced homelessness attribute their lack of housing to several factors. Youth reported the leading cause of homelessness to be "told to leave/being locked out (30%; Lindberg, Pittman, & Decker Gerrard, 2015)." Other reasons youth reported being homeless were due to:

- High frequency of fights with parents/guardians
- Youths not willing to abide by parents' rules
-Parents neglecting youth's basic needs
- Parents who use drugs or alcohol
- Youths not feeling safe due to violence in the house
- Family losing their housing
-Lack of housing space for everyone to live
- Parents or guardians having mental health problems
- Youth participating in high risk activities (Lindberg et al., 2015).

At present, numerous shelters and programs offer services to youth who experience homelessness (Walsh & Donaldson, 2010). What has been neglected in literature is the population of youth experiencing homelessness who do not utilize shelters and programs. Many youth experiencing homelessness have reported not using services because of lack safety (Heinze & Jozefowicz-Simbeni, 2009). Some youth refuse to go to shelters due to negative things they hear from others on the streets, how media portrays shelters or because of personal experiences.

Limitations or features of programs that youth found problematic included rigid or unrealistic structures ("too many rules"), difficult or invasive procedures for accessing resources, service providers who were not understanding, lack of safety, and poor physical

environments (depressing, dirty, lack of privacy). Inadequate support for homeless youth was exacerbated by the absence of supports and services that could prevent homelessness (Stewart, Reutter, Letrourneau, Makwarimba & Hungler, 2010).

Youth who identify as homeless often report their homelessness due to safety reasons. Safety is the biggest concern when talking about youth experiencing homelessness. Safety in schools is correlated with teacher support and school policies against school violence which contribute to a greater safety in school (Kõiv, 2014). However, not all school safety interventions are effective. School-based interventions do have potential; yet, they are few in number. Therefore, homeless youth are unlikely to be enrolled at a school (Stewart, Reutter, Letourneau & Edward, 2009).

Recently there has been an increase in school enrollment for youth experiencing homelessness. In 1994, 52 percent of homeless youth aged 17 years old and under were enrolled in school; in 2014 it rose to 73 percent (Lindberg et al., 2015). Schools are now noticing that they can do more to help youth experiencing homelessness. Schools are raising awareness, attending to basic needs, providing effective instruction, creating a supportive environment, providing additional supports, collaborating with organizations, and providing parental involvement (Murphy & Tobin, 2011).

Homelessness among youth in the United States is on the rise. An estimated 1.35 million youth have experienced homelessness (The National Coalition for the Homeless [NCH]; 2005). The majority of these youth; over one million indicate that they became homeless after being told to leave home by parents, guardians, and in some case institutions (Aviles de Bradley, 2011). Which results in at least 52,000 homeless youth who end up living on their own (Aviles de Bradley, 2011). On any given night, an estimated 4,080

Minnesota youth experience homelessness. This includes an estimated 2,211 minors ages 17 and younger, and 1,869 young adults aged 18-21 (Lindberg et al., 2015). Minnesota's homeless youth make up a key portion of Minnesota's long-term residents. The vast majority of homeless youth grew up in Minnesota (76%), including 43 percent who grew up in the metro area, and 32 percent who grew up in greater Minnesota. Compared to 2009, this proportion has increased (up from 69%) (Lindberg et al., 2015).

Youth experiencing homelessness is a population that is made from different races, ages, and sexual orientations. Racial disparities are in existence with Minnesota's homeless youth. Youth experiencing homelessness have been reported to be more likely than the youth population as a whole to be persons of color. Seven in 10 homeless youth (70%) identified as African American, American Indian, Asian, Hispanic, or of mixed race, compared to just 24 percent of all Minnesota youth (Lindberg et al., 2015). Youth experiencing homelessness are disproportionate in the Twin Cities area alone; 82 percent are youth of color; whereas in greater Minnesota, youth of color are 48 percent of the youth homeless population (Lindberg et al., 2015).

The percentage of homeless youth who are young adults (aged 18-24 years old) is 86; 14 percent of whom are minors (under 18 years old) in the state of Minnesota (Lindberg et al., 2015). The average age of all homeless youth is 19 years old; the average age of unaccompanied homeless minors is 16 years old (Lindberg et al., 2015). Minors are more likely to be in greater Minnesota than the metro area (56% vs. 44%), while young adults are more likely to be in the metro area than greater Minnesota (59% vs. 41%) (Lindberg et al., 2015).

Sexual orientation has continued to play a part with the homeless youth population. Fifty-five percent of homeless youth identified as female (Lindberg et al., 2015). Eighty-five percent of homeless youth identify themselves as heterosexual (Lindberg et al., 2015). Fifteen percent of homeless youth identify themselves as lesbian, gay, bisexual or unsure of their sexual orientation and two percent overall said they considered themselves to be transgender (Lindberg et al., 2015).

Overall, a low percentage of youth experiencing homelessness reported homelessness due to sexual orientation or gender identity (Lindberg et al., 2015). 15 percent of homeless youth identified themselves as lesbian, gay, bisexual, or transgender; 29 percent of the LGBTQ percentage reported this as the contributing factor to their homelessness; 15 percent identified it as the main cause (Lindberg et al., 2015).

Historically, interventions in addressing safety among youth experiencing homelessness has been an ongoing development with shelters and programs. Models and programs that are known to the public typically accommodate homeless youth through community collaboration and partnership with businesses, youth service agencies, community leaders, and dedicated volunteers (Walsh & Donaldson, 2010). Some models are not only an intervention program but are also a prevention program for youth who are at risk of displacement (Walsh & Donaldson, 2010). Future models and programs would benefit from impacting safety in two ways; intervention and prevention (Walsh & Donaldson, 2010). With more programs and organizations acquiring both intervention and prevention aspects, youth experiencing homelessness may have a chance of getting out of poverty.

Barriers to addressing safety among youth who experience homelessness have included development, trauma, mental illnesses, and survival. Youth who experience

homelessness also transition through many difficult areas of development, especially adolescence and puberty. During this stage of life youth experiencing homelessness may be under stress, experiencing trauma, mental illness, detachment, identity crisis, anxiety, psychotic symptoms, self-harm and puberty in general which is often time looked at as high risk behavior due to the increased sexual interactions (McCay, Langley, Beanlands, Cooper, Mudachi, Harris, et al., 2010). Unfortunately, adolescence is a hard transition for anyone. Therefore, when homelessness is added to the stressful formula of development and adolescence it is not uncommon to see or hear of youth engaging in risky behaviors such as survival sex for example.

Overall, homeless youth experience many challenges in their lives such as increased levels of trauma; high risk behavior including: substance use, self-harm, survival sex: and lower levels of support which include: peer support, untreated health, and barriers to health care (Moskowitz, Stein, & Lightfoot, 2013; Strike, Vandermorris, Rudzinski, Mozygemba, Wekerle, & Erickson, 2014). Youth experiencing homelessness need attention in order to encourage safety for them.

This systematic review focuses on clinical interventions that promote safety among youth who experience homelessness. The goal of this study was to highlight empirical research and how it has promoted safety in clinical intervention for youth who are currently or have experienced homelessness.

Literature Review

This systematic review is structured and laid out in sections. The first section was the above section with the introduction that gave an overview of who make up the population of youth experiencing homelessness and some of the challenges they encounter. Next, the literature review tells us what is already known about this population and what has been studied. This paper has broken down the literature review in three sections; barriers and challenges, mental health, and current support programs. The next section focuses on the conceptual framework and what perspective guided this study. After the conceptual framework, is the methodology section where the research process is explained in detail. Following methodology, is the findings section where the research has been analyzed, categorized, and conceptualized into common themes. Lastly, there will be a discussion section where further questions are asked and what could still be studied.

This systematic review focuses on safety as a holistic approach. Meaning safety will be analyzed as a whole, and looked at from all angles on how it affects youth. The term safety, "is a hard construct to measure" because safety is not always clearly defined. The word safety may also look different across cultures and races. On the other hand, the opposite of safety, such as; harmful, risky, or dangerous are actually better defined throughout literature and are the focus of most studies on youth and youth who are experiencing homelessness.

For this paper, the term *safety* will refer to youth feeling safe, having a place to go when needing to feel safe (community programs), having resources and services available for mental health and physical health, having a support system, and youth having developmental principles and knowing when to use soft skills: which characterize relationships with other

people, or which are about how you approach life and work and hard skills: job-specific skills (National Center for Homeless Education; Rao, 2013). The other key word throughout this systematic review is the term *homelessness*. For this paper *homelessness* will refer to youth who are experiencing an unstable residence, who often attend street shelters, couch hop, and are in a transitional living program; a safety net and strong emotional support system for young people to transition into self-sufficiency (Family and Youth Service Bureau, 2015; Grabbe, Nguy & Higgins, 2011). *Youth* for this paper will refer to the ages between 12 to 24 years old (Grabbe et al., 2011; Lee, Liang, Rotheram-Borus & Milburn, 2011). This paper will focus on *unaccompanied youth*; youth who are not in physical custody of a parent or guardian (McKinny Vento Act, 2015). The homeless youth population has been broken down and categorized as *runaways*, who have left the parental home, sometimes due to abuse experienced in the home; throwaways, who have been kicked out of the home by their parents, often due to parental dysfunction and/or youth behavior problems; *street youth*, who can be found in various street settings and often engage in prostitution, drug dealing, and other dangerous and/or criminal behaviors; and *systems youth*, who, after spending time in foster care or other formal systems of care, "fall through the cracks," and end up homeless. (Toro, Tegan, & Braciszewski, 2004, p. 2). For the purpose of this study all categories of youth experiencing homelessness will be included.

Research surrounding youth experiencing homelessness has been and continues to be gaining popularity. In 1998, research on youth experiencing homelessness began by viewing them as vulnerable and dependent subjects of research, (Martinez, 2010, p. 39). However, the study of youth experiencing homelessness has shifted emphasis overtime from viewing them

as vulnerable, "to social agents, competent and capable of making informed decisions about their lives and experiences" (Martinez, 2010, p. 39).

> When youth are viewed as such, their perception of realty and how they attach meaning to their experiences and to their environment become indispensable resources and guides in understanding them and in creating regulations and programs directed at helping them (Martinez, 2010, p. 39).

Today, most current literature on homeless youth focuses on barriers and challenges homeless youth encounter such as substance use (Hyun, Chung, & Lee, 2005), survival sex (Grabbe et al., 2011), lack of education (Grabbe et al., 2011), mental health (Toro et al., 2011), less social support (Toro et al., 2011), and lack of shelter use (Rakfeldt, 2005).

Barriers and Challenges

When youth experiencing homelessness reach out for basic needs such as assistance, housing and food they often encounter barriers and challenges. Homelessness appears to have awareness on the federal level yet lacks in the local level (Walsh & Donaldson, 2010). Lack of awareness in the local level is demonstrated by the deprivation of concern from the general population. The perception of homeless as troublemakers is echoed throughout communities across the nation (Walsh & Donaldson, 2010).

Many youth experiencing homelessness were exposed to violence, trauma or abuse in some form which can trigger many emotions and feelings. Often times that is why youth do not say anything to anyone or report abuse because they are scared of what might happen next. Therefore, if youth are used to not saying anything and withdrawing emotionally from situations naturally, a very vulnerable population has been created. Youth experiencing homelessness are also vulnerable due to negative interactions with the police. Therefore, it is

not uncommon for homeless youth to be reluctant when reporting crimes they have witnessed or have been committed against them because they feel that the police will not help (Walsh & Donaldson, 2010).

Youth experiencing homelessness also have barriers in social ties and relationships. When youth lack social assets it becomes an important and potentially modifiable risk factor for homeless youth. Those who lack social ties are more likely to engage in substance use and transactional sex when compared to those who do have access to social support.

Transactional sex occurs when someone under the age of 18 engages in commercial sexual activity. A commercial sexual activity occurs when anything of value or a promise of anything of value (e.g., money, drugs, food, shelter, rent, or higher status in a gang or group) is given to a person by any means in exchange for any type of sexual activity. A third party may or may not be involved (Atella, Schauben & Connell, 2015, p. 5).

According to Walls and Bell (2011), common synonyms to transactional sex are prostitution, sex work, and survival sex. These terms have been used interchangeably in the academic literature at times, but more often used to mean various forms of transactional sex. It was noted from previous studies that the terms prostitution and commercial sex are most commonly used when defining an exchange of sex for payment—most often money—and that this exchange occurs on a more or less professional basis. When an exchange is not as straightforward as a cash transaction or when the exchange is not pursued on a professional basis, and is seen more as a consequence of poverty and economic dependence; the term survival sex is used. In other words, survival sex is viewed as a legitimate way of supporting themselves on the streets, many homeless youth and young adults end up engaging in

survival sex as a last resort in return for food, money, shelter and survival on the streets (Walls & Bell, 2011).

Those with social support assets are associated with having better physical and mental health outcomes (Green et al., 2012). It was also noted from another study, the longer a person is homeless the increased likelihood the youth or young adult is to turn to survival sex as a subsistence strategy (Walls & Bell, 2011). In one study, a differentiating level of risk for engaging in survival sex was whether youth and young adults stayed in youth shelters or lived on the streets (Walls & Bell, 2011). It was noted from previous studies that the prevalence of risky behavior, like survival sex appeared to be lower among youth who stayed in shelters when compared to youth who lived on the streets (Walls & Bell, 2011).

The findings were not clear whether the difference in prevalence between youth in shelters verses youth on the streets was due to the need to support oneself being greater among street youth than shelter youth, or if there were other underlying variables that helped explain the difference in prevalence (Walls & Bell, 2011).

Other barriers reference the use of shelters and the unsafe feeling some youth experience while at shelters. These obstacles to shelters consist of: disruptive or undesirable settings; rigid rules or excessive responsibilities; disrespectful, uncaring or unavailable staff; and lack of individualized programming (Heinze & Hernandez Jozefowicz-Simbeni, 2009). It is common for studies on youth experiencing homelessness to typically focus on deficits and "quick-fix" interventions, rather than enhancing youth strengths and addressing long-term needs (Heinze & Hernandez Jozefowicz-Simbeni, 2009). Given the barriers to accessing long term care and the limitations in service provision, it is not surprising that many homeless youth do not access services. Many youth do not seek out shelter use despite the increased

risk for negative outcomes such as school dropout, arrest, psychological disorders, substance abuse, risky behavior and risk of exploitation because of their lack of feeling safe in a shelter is a bigger issue than feeling safe on the streets (Heinze & Hernandez Jozefowicz-Simbeni, 2009).

Another barrier youth experiencing homelessness face are resources to health care and mental health. As with mental health, participation in survival sex activities or exploitation were associated with increased physical risks. Youth experiencing homelessness may also have a higher risk of physical abuse, if exploited, by their exploiter or buyer. Sexually transmitted infections are common among youth experiencing homelessness. One study found that homeless youth who had engaged in survival sex had the second highest Human Immunodeficiency Virus (HIV) risk rating, following by homeless youth and young adults who were Intravenous (IV) drug users (Walsh & Bell, 2011).

Youth experiencing homelessness face many barriers. Medical help is a significant barrier youth experiencing homelessness face due to lack of resources and health insurance. Homeless youth often have untreated health problems and experience barriers to care when trying to access care for mental, physical or sexual medical help (Strike et al., 2014).

Youth who experience homelessness also may experience many different types of trauma/abuse. Abuse can come in many different forms; physical, sexual, verbal, and neglect. Lindberg et al., (2015) found that 44% of youth experiencing homelessness have experienced physical abuse. 27% reported experiencing sexual abuse, and 31% reported neglect while growing up as a child.

One study noted youth who experience violence in intimate partner relationships have increased risk of abusing substances (Coker, Smith, McKeown, & Ling, 2000). Youth who

use substances are more likely to experience difficulties in school, including irregular attendance and truancy, as well hindering the bond formation in social institutions and supportive others (Ferguson & Xie, 2012).

Furthermore, rates of substance abuse, dependence, and experimentation are also elevated among street-youth according to another study (Ferguson & Xie, 2012). One study reported 81% of their youth sample used alcohol, 75% used marijuana, and 49% crack (Ferguson & Xie, 2012). Often times when homeless youth are being studied, they are assessed on a risk based framework. Examples include substance abuse, homelessness history, transience, gang involvement, truancy, family abuse and victimization, delinquent behavior and peer pressure (Ferguson & Xie, 2012). When society views homeless youths with the above labels it negates larger systemic and structural forces that influence their outcomes; also neglecting their strengths and protective influences operating in their lives (Ferguson, & Xie, 2012).

Relationships have been documented between substance use and early abuse, family dysfunction, length of time on the street, depression, and involvement with high-risk peers (Rhule-Louie, Bowen, Baer, & Peterson, 2008). This leaves substance use and coexisting health and safety areas to be examined in youth experiencing homelessness. One study proposed a risk-amplification model whereby early life trauma (physical and/or sexual abuse) leads to a greater length of time on the street and association with high-risk peers, which consequently increase youth's substance use, involvement in unexpected subsistence strategies, and risky sexual behavior (Rhule-Louie et al., 2008).

Mental Health

Strike and colleagues (2014) found that youth who are experiencing homelessness are at increased risk of a myriad of health issues including sexually transmitted infections, substance abuse, injury, acute infections, malnutrition, suicide, and homicide. It has been noted from studies that youth living in shelters have identified medical needs as a primary.

Walls and Bell (2011) found youth experiencing homelessness to have clear associations between survival sex and mental health issues, as well as with histories of child maltreatment. Homeless youth who engage in survival sex are at a greater risk for depression than their counterparts who have not. It was noted from a previous study that having a previous psychiatric hospitalization has been found to be associated with an increase in likelihood of engaging in survival sex. Survival sex was associated with previous suicide attempts; homeless youth and young adults who engaged in survival sex were 4.5 times more likely to have attempted suicide than those who had not engaged in the behavior.

There are many reasons why youth engage in self-harm or attempt suicide. Emotional distress can take a toll on an individual. Runaway youth are more likely to experience depressive symptoms than non-runaway youth, and levels of depression have been found to be significantly associated with cutting or self-harm (Moskowitz, Stein, & Lightfoot, 2013).

Psychological health is an area where youth experiencing homelessness face challenges; such examples include self-harm and suicide. Self-harm is defined as the act of intentionally harming oneself without suicidal intent (Moskowitz et al., 2013). Self-inflicted injuries often include cutting, scratching, or burning of the skin (Moskowitz et al., 2013). Self-harm is often performed when an individual is dealing with stress and this is particularly true in youth populations, as youth often do not have the skills required to deal effectively

with many life stressors (Moskowitz et al., 2013). Suicide is noted to be the third leading cause of death in youth aged 15-24 (Center for Disease Control and Prevention [CDC], 2009) but is the leading cause of death among homeless youth (Moskowitz, Stein, & Lightfoot, 2013).

Runaway youth often lack adaptive and healthy coping mechanisms to mitigate self-harm behaviors and deal effectively with the challenges they encounter while living on the streets (Moskowitz et al., 2013). At-risk youth often employ maladaptive behaviors to cope with their problems that are associated with higher levels of depression (Rice, Stein, & Milburn, 2008).

Support Programs

Since many homeless youth go on to be homeless adults (Coates, & McKensie-Mohr, 2010) looking at current support programs is a must. Although studies have identified characteristics of homeless youth that predict the receipt of support (e.g., Bao, Whitebeck, & Hoyt, 2000; Ennett et al., 1999; Falci et al., 2011; Johnson, Whitbeck, & Hoyt, 2005), there is sparse literature examining the characteristics of people providing that support, or the relational social contexts in which it is provided. Research has increasingly shown that the social networks of homeless youth are diverse and often include varying proportions of family, street- and home-based peers, service providers, and sexual partners (Johnson et al., 2005; Rice, 2010; Tyler & Melander, 2011; Wenzel et al., 2010, 2012).

Social support is known to benefit individuals by buffering the negative health effects (both biological and behavioral) of stressful events (Cohen, 2004). Homeless youth who can access tangible support such as money, food, or basic resources may be less likely to experience stress, and those who receive emotional support (which fosters the experience of

belonging and being valued) may have more positive self-evaluations and stronger self-efficacy (Cohen & McKay, 1984).

Current literature suggests that family is an important area when it comes to support. One study noted that all types of support mostly come from family. On average, youth had three to four family members in their social network. Previous research has identified family as an important source of tangible resources for homeless youth (Green et al., 2012).

Another study reported that support has also been found to protect at-risk youth from becoming homeless (Tavecchio, Thomeer, & Meeus, 1999) and so may be an important factor in helping youth transition from and remain off the streets. A lack of social assets is an important and potentially modifiable risk factor for homeless youth (Haye, Green, Kennedy, Zhou, Golinelli, Wenzel, & Tucker, 2012).

Walsh and Donaldson (2010) identified The National Safe Place as an outreach and prevention program that is uniquely designed to provide immediate safety and access to services for any youth in need. The National Safe Place is in partnership with over 360 youth serving agencies and 10,000 businesses and community organizations across the United States. National Safe Place program not only connect youth to services but also educates youth about alternatives to running and away and homelessness. National Safe Place is an intervention program for youth who are already on the streets and a prevention program for youth who are at risk of displacement. National Safe Place set up an easy access for all youth in the need of help. All youth have to do is text message the word SAFE and their current location to the new Txt 4 Help number.

Another type of current support for youth experiencing homelessness is the McKinney-Vento Homeless Assistance Act (2002). In this act, homeless youth are ensured

equal access to education. Homelessness is defined as "lacking regular, fixed, or adequate night time residence", including places not designed for habitation (e.g. cars, abandoned buildings, bridges), and other temporary or inadequate residences, such as shelters, motels or camping grounds; and residences of friends of family members (Heinze & Hernandez Jozefowicz-Simbeni, 2009).

Policies and Rules of Street Shelters

Current literature indicates how some youth choose to stay "in the streets" rather than stay in shelters. Heinze and Hernandez Jozefowicz-Simbeni (2009) have described several rules and practices that are perceived as unfair, such as early curfews, loss of privileges for being late and consequences for missing meetings due to school, lack of childcare or public transportation. Suggesting, youth have difficulties in meeting program guidelines and policies in youth shelters. Some youth related program requirements, such as mandatory meetings and chores, are difficult to adjust to and leave little time for doing homework or engaging in social activities (Heinze & Hernandez Jozefowicz-Simbeni, 2009).

The same study mentioned how staff emphasized the positive aspects of rules and organization, describing the agency as a place young people can go and find stability (Heinze & Hernandez Jozefowicz-Simbeni, 2009). Staff members focused on how they were providing services in a way that people could count on them while meeting needs in a consistent way (Heinze & Hernandez Jozefowicz-Simbeni, 2009). Staff described ways in which the agency maintained structure, including staff training, use of handbooks, communicating and upholding expectations and consistency in programming (Heinze & Hernandez Jozefowicz-Simbeni, 2009).

It was noted that a grounded theory approach with enhancing empowerment and leadership among youth who are experiencing homelessness in an agency and/or community setting has been tried. Youth who participated in this theory demonstrated results in which youth had a voice and ownership, emotional safety, power and reciprocal support (Ferguson, Kim, & McCoy, 2010).

In this systematic review, clinical interventions that promote safety with youth ages 13 to 25 years old who experience homelessness are reviewed. Current literature on youth experiencing homelessness has primarily been focused on exploitation, substance use and or high risk behavior. This systematic review's aim was to help narrow the gap in research on youth experiencing homelessness by focusing on encouraging safety. Identified were five areas of safety: chemical health reduction, promoting harm reduction, psychological health, resilience, and service utilization. Gaining a better understanding of how youth and staff experience existing services and how research can improve clinical interventions and empower decision makers to advocate for effective development with encouraging safety toward interventions for youth experiencing homelessness.

Most current literature on topics of homelessness and youth are comprised of ideas of what can be done about homelessness, correlations of homeless youth and deviant behaviors such as substance use, survival sex, criminal activity, and truancy rather than actual carried out interventions. Many homeless youth struggle through emotions and face multiple barriers. Homeless youth have difficulty feeling an internal sense of self-efficacy and safety (McManus, & Thompson, 2008). These individuals also tend to grapple with issues of shame and have diminished understanding of self-care. Identifying emotions can be a challenge for many youth who experience homelessness. Newman (2000) encourages therapy with

chronically traumatized persons with goals to suggests goals to (a) develop trust appropriately; (b) exercise control over their own lives and internal experience; (c) decrease shame; and (d) increase self-esteem and self-care (McManus & Thompson, 2008).

Literature on youth experiencing homelessness lacks emphasis in areas of interventions on how to stop/decrease youth homelessness. To date, the majority of research literature emphasizes experiences of homelessness; how homeless youth are a hard population to study, the relationships/correlations of homeless youth and substance abuse, and shelters for homeless youth. Gaps in literature include how to stop youth homelessness or how to prevent youth homelessness. Intervention programs and models for youth homelessness were slightly touched on and rarely carried out in the actual studies.

This research project is relevant to clinical social work because many of our clients are youth who experience homelessness. Whether it is a school social worker, family worker, case manager, working with policies or working in juvenile correction centers. Many environments assist youth, and if we can find a way to make youth homelessness easier, safer and less prominent then I would say challenge accepted.

Conceptual Framework

The purpose of this study is to examine the current literature on interventions for homeless youth through an ecological approach and evidence-base practice lens of how safety and youth are viewed in the levels of micro, mezzo, and macro and how safety has been addressed with youth experiencing homelessness in current literature. Conceptual framework in regard to a research study is the focused perspective, structure of assumptions, principles, and rules that holds together the ideas comprising a broad concept. Conceptual framework is defined as "products of qualitative processes of theorization; to explore the process of building conceptual frameworks" (Jabareen, 2009, p. 50).

Ecological Framework

The ecological framework has provided a conceptual framework for this systematic review because of the different lenses allowed and applied within in a lifespan. Originally the ecological framework consisted of four systems: (1) micro, (2) mezzo, (3) exo, and (4) macro (DePoy & Gilson, 2012). However, recently a fifth system was proposed; chrono, which references the element of time (DePoy & Gilson, 2012). The ecological framework is explained as a systems phenomenon which blurs boundaries between systems and developmental theories (DePoy & Gilson, 2012). The micro system is defined as immediate surroundings of the individual such as family, home, work and school; the mezzo system is described as sets of microsystems such as communities or neighborhoods; the exo system is described as the systems that indirectly influence an individual such as a mother's workplace or a sister's school; the macro system is described as the abstract system which guides and shapes systems such as the economy, cultures and policy; lastly, the chrono system is the system of time and history (DePoy & Gilson, 2012). The fifth system allows a view of

ecological framework as it changes within the history and the span of a life (DePoy & Gilson, 2012). The ecological framework is a combination of time measured by an individual's chronological aging as well as the chronological movement within the systems (family, national history; DePoy & Gilson, 2012).

For the purpose of this systematic review, only macro, mezzo, and micro levels will be analyzed and demonstrated. From an ecological perspective, macro is described as an abstract system which guides and shapes systems such as the economy, cultures, and policy (DePoy & Gilson, 2012). According to this perspective, youth who have housing and support at this level do not have as high of chances in discrimination, poor school performance, and risk for educational delays. Youth who experience homelessness that do not have support at the macro level experience discrimination, poor school performance, and face a heightened risk for educational delays (Stewart et al., 2010). An example of a policy that is addressed at the macro level is The Homeless Youth Act. The Homeless Youth Act promotes stability among youth who are experiencing homelessness.

From an ecological perspective, mezzo is described as sets of microsystems such as communities or neighborhoods (DePoy & Gilson, 2012) and include intermediate systems such as schools. According to this perspective, youth who have housing may be able to take advantage of school level supports such as extracurricular activities. Youth who experience homeless that do not have support at the mezzo level may not be able to take advantage of supports like extracurricular activities due to barriers such as money. An example of a mezzo level approach in work with youth experiencing homelessness is the use of harm reduction (when an agency's aim is to reduce risk).

From an ecological perspective, micro is described as the immediate surroundings of the individual such as family, home, work and school (DePoy & Gilson, 2012). According to this perspective, youth who have housing have a decreased exposure rate to trauma and violence. Youth who have housing are also more inclined to reach out for help and have multiple opportunities and facets of formal support groups. Youth who experience homelessness that do not have support at the micro level will have higher rates of exposure to trauma and violence, have a sense of isolation, and lack formal support systems (Stewart et al., 2010). An example of a micro level intervention that is currently being addressed are workers who collaborate with youth experiencing homelessness. The youth workers teach independent living skills to youth experiencing homeless to promote success and autonomy.

Critical Race Theory

Another framework that helped mold this systematic review was critical race theory. Delgado and Stefancic (2012) explained critical race theory (CRT) as a collection of activists and scholars who were interested in studying and transforming relationships among race, racism, and power which led to a movement. Critical race theory questions the foundations of liberal order, including equality, legal reasoning, enlightenment rationalism and neutral principles of constitutional law. Critical race theory originally began as a movement in the law, however, now it is used in the field of education to address ideas of discrimination and social injustice in school discipline and hierarchy, tracking, affirmative action, high-stakes testing, controversies over curriculum and history, and alternative charter schools.

Critical race theory may be used in other settings as well, however, it is important to note that the CRT not only dares to treat race as central to the law but also challenges society to look beyond the popular belief that, getting rid of racism means simply getting rid of

ignorance, or encouraging everyone to get along. A common theme of critical race theory is the social construction thesis which holds race as a product of social thought and relation instead of as a product of objections. It is noted that CRT is not fixed, instead it corresponds to no biological or genetic reality; rather, races are categories that society invents, manipulates, or retires when convenient (Delgado & Stefancic, 2012).

Personally the aforementioned frameworks motivate me to be a better and more understanding individual in the way I view and analyze what has already been done and how systems affect each other. Knowledge in the ecological and critical race theory frameworks allows me to be more competent and prepared when advocating for clients. It also allows me to have insight in their situations and struggles on all levels.

Conceptualizing this research with an ecological framework and critical race theory allows for the comparing and contrasting of numerous interventions/shelter approaches and looking at what has worked and what has not. Also, literature on homeless youth speaks loudly about relationships and rational thought process while the evidence-base practice allows for interventions that have truly worked to keep our homeless youth safe.

Personal Motivation

My personal motivation for this systematic review is to create awareness around youth experiencing homelessness. This population is a difficult population to study in general, but what needs even more attention are the youth who are experiencing homelessness that do not utilize or are aware of services.

I want to address the barriers and challenges youth experiencing homelessness struggle with and how we can assist them in meeting needs. I am curious to find out what youth experiencing homelessness are saying their needs are and what services and resources

they are aware of. I also would like to learn how we can take what youth are saying and develop new interventions that would help reduce youth homelessness and allow homeless youth safety options when shelters are not an option.

Professional Motivation

My motivation is to create new literature on youth experiencing homelessness and how we can contribute and assist youth in feeling safe when experiencing homelessness. I conducted a systematic review focused on safety interventions involving youth experiencing homelessness.

My intentions for this study are to deepen the understanding of what interventions have been done and what interventions have proven to be successful as well as addressing current literature and the gaps in literature. This research focuses on key safety areas of youth experiencing homelessness and what is necessary and common when creating interventions. This study will also analyze homeless youth's needs and if safety concerns have decreased post intervention.

Methodology

An examination of current literature on homeless youth interventions identifies extensive diversity in the definitions of the safety of homeless youth, the applications of models and techniques of interventions, the populations and problems with which interventions are used, and the various documented outcomes. Due to the volume of current literature regarding homeless youth and a lack of identified themes, theories, and models/interventions, a systematic review was used to explore these issues.

There are several questions regarding safety for youth experiencing homelessness that this study aimed to explore. The main focus of this study was to explore and identify any consistency surrounding the purpose of the study, the use of interventions/frameworks and concerns toward safety for youth experiencing homelessness that were discussed in current literature. Additionally, areas of focus on safety were identified and analyzed in this systematic review to create a working definition around safety for youth experiencing homelessness.

Selection Criteria

The objective was to review (1) all available published studies that explored youth homelessness and interventions (2) theoretically or empirically, that identified (3) intervention strategies or safety toward youth experiencing homelessness (4) the specific components incorporated in safety and interventions for homeless youth. Since the preliminary search for literature identified thousands of articles varying in relevance to this research project, only articles that contained the words of interventions and safety for homeless youth in the title were considered for initial inclusion as well as articles that were

currently available. Unpublished studies, such as dissertations were also excluded. All studies that met search criteria were reviewed.

Search Strategy

The literature search was carried out from July 2015 to December 2015 using the data base Socindex using the search terms *safety and homeless youth* and *interventions for homeless youth*. The preliminary search results identified 4,227 studies. The key word *safety* identified 4,227 studies, the term was then narrowed to *safety and youth* which produced 1,392 studies. Again, the search was reduced by the term *safety and homeless youth* which revealed 18 clinical interventions. All 18 clinical interventions identified were reviewed in full to ensure they met the search criteria, those that did not were rejected. Out of the 18 clinical interventions, 10 were rejected due to repetition in authors along with clinical interventions that unclearly mentioned homeless youth. Out of the 18 clinical interventions, eight were left to be used in this systematic review.

The other search term used was *youth interventions* which produced 5,709 studies. The term was narrowed to *homeless youth interventions* which produced 135 studies. Lastly, the search was refined by identifying only academic journals which reduced the search to 123 clinical interventions. All 123 titles and abstracts were read, eliminating studies that loosely mentioned homeless youth and studies that did not meet criteria for a working clinical intervention. Out of the 123 clinical interventions, two met criteria. The total number of studies used for this systematic review from both search terms were 10.

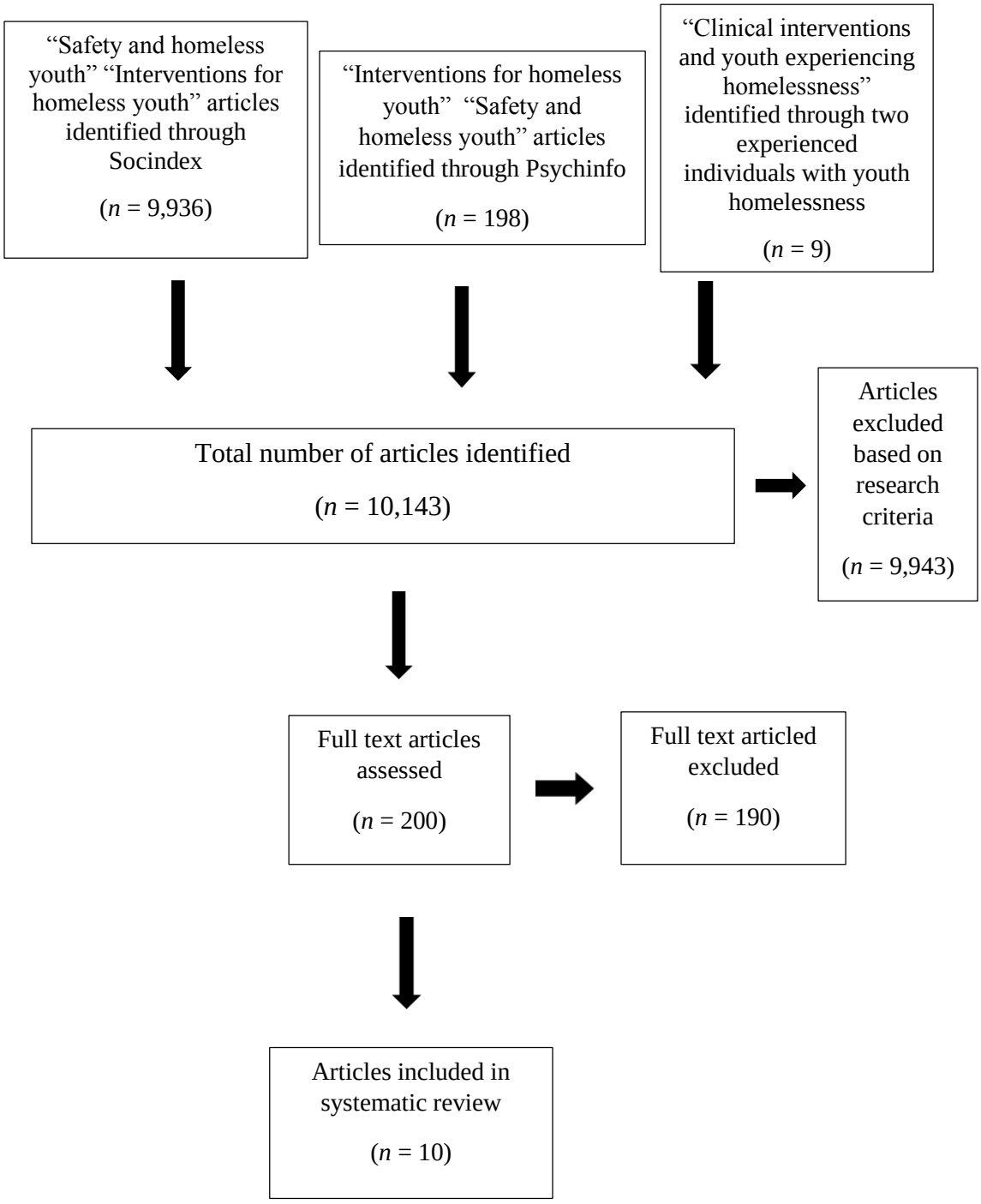
The 10 clinical interventions were then reviewed by the research chair; eight out of the 10 clinical interventions were rejected for the analysis. Data was then drawn from the data base Psychinfo. In Psychinfo the same search terms were used, *interventions for*

homeless youth and *safety and homeless youth*. The term *interventions for homeless youth* brought up 171 studies. To reduce the findings the search terms *homeless,* i*ntervention,* and *prevention* were each added to reduce the search to 40 studies. All abstracts were read to determine appropriateness use of this research. Out of the 40 studies, four clinical interventions were decided as appropriate use for this study.

The next term used for searching clinical interventions was; s*afety for homeless youth,* which produced a total of 27 studies. To refine the search even more the specific age group of adolescence was used and produced 16 studies. All titles and abstracts were read and two clinical interventions met criteria for this research. At this time a total of eight clinical interventions have met full criteria for the research when the goal was 10 clinical interventions.

In order to meet research goals two individuals were sought out and connected with because of expertise and experience with youth homelessness. One individual responded with four studies on homeless youth; one clinical intervention was found and met full criteria. The other individual responded with five studies on youth homelessness; one clinical intervention was found and met full criteria. Ten clinical interventions on youth experiencing homelessness were found and used for this systematic review. The outcome of the systematic search and selection process is summarized below in the flow diagram.

Figure 1. Flow diagram of studies throughout the selection process



Data Abstraction and Analysis

Data was included and analyzed in full for this systematic review. Each of the 10 clinical interventions included were critically reviewed four separate times. Important data from each article was extracted during these reviews. During the first critical review, data was extracted surrounding the intervention or framework used to inform safety toward youth experiencing homelessness. From the second critical review, data was extracted regarding the concerns/components of safety for homeless youth. During the third critical review, data was analyzed to see what was missing and/or what I wished was in the literature. When appropriate, during the fourth and final critical review, data was extracted that concerned suggestions to improve safety or interventions toward youth experiencing homelessness. Once the data had been extracted it was compiled into summary tables for analysis and synthesis.

Findings

Ten clinical interventions met selection criteria for this systematic review. This findings chapter both summarizes the studies and breaks down the clinical interventions into three categories of psychological health (five studies), chemical health reduction (three studies), and promoting harm reduction (two studies). A brief summary of the 10 clinical interventions can be found below in table 1.

Table 1

Summary of Clinical Interventions Used in Systematic Review for Youth Who Experience Homelessness

Youth experiencing homelessness research	Substance use homeless youth	Domestic homeless youth in sex trafficking	Homeless youth
Study	Baer et. al	Countryman-Roswurm et. al	Grabbe et. al
Year	2007	2014	2012
Study question	Will BMI improve over treatment responses?	Will DMST awareness lower youth risks?	Will spirituality decrease impulsiveness and psychological symptoms?
Evaluation aim	Raise youths' concerns on substance use, support harm reduction, and encouraging greater service utilization.	To examine the factors that may put youth at risk for DMST.	To have youth be able to identify such thoughts and feelings and substitute alternative way to understand and respond.
Primary safety focus	Promoting harm reduction	Promoting harm reduction	Psychological health
Location	Urban area	Midwest urban drop in center	Southeastern United States-large urban city
Sample size	117 (male & female)	23 (male and female)	39 (male & female)
Age	13-19	14-21	18-21
Inclusion criteria	Aged 13-19, homeless, 1< binge drinking episode, no treatment in past 30 days, stayed in urban area for more than one week.	Aged 14-21, in the drop in center	One of three sites: shelter –long stay traditional program, walk-in community service center and emergency shelter.
Intervention (IV)	Brief motivational	Group psychoeducation	Meditation 3-S program
Treatment	5-7 M.I sessions on topics of individual's interest	Weekly hour, 10-session group intervention,	8 educational classes on meditation (Yale's 3S program)
Design	Pre/post	Pre/post	Pre/post
Selection	Random assignment-drop in	Convenience sample	Convenience sample from a shelter
Measures	5pt likert scale on individual characteristics, service utilization, counselor rating, and client satisfaction. Self-report for drug use.	Rosenberg self-esteem sclae	Self-report on measures of impulsiveness, resilience, spirituality, mental wellness, and psychological symptoms. Brief Symptom Inventory-18
Statistical analysis	Cohen's D	Compared surveys from pre/post	Quasi-experimental
Fidelity	Supervised audio sessions	Not specifically discussed	Not specifically discussed
Findings	Actions went back to baseline when did post test	Psychoeducational groups; safe, encouraging, and youth friendly environment-develop protective factors against sex trafficking.	The spirituality development class was well received: improvement on measures of spirituality, mental wellness, psychological symptoms and resilience, no stat. sig in impulsiveness scores.
Limitations	Brief intervention	Small sample, lack of randomization, access to other services threatens validity.	All participants did not completed all 8 sessions and were easily distracted. Small sample size, one group nonrandom pre-posttest, could not associate positive changes to the intervention.
Recommend.	Elucidate mechanisms of change and service engagement for highly vulnerable youth.	Explore mental health of caretaker, youth themselves abused and/or exploited a partner.	Randomize control to examine long-term impacts on training on psychological status and behavioral outcomes (educational path, work attainment, and drug and alcohol use).

Table 1

Summary of Clinical Interventions Used in Systematic Review for Youth Who Experience Homelessness

Youth experiencing homelessness research	Homeless youth	Homeless youth	Substance use homelessness youth
Study	Hyun et. al	McCay et. al	Nyamathi et. al
Year	2004	2011	2012
Study question	Will CBT be effective in increasing self-esteem and decreasing depression?	How does a relationship impact youth receiving services?	Will a nursing intervention decrease use of drugs and alcohol?
Evaluation aim	Change thinking, to integrate residents into society	To guide, support and nurture youth	Reductions in drugs and alcohol: substances are linked to IHIV/AIDS
Primary safety focus	Psychological health	Psychological health	Chemical health reduction
Location	Seoul, South Korea	Toronto Canada	Santa Monica, CA
Sample size	27 (male)	15 (male and female)	154 (male and female)
Age	n/a	16-24	15-25
Inclusion criteria	Male sex Runaway adolescent Resident in shelter	Aged 16-24 In shelter, without home for at least one month, able to read, comprehend and speak English.	Homeless 15-25 years old Actively involved in drug use the past six months
Intervention (IV)	CBT program	Relationship-based	Nurse led HIV/AIDS program and artist led art messaging program
Treatment	8 sessions of CBT over 8 weeks	6 week relationship group, each group 1.5 hours long, youth directed	Three session program, session 2-3 hours long
Design	Pre/post	Baseline/post	Baseline/post/six month follow up
Selection	Random assignment-shelter	Convenience sample	Convenience sample
Measures	Wilcoxon signed rank test Self-esteem Inventory	SCL-90, CES-D, BHS, RS, RSES, SCS-R, MAST, DSI-SS, SH	Sociodemographic variables, Drug history form, CES-D, MHI-5
Statistical analysis	Cronbach's alpha, BDI-21, Self Efficacy scale	Analyzed by Statistical Package for the Social Sciences for Windows-frequencies, means, and SD	Log linear analysis, T-tests
Fidelity	Not specifically discussed	Not specifically discussed	Not specifically discussed
Findings	Depression decreased Self-efficacy increased No change on self-esteem.	Providing a relationship interventions to street-involved youth has strengthened social relationships and has helped with the overwhelming feelings of hopelessness and despair.	Sig. reductions in alcohol and marijuana in both HHP and AM programs. HHP had additional reductions in meth, cocaine, and hallucinogens at six month follow up
Limitations	Small sample, characteristics limit generalization, only male participants, most were Christians (not typical)	Small sample, only group work	Small sample size, no control group
Recommend.	Do again to detect potential mediating effect of the factors on treatment outcome with a larger and more diverse sample.	Redo with group of youth with a big degree of disconnect, and again with both individual and group components that focus on engagement.	Try again with a random sample and not a convenience sample.

Table 1

Summary of Clinical Interventions Used in Systematic Review for Youth Who Experience Homelessness

Youth experiencing homelessness research	Homeless youth	Substance use homeless youth	Substance use homeless youth
Study	Rakfeldt	Rhule-Louie	Slesnick et. al
Year	2005	2007	2015
Study question	Will DBT be effective with the youth population experiencing homelessness?	What relationships are related to substance use, safety, and youth experiencing homelessness?	Which of these interventions for homeless youth are successful: CR, MET, and case management interventions?
Evaluation aim	Helping youth with SED, emerging mental illness, and integrating into the community	What associations are made with health and safety of homeless youth	Reduce high risk behaviors
Primary safety focus	Psychological health	Chemical health reduction	Chemical health reduction
Location	South Central Connecticut	Seattle, Washington	Central Ohio
Sample size	15 (male and female)	285 (male and female)	270 (male and female)
Age	n/a	13-19	14-20
Inclusion criteria	Youth in residential programs in Connecticut who classify as transitional youth	Ages 13-19, homeless, used street drugs <4 times past 30 days, not been in treatment the past 30 days	Ages 14-20, homeless youth
Intervention (IV)	DBT intervention plus skills training	Brief intervention to reduce substance use and increase help-seeking behavior.	CRA (operant based therapy), MI, and strengths based case management model.
Treatment	Individual DBT with weekly two hour skill training group, intervention lasts 12.4 months plus 24 hour service provided	Motivational Enhancement 3 sessions	CRA- individually meet with counselor until both agree met goals, MI-assessment plus two sessions, Treatment plan is made and based off that for case management
Design	Pre/post	Experimental, two control groups baseline only	Baseline/post at three, six, and twelve months after
Selection	Convenience sample	Random assignment	Random assignment
Measures	Modified global assessment of functioning scale, purposeful productive activity and quality of life scale.	Demographic information, MAYSI-29, TLFB	Form90, BDI-11-21
Statistical analysis	Mean, SD, t-value, p-value	Path model	RC, Cohen's D
Fidelity	Not specifically discussed	Not specifically discussed	Not specifically discussed
Findings	Group improved in global functions, social relationships and productive time, not in vocational functioning	Measures of substance use were not sig. to youth's medical problems. Drugs had relationship between psychological distress and alcohol, cocaine and amphetamine use.	Substance use and associated problems were sig. reduced in all three interventions across time. Little evidence of superiority or inferiority of the three interventions.
Limitations	Small sample size, lack of random assignment,	Self-report, small sample, the variables assessed a limited number of aspects of health and safety of homeless youth.	Convenience sample, lack of diversity, those who agreed to participate may have been more motivated for treatment.
Recommend.	A larger sample is needed to further explore the efficacy of CB approach.	Explore associations reported herein longitudinally to clarity the direction of relationships between substance us and health and safety.	Successful treatment require development of a trusting relationship which may be key to further change.

Table 1

Summary of Clinical Interventions Used in Systematic Review for Youth Who Experience Homelessness

Youth experiencing homelessness research	Complex Trauma
Study	Stewart et. al
Year	2009
Study question	Will support increase youth experiencing homeless' social network, self-efficacy, and improve mental health?
Evaluation aim	To optimize peer influence
Primary safety focus	Psychological health
Location	Canadian City
Sample size	56 (male and female)
Age	16-24
Inclusion criteria	In the drop in center, aged 16-24, and either currently homeless or in transitions from homelessness.
Intervention (IV)	Support Intervention
Treatment	20 week pilot-4 support groups (meet once a week for 3-4 hours), optional one on one support, group recreational activities and meals.
Design	Pre/mid/post
Selection	Convenience sample
Measures	UCLA loneliness scale, CES-D depressive symptoms, and Proactive coping inventory
Statistical analysis	Anova, t-test, measures of central tendency
Fidelity	Not specifically discussed
Findings	Increased satisfaction with support, decreased loneliness, increased support-seeking coping, increased self-confidence and efficacy, improved health behaviors
Limitations	Attrition (small sample), had differential doses at data-collection, population made it impossible to discover reasons for this attrition.
Recommend.	Replication of this study at other sites with a larger sample.

Summary of Intervention Studies Used in Systematic Review

Demographics. All 10 clinical interventions were recent studies between the years 2004 to 2015. All interventions met selected criteria for the population of youth who are experiencing homelessness and all also included youth over the age of 18 years old. The sample ages ranged from 13 to 25 years old. Sample sizes ranged from 15 to 285 participants. Out of the 10 interventions, only one intervention focused primarily on male participants: all other interventions included male and female participants. Geographically, three out of the 10 studies were outside of the United States; two in Canada and one in South Korea, all other interventions were conducted in the United States.

Interventions. The clinical interventions tested in this systematic review were brief motivational interviewing, psycho education groups, meditation 3-S group (spiritual self-schema), cognitive behavioral therapy, relationship based interactions, dialectal behavioral therapy, and support interventions. Evaluation aims from the clinical interventions focused on youth experiencing homelessness and varied from raising concerns about substance use and service utilization, factors that put youth at risk, decrease substance use and psychological symptoms and to emerge these youth back into the community. The three major focus areas of safety identified in the 10 clinical interventions were: chemical health reduction, promoting harm reduction, and psychological health. There were a total of five focus areas identified, however when looking at primary focus areas only three focus areas were prominent. The most prominent focus area in safety was psychological health in five clinical interventions. Three interventions had chemical health reduction as their primary focus and two inventions had promoting harm reduction as their primary safety focus.

All treatments included some kind of weekly session whether it was an hour a week or five hours a week. Each treatment either had individual sessions, group sessions or a combination of both. Three of the 10 interventions included one on one sessions in addition to group meetings.

Methods. Eight out of the 10 interventions were quantitative studies; two were qualitative studies. Inclusion criteria for interventions were between 13 to 25 years of age, homeless, and three interventions included substance use within the past 30 days to six months. Six of the ten interventions used a convenience sample, while the other four interventions used random assignment in their sample.

Nine of the 10 clinical interventions did not mention fidelity in the study. One intervention mentioned a supervised audio session in regard to fidelity. All ten interventions had a pre-test and post-test; two of the interventions had an additional follow-up post-test at six months and at 12 months. Six of the 10 interventions had measures related to symptoms, the other interventions focused more on global and demographic measurements. The statistical analyses used in the clinical interventions varied from Cohen's D, compared surveys from pre/post-tests, quasi-experimental, Cronbach's alpha, log linear analysis, T-tests, and path models.

Intervention studies by category. Throughout the 10 clinical interventions five focus areas of safety were identified. The outcome of the systematic findings are summarized in the table below. The five components of safety were found and analyzed based on the purpose and question of the study and the concerns for interventions toward safety among youth experiencing homelessness. The focus safety areas identified were:

- Chemical health reduction

- Promoting harm reduction

- Psychological health

-Resilience

-Service utilization

All 10 clinical interventions on youth experiencing homelessness ranged from having one to three focus areas which fell into one of the five focus areas of safety found from analyzing the 10 interventions. The majority of findings fell within the safety focus of psychological health. A total of six of the 10 clinical interventions focused on psychological health on youth experiencing homelessness. The next highest safety focus was chemical health reduction with a total of four of the 10 clinical interventions, followed by the safety focus of service utilization with a total of three of the 10 clinical interventions. The focus area of promoting harm reduction was next in popularity with the findings of two of the 10 clinical interventions. The last focus area found in safety was resilience, one of the 10 clinical interventions focused on resilience.

Table 2

Focus Areas in Safety Interventions on Youth Experiencing Homelessness

Areas of safety focus	Chemical health reduction	Promoting harm reduction	Psychological health	Resilience	Service utilization	Total focus areas of safety found in each intervention
Total number in each focus area	4	2	6	1	3	
Baer et al. (2007)	x	x			x	3
Countryman-Roswurm et al. (2014)		x			x	2
Grabbe et al. (2012).			x	x		2
Hyun et al. (2004.)			x		x	2
McCay et al. (2011)			x			1
Nyamathi et al. (2012)	x					1
Rakfeldt (2005)			x			1
Rhule-Louie (2007)	x					1
Slesnick et al. (2015)	x		x			2
Stewart et al. (2009)			x			1

When analyzing primary safety focuses in the clinical interventions, the five focus safety areas were consolidated to three primary focus areas of safety:

- Psychological health (five studies)

-Chemical health reduction (three studies)

-Promoting harm reduction (two studies)

Psychological health. (five clinical interventions) Of the 10 identified clinical interventions, five explored the idea of psychological health as a primary safety focus (studies 3, 4, 5, 7, and ten). Two of the five interventions were held in the United States and

the other three interventions were held outside of the United States; two in Canada and one in Korea.

One of the five clinical studies to be categorized in psychological health as a primary safety focus are Grabbe, Nguy, and Higgins; (2012). They used Yale's 3-S (spiritual self-schema) meditation group for their intervention. This program consists of eight educational classes on meditation. Findings from the pre and post-test indicate the spirituality development classes were well received. Areas of improvement were found in spirituality, mental wellness, psychological symptoms and resilience. There was no significant difference in impulsiveness scores from the pre and post-tests.

Their primary focus is grouped under the psychological health safety area because of the evaluation aim. The evaluation aim was to have youth be able to identify their own thoughts and feelings and to substitute alternative ways to understand and respond to their thoughts and feelings. Researchers were hoping to find spirituality as a technique to decrease impulsiveness and psychological symptoms.

The second clinical study to be categorized in psychological health as a primary safety focus are Hyun, Chung, and Lee, (2004). They used a cognitive behavioral program (CBT) to raise awareness in psychological health. This study used only male participants and was conducted in Seoul, South Korea. This intervention consisted of eight CBT sessions over the course of eight weeks. Findings from the pre and post-tests indicated a decrease in psychological symptom of depression, and increase in self-efficacy and no change on self-esteem.

Their primary focus is grouped under the psychological health safety area because of the evaluation aim and study question. The evaluation aim was to be able to change youths'

thinking and to integrate the youth into society. Researchers were hoping to see if cognitive behavioral therapy would increase self-esteem and decrease depression.

The third clinical study to be categorized in psychological health as a primary safety focus are McCay, Quesnel, Langley, Beanlands, Cooper, Blidner, and ... Bach, (2011). They used relational based groups as their intervention to focus on psychological factors of youth experiencing homelessness in Toronto Canada. This intervention consisted of a six-week relationship group which lasted an hour and a half each week and was led by the youth. Findings from the pre and post-tests indicate relationship interventions involving street-involved youth has strengthened social relationships and has helped with the overwhelming feelings of hopelessness and despair. This intervention supports the decrease and raised awareness in psychological symptoms.

Their primary focus is grouped under the psychological health safety area because of the evaluation aim and study question. The evaluation aim was to be able to guide, support and nurture youth experiencing homelessness. Researchers were hoping to find a correlation between relationships and receiving services.

The fourth clinical study to be categorized in psychological health as a primary safety focus is Rakfeldt's (2005). Rakfeldt used a dialectal behavioral therapeutic (DBT) approach in his intervention focusing on psychological factors with youth experiencing homelessness. This intervention consisted of DBT and skill training sessions with 24-hour service provided. Each participant had individual weekly DBT sessions with a two-hour skill training group. This intervention lasted about 12.4 months. Findings from the pre and post-tests indicated group improvement in global functions, social relationships and productive time. This intervention supports awareness in psychological symptoms.

Rakfeldt's (2005) primary focus is grouped under the psychological health safety area because of the evaluation aim and study question. The evaluation aim was to help youth with emerging mental illnesses and to integrate them back into the community. Researchers were hoping dialectal behavioral therapy would be effective with the population of youth experiencing homelessness who also have emerging mental illnesses.

The fifth clinical study to be categorized in psychological health as a primary safety focus is Stewart, Reutter, Letourneau, and Makwarimba (2009). They used a support intervention to raise awareness in psychological symptoms among youth who were experiencing homelessness. This intervention was conducted in Canada. This support intervention consisted of a 20-week pilot study that included four support groups who met once a week for three to four hour, had optional one on one support and had group recreational activities and meals. Finding from pre, mid, and post-tests indicated satisfaction with support, decreased loneliness, increased support-seeking coping, increased self-confidence and efficacy and improved health behaviors. This intervention supports awareness to psychological symptoms.

Their primary focus is grouped under the psychological health safety area because of the evaluation aim and study question. The evaluation aim was to optimize peer influence. Researchers were intending to find if having support increased youths' social network, self-efficacy, and improve mental health.

Chemical health reduction. (three clinical interventions) Of the 10 identified clinical interventions, three explored the idea of chemical health reduction as a primary safety focus (studies 6, 8, and 9). All three clinical interventions were done in the United States: Seattle, Washington; Central Ohio; and Santa Monica, California. All three

interventions used psycho-education groups with their sample to articulate the aim of increasing awareness of chemical health and decreasing chemical health use.

One of the three clinical studies to be categorized in chemical health reduction as a primary safety focus are Nyamathi and colleagues (2012). In this study they had two sample groups: a nurse led program to educate youth on substance use and HIV/AIDS and Hepatitis Health Promotion (HHP) and an Art Messaging (AM) program led by artists. This intervention consisted of a three session psycho-education program on health promotion or art messaging; each group session lasted between two and three hours in length. Post intervention findings found significant reductions in alcohol, marijuana use and binge drinking in both programs. Additional findings were found in the HHP group where methamphetamine, cocaine, and hallucinogens also decreased in youth experiencing homelessness.

Their primary focus is grouped under the chemical health reduction safety area because of the evaluation aim and study question. The evaluation aim was to reduce drug and alcohol use in youth experiencing homelessness because these substances are linked to HIV/AIDS. Researchers were hoping to find a reduction in substance use after introducing a nursing intervention geared towards chemical health.

The second clinical study to be categorized in chemical health reduction as a primary safety focus is Rhule-Louie (2007). Rhule-Louie used the intervention of motivational interviewing (MI) to reduce substance use and increase help-seeking behavior. A brief intervention was conducted throughout three sessions. Post intervention findings were non-significant between measure of substance use and youth's medical problems. Some

relationships were made between specific drugs, psychological distress, alcohol, cocaine and amphetamine use.

Rhule-Louie's primary focus is grouped under the chemical health reduction safety area because of the evaluation aim and study question. The evaluation aim was to see what associations were made with health and safety of youth experiencing homelessness. Researchers were hoping to find a relationship between substance use, safety and youth experiencing homelessness.

The third clinical study to be categorized in chemical health reduction as a primary safety focus are Slesnick, Guo, Brakenhoff, and Bantchevska (2015). They used an intervention combination of operant based therapy, motivational interviewing and a strengths based management model to reduce substance use and psychological symptoms. The intervention consisted of individual meetings with a counselor, two motivational interviewing sessions and a tailor-made treatment plan for the participant. Post intervention findings were found significant between reduced substance use and psychological symptoms and the methods of interventions.

Their primary focus is grouped under the chemical health reduction safety area because of the evaluation aim and study question. The evaluation aim was to reduce high risk behaviors with youth experiencing homelessness. Researchers were hoping to find interventions for youth experiencing homelessness in case management, motivational interviewing, and operant based therapy.

Promoting harm reduction. (two clinical interventions) Of the 10 identified clinical interventions, two explored the idea of promoting harm reduction as a primary safety

focus (studies 1 and 2). Both of these interventions were done in urban communities. Both interventions used a different approach with their sample group of promoting harm reduction.

One of the two clinical studies to be categorized in promoting harm reduction as a primary safety focus are Baer, Peterson, and Wells (2007). They used motivational interviewing as their interventions to promote harm reduction in youth experiencing homelessness who have a history of substance use. Each participant was given five to seven individual motivational interviewing sessions on topics of the individual's interest. A pre and post-test was given to each participant. The findings indicated no significance in the motivational interviewing intervention. Findings showed post-test scores to be no different from the pre-test scores with substance use, service utilization, and promoting harm reduction.

Their primary focus is grouped under the promoting harm reduction safety area because of the evaluation aim and study question. The evaluation aim was to raise youths' concerns on substance use, support harm reduction, and to encourage greater service utilization. Researchers were hoping to find an improvement in treatment responses after using motivational interviewing as an intervention.

The second clinical study to be categorized in promoting harm reduction as a primary safety focus are Countryman-Roswurm and Bolin (2014). They used psycho-education groups on homeless youth who had been sex trafficked to promote harm reduction as their intervention. Each psycho-education group lasted one hour a week for 10 weeks. Findings from the pre and post-test showed that runaway, homeless and street youth who were provided with a psycho-educational intervention group was able to define and develop

protective factors against sex trafficking. This intervention was able to help support the promotion of harm reduction.

Their primary focus is grouped under the promoting harm reduction safety area because of the evaluation aim and study question. The evaluation aim was to examine factors that may put youth experiencing homelessness at risk for domestic homeless youth sex trafficking. Researchers were hoping to find reduced youth risk for domestic homeless youth sex trafficking after having a psycho-education group on awareness of sex trafficking.

Discussion

Through a review of 10 clinical interventions, which all acknowledged encouraging safety toward youth experiencing homelessness through theoretical frameworks, numerous similarities, differences, as well as possible future questions were identified. These 10 clinical interventions identified the primary focus areas of safety concerns toward youth experiencing homelessness with various interventions to encourage safety in the population of youth experiencing homelessness.

This systematic research study analyzed what safety interventions homeless youth have resources to; as well as to add to the growing amount of research concerning youth homelessness. This study examined current literature on interventions among homeless youth in order to identify any consistent intervention focuses regarding what makes up safety for youth experiencing homelessness. Identifying if there are any consistencies between models used, as well as exploring the populations being served by homeless shelters and programs.

When reviewing the 10 clinical interventions some findings were found to be successful in validity. Only one clinical intervention had findings go back to baseline at the post-test of treatment. Common findings are but not limited to: decreased psychological symptoms and substance use at the post-test, increased strengthened social relationships which helped with overwhelming feelings, increased global functions, and time management with youth experiencing homelessness.

This research supports the need for a stronger development of interventions that encourage safety toward homeless youth, especially those who do not seek out shelters and homeless youth programs. As can be seen throughout this research, a wide array of safety focuses have been identified as well as clinical interventions. There is still a lack of

understanding as to what components are necessary when developing interventions for youth experiencing homelessness and how to incorporate them.

Strengths and Limitations

Strengths. This systematic review had two major strengths: the large amount of literature available on the youth population and the emphasized lack of literature on encouraging safety for youth experiencing homelessness.

One major strength to this systematic review was the large amount of literature on the youth population in general. The available literature on youth allowed insight on what was lacking in areas of youth experiencing homelessness and the safety concerns associated with youth homelessness. Literature on youth homelessness has typically been associated with high risk behavior, substance use, and demographics on who makes up the homeless youth population (Kennedy, 2007; Rhule-Louie et al., 2008).

Another strength this systematic review offers is the area of emphasis on encouraging safety for youth experiencing homelessness. Up until now, there has been little to no research on how to promote, follow-through, and carry out other interventions encouraging safety for youth experiencing homelessness.

Limitations. The major limitations to this systematic review was the lack of data bases; only two data bases were able to produce clinical interventions. From the multiple studies found only ten clinical interventions met full criteria for this systematic review. Furthermore, books were reviewed for general information, however; no review was conducted on clinical interventions for youth experiencing homelessness.

Additionally, the sample cannot be assumed to be representative all of youth experiencing homelessness. Most samples were youth from urban areas. Second, the sample

likely had an overrepresentation of youth who received services at community-based social service agencies, either in shelter programs or who receive support services through outreach programs. As such, we would expect an underrepresentation of youth experiencing homelessness who do not seek services at youth agencies or who avoid street outreach teams. Third, the relatively small number of participants representing different ethnic minority groups prevented exploration of potential differences in patterns of relationship by ethnicity.

As most of the interventions were successful they still had many limitations that challenged the interventions. Limitations found were brief intervention periods, small samples sizes, lack of randomization, inconsistent of attendance of multiple session interventions, and lack of control groups.

Implications for Further Social Work Practice

A better understanding in this area of youth experiencing homelessness could lead to changes and improvements in: street shelter policies and enforcement; the way youth are looked at and treated; how clinical social work and therapy are conducted; and the typical timeline of youth experiencing homelessness.

Another area where further research could be conduction is on the population of youth experiencing homelessness who do not utilize services. Most research that has been conducted with youth experiencing homelessness has been with youth who utilize shelters, programs and services.

Future social work practice would benefit from a more in-depth look at street shelters and the struggles and barriers youth experiencing homelessness encounter on daily basis as well as what they truly need at the moment. Policies may be in need of a change to help keep youth safe. Researchers have advocated for contextually relevant, developmentally informed

interventions that reduce utilization barriers and target strengths (Haber & Toro, 2004; Lener & Castellino, 2002).

Implications for Clinical Social Work Practice

Implications for clinical social work practice are too analyze the major recommendations in current clinical interventions so the promotion of youths' wellbeing can be addressed and increased.

Major recommendations in current literature for clinical interventions toward youth experiencing homelessness were to be replicable with a larger and randomized sample and to explore in detail areas such as: mental health, mental health of caretakers, whether youth themselves had abused and or exploited a partner, in the CBT approach, developing a trusting relationship, and relationships found between substance use and safety.

When working to promote the wellbeing of homeless youth, social workers can utilize various interventions and models. One model could be assisting homeless youth to focus on building relationships that are supportive and promote a healthy life-style through the combination of programs that focus on individual-level change (e.g., risk behaviors, mental health) or vocational change such as social enterprise interventions (Green et al., 2012). Indeed, interventions that focus on the family system and rebuilding family relations have been associated with positive outcomes for run-away youth (Green et al., 2012). It would be interesting to research and address the positive experiences youth have experienced through services in the future.

Conclusion

This systematic review focused on encouraging safety for youth experiencing homelessness by selecting and analyzing 10 clinical interventions. Interventions ranged in efforts and some were significantly successful in their findings.

Youth experiencing homelessness has growing amounts of literature available for research; however, there is a literature gap in encouraging safety for youth experiencing homelessness. Homeless youth make up a large segment of the youth population and they regularly face stressful environments and circumstances. However, if youth experiencing homelessness have social support it becomes manageable to protect them from negative, physical and mental health outcomes that are so prevalent in this population (Green; et al., 2012). According to literature, encouraging safety for homelessness can be as simple as linking youth to early interventions which can help reduce the risk of running away and homelessness among youth (Walsh & Donaldson, 2010). Educating each other on the topic of youth homelessness and areas to help support safety for youth experiencing homeless may be the first stepping stone to encourage safety for youth experiencing homelessness.

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