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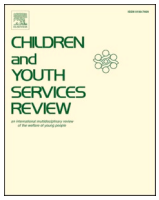

What are youth refuge practice models and how effective are they in improving outcomes for youth experiencing homelessness? A systematic narrative review

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ABSTRACT

Youth homelessness is a global problem. Preventing youth homelessness has many individual and societal benefits. Internationally, a key response to youth homelessness is the provision of a standard youth refuge model which includes short-term accommodation staffed by support workers who provide case management and referrals, with other varying health, hygiene and crisis services attached. However, it is unclear what is offered within these settings, and whether youth refuge improves any outcomes for youth experiencing homelessness. Homelessness services have also been increasingly encouraged to embed trauma-informed or psychologically informed practice models into service delivery. Like broader evaluations of the standard model, little is currently known about the extent to which these practice models are being implemented, how they are implemented, and whether they improve outcomes beyond standard models. Therefore, this systematic narrative review aimed to: (1) identify what services youth refuges provide, and which practice models are used; and (2) examine how effective youth refuge practice models are in improving health, behavioural, psychosocial, and/or housing outcomes for youth experiencing homelessness. Database and grey literature searches identified ten articles to be included. Seven articles evaluated a standard refuge model, two included strengths-based practice models, and one included an empowerment philosophy. No practice model offered evidence of its efficacy above what was offered by the standard refuge model, and limited detail about implementation of any model was found. Two cohorts emerged within refuge: (1) a younger cohort who could reconcile with family with therapeutic intervention; and (2) an older cohort who needed other options. Generally, results demonstrated short- to medium-term improvements in all health, wellbeing, and housing outcomes, with most gains reported in vocational status and improved family relations. Housing stability was a key contributing factor for outcome achievement. Most studies were of low methodological quality hence more rigorous, standardised, mixed-methods research is needed before conclusions about the efficacy of youth refuge and any practice models can be made.

1. Introduction

Youth homelessness occurs globally. In 2023–24, 38,600 youth experiencing homelessness were the third largest group seeking specialist homelessness support services within Australia (AIHW, 2025). In the UK, an estimated 118,134 youth were homeless during the same year (Centrepoint, 2024).Youth homelessness rates are forecast to increase worldwide due to a lack of social and affordable housing, warfare and worsening socioeconomic conditions globally (OECD, 2020c). Youth homelessness statistics could also be higher as varying definitions of both 'homelessness' and 'youth' are in use. Additionally, there is a lack of reliable, comparable, and consistent homelessness data collected internationally, with data from OECD countries more readily available versus less developed countries for which there is often very little to no information provided (Minnery & Greenhalgh, 2007; Ortiz-Ospina & Roser, 2017) resulting in an unclear picture of a global challenge and a focus on wealthier nations. What is universally agreed upon is that youth homelessness is attributed to various individual, systemic, and structural

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drivers – poverty, relationship breakdown, and family violence are the most oft-cited reasons for homelessness for this cohort (AIHW, 2021; MacKenzie, Flatau, Steen, & Thielking, 2016; OECD, 2020c).

Youth homelessness is important to address because traumatic experiences during adolescence can lead to health and wellbeing issues that, without intervention, frequently become chronic. Homelessness can be considered a cause of trauma as it adversely impacts young people's physical health through reduced access to healthcare, higher mortality and illness rates, and earlier development of chronic diseases (ABS, 2012; AIHW, 2020). It also negatively impacts psychological health (e.g., high rates of posttraumatic stress disorder [PTSD], physical/sexual abuse, depression, substance use, self-injury, and increased risk of suicide), educational achievement, and socioemotional development (e.g., difficulties with self-regulation and establishment of relationships, social exclusion, discrimination, low self-esteem, and loneliness [see for example, Bender, Thompson, Ferguson, Yoder, & Kern, 2014; Briere & Jordan, 2009; Crosby, 2015; Hadland et al., 2015; Johnstone, Jetten, Dingle, Parsell, & Walter, 2015; Kahan, Lamanna, Rajakulendran, Noble, & Stergiopoulos, 2020; Kidd, 2007]). Youth have also been found to be at an increased risk of experiencing polytraumatisation whilst homeless due to an increased probability of: (a) witnessing physical violence and/or being physically attacked; (b) being sexually assaulted; (c) seeing someone overdose; and/or (d) being threatened with death and/or harm (Bender et al., 2014). Individuals who experience trauma in adolescence are also more likely to experience prolonged or frequent episodes of homelessness in adulthood (Taylor & Sharpe, 2008), thus calls have been made for interventions that prevent youth homelessness.

Many interventions have therefore been developed specifically for youth experiencing homelessness (henceforth 'youth') and, to date, four systematic reviews have evaluated their efficacy (Altena, Brilleslijper-Kater, & Wolf, 2010; Morton, Kugley, Epstein, & Farrell, 2020; Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009; Wang et al., 2019). Most of these reviews examined targeted interventions that focused on specific outcomes in one or more health or wellbeing domains, for example, a time-limited mental health intervention to reduce depression, delivered in community or shelter settings. Despite these interventions being specifically designed for youth, Morton et al. (2020) review found that only 36 % of included interventions evaluated housing as an outcome. In Wang et al. (2019) review, only 16 % of studies included housing outcomes. These results suggest that current efforts for youth focus most on reducing the consequences of being homeless, rather than reducing homelessness episodes. Consequently, the literature currently offers little direction about what leads to the highest likelihood of obtaining and sustaining housing outcomes or preventing repeated episodes of homelessness. This is a surprising omission given the increasing recognition that being homeless can lead to trauma which results in many of the health burdens these interventions are actively trying to improve (Goodman, Saxe, & Harvey, 1991; Hopper, Bassuk, & Olivet, 2010; McKenzie-Mohr, Coates, & McLeod, 2012). Thus, this current paper attempts to determine whether services designed to assist youth to exit homelessness are achieving these outcomes, and how.

1.1. Youth refuge

A high percentage of targeted interventions are provided within youth refuges which are a common international strategy for youth homelessness. Globally, a youth refuge is typically the first response for youth who seek help (OECD, 2020b; Peled, Spiro, & Dekel, 2005; Vitopoulos, Cerswell Kielburger, Frederick, McKenzie, & Kidd, 2017). Youth refuge may be referred to as crisis services, hostels, or emergency shelters (henceforth 'youth refuge'). Much like the scope of youth homelessness, it is hard to get an accurate picture of youth refuges globally, as definitions, cohorts, funding sources, service offerings and time frames vary not only between countries but also within states, regions, and geographical areas. Typically, a standard youth refuge model includes short-term accommodation varying between one night to eight weeks, access to a support worker for case management/referrals, basic material aid (e.g., food, clothes), and variable levels of assistance with health care, education, employment, and/or counselling services dependent on refuge resources (Milburn, Rosenthal, & Rotheram-Borus, 2005; Vitopoulos et al., 2017).

Considerable public expenditure is required to provide homelessness services; in Australia, it costs approximately $747 million per year to provide youth with specialist homelessness support (MacKenzie et al., 2016). Considering this enormous cost and despite being one of the main support strategies for youth, there is little research about youth refuge, with previous reviews excluding studies which have evaluated this setting due to methodological concerns (Altena et al., 2010; Morton et al., 2020; Wang et al., 2019). Thus, it is currently unclear what youth refuges provide, how they are run, and whether this setting is effective in reducing homelessness or creating other positive changes for youth.

1.2. Practice models

Unlike the scarcity of research examining the efficacy of youth refuge, there is growing evidence regarding the role of trauma both as a precursor to, and a consequence of, homelessness (DeChants, Bender, & Stone, 2019; Hopper et al., 2010) and widespread recognition of the specific developmental needs of adolescents (Christie & Viner, 2005; Rew, 2008). As such, youth homelessness services have been encouraged to embed trauma-informed or psychologically informed practice models (henceforth 'practice models') into service delivery (Goodman et al., 1991; Grey, Woodfine, Davies, & Azam, 2019; McKenzie-Mohr et al., 2012; O'Donnell, Varker, Cash, Armstrong, Di Censo, Zanatta, & Phelps, 2014). Two of the most common of these approaches are psychologically informed environments (see Haigh, Harrison, Johnson, Paget, & Williams, 2012; Johnson & Haigh, 2010; Woodcock & Gill, 2014) and trauma-informed care (see Hopper et al., 2010). Most of these practice models are typically shared via internal practice guides and descriptive studies rather than via peer-reviewed, systematic evaluation. Thus, like broader evaluations of the standard refuge model, there is limited evaluation of practice models within youth refuge, hence their implementation and efficacy are largely unknown.

Consequently, the aim of this review was to: (1) identify what services youth refuges provide, and what practice models are utilised; and (2) explore how effective youth refuge practice models are in improving health, behavioural, psychosocial or housing outcomes for youth.

2. Method

This systematic review conforms to the reporting standards of the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA 2020 [Page et al., 2021]).

2.1. Inclusion and exclusion criteria

A PICO (Population, Intervention, Comparison, Outcomes) framework was utilised to determine if a paper was eligible for inclusion in this review (see Supplementary Table 1). The population of interest was unaccompanied youth participating voluntarily in youth refuge aged 12–26 years. A wide age range was chosen to include as many youth refuges as possible, as definitions of 'youth' vary worldwide. Studies were included if they: (1) were peer-reviewed; (2) were in English; and (3) reported any health, behavioural, psychosocial, or housing related outcome(s) for youth that resulted from participation in a youth refuge using a standard model of care or any other reported practice model. Studies were excluded if: (1) they were program guides or other documents used in-house by services without peer-review; (2) they included accompanied youth or youth in non-voluntary settings, e.g., out-of-home care, respite, juvenile detention centres or foster/kinship care; or (3) they only assessed a targeted intervention conducted within a

refuge setting and not the model for youth refuge itself, e.g., a mental health intervention designed to reduce depression offered within a refuge setting.

2.2. Search strategy

The following databases were systematically searched without date or study methodology limits from inception until November 2022: Medline and Epub Ahead of Print, In-process, In-data Reviews and Non-indexed citations, AMED (Allied and Complementary Medicine), Embase Classic + Embase, PsycINFO, all Evidence-Based Medicine (EBM) review databases, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Central Register of Controlled Trials, Sociology databases (ProQuest), Scopus, and Social Sciences Citation Index (Web of Science). The first author emailed organisations that provide youth refuge internationally to ascertain if additional unpublished papers existed. Grey literature searches were conducted via homelessness organisation websites and Google Scholar.

A systematic search strategy was developed using the Ovid platform and then translated to other databases. Search terms were collected from research literature on youth homelessness and are outlined in Table 1.

2.3. Screening of search results and study selection

First author (AJ) independently assessed all titles and abstracts as per the inclusion criteria, and independently completed the full-text review using the Covidence tool. Duplicates were automatically removed. Fourth author (EG) independently cross-checked a random sample of 25 % of both the titles and abstracts and full text review. Any conflicts were resolved via discussion until consensus.

2.4. Data extraction and synthesis

A data extraction form was created to guide the extraction of data from each of the included studies. Extracted data included general sample, design, method, intervention, and outcome details. Due to the heterogeneity of studies in terms of study design, outcomes, measures, and data reporting, meta-analysis was not feasible. Therefore, data were synthesised narratively.

2.5. Assessment of risk of bias

Due to the combination of randomised-controlled trials (RCT) and non-RCTs, the risk of bias of studies was independently assessed by first author (AJ) and fifth author (MS) using the Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong et al., 2018). This tool applies different quality criteria for different study designs, taking into consideration the unique characteristics of each design. After two initial screening questions, studies are rated on four areas of methodology categorised by study design; studies are rated on five items within each of these areas as either 'yes', 'no' or 'can't tell'. A total risk of bias score is calculated by awarding 20 % for each item that meets criteria (range from 0 % to 100 %). If a study achieved a score of 80 % or above within its study design category, it was rated as 'high quality'. Anything <80 % was categorised as 'low quality'. Both authors (AJ and MS) came to 100 % inter-rater agreement on individual item ratings and an overall score for each study (see Supplementary Table 2). No studies were excluded based on methodological quality.

Table 1
Search terms for ovid databases.

Category	Search terms
Youth	young, youth*, adolescen*, teen*, young adult, child*, minor, juvenile
Practice Models	psychologica?ly informed, psychological?ly minded, enabling environ*, trauma* informed, therap* informed, therap* minded, therap* communit*, informed planned environ*, relationship based care, therap* environ*, psych* trauma
Homelessness	homeless*, houseless*, house-less*, hostel?, runaway* or run-away*, throwaway*, refuge, refuges, sleeping rough, rough sleeping, shelter*, housing, street*

3. Results

3.1. Study selection

A total of 10 articles were included. Of 6931 articles retrieved from databases, 732 duplicates were removed, and 6199 articles were screened using titles and abstracts. Of these, 6166 were excluded for not meeting the PICO or inclusion criteria. The remaining 33 articles were reviewed in full, with 31 excluded with reasons documented in Fig. 1. Citation searches of reference lists of all full text papers was conducted, with 14 articles identified. Five papers were also identified via correspondence with international authors and organisations that provide youth refuge. Of these additional 19 papers, 11 papers were excluded with reasons (see Fig. 1).

3.2. Risk of bias

The overall risk of bias totals for the ten included studies ranged from 40 % to 80 % with a median value of 40 % (see Table 2 and Supplementary Table 2). Nine out of ten studies were 'low quality'. Eight out of ten studies considered confounding variables, with six of these studies reporting significant differences between completers and non-completers. Only two out of ten studies met the criterion for complete data. Three studies interviewed proxies at follow-up when youth could not be located (parents or social workers). Most studies used reliable and valid measurements. Only one study evaluated treatment adherence and subsequently reported low fidelity (Krabbenborg et al., 2017).

3.3. Summary of studies, services, and participants

There was heterogeneity in study designs, measures, and outcomes. One study was a cluster randomised controlled trial that compared a standard refuge model to a Houvast practice model (described in Table 4) (Krabbenborg et al., 2017), one was a case-control study (Thompson, Pollio, Constantine, Reid, & Nebbitt, 2002), one was a mixed methods study (Dostaler & Nelson, 2009) and seven were cross-sectional studies (Barber, Fonagy, Fultz, Simulinas, & Yates, 2005; Gwadz et al., 2017; Heinze, 2013; Thompson, Pollio, & Bitner, 2000; Peled et al., 2005; Pollio, Thompson, Tobias, Reid, & Spitznagel, 2006; Spiro, Dekel, & Peled, 2009). Two primary research aims emerged: half of the studies investigated postintervention outcomes (Barber et al., 2005; Krabbenborg et al., 2017; Pollio et al., 2006; Thompson et al., 2000; Thompson et al., 2002) whilst the other half assessed whether youths' satisfaction with or rating of some aspect of the refuge impacted on outcomes (Dostaler & Nelson, 2009; Gwadz et al., 2017; Heinze, 2013; Peled et al., 2005; Spiro et al., 2009). Within these aims, a diverse range of outcomes across health, behavioural, and psychosocial domains were evaluated. Table 3 outlines participants, service focus, outcomes, and results for each study.

Included services also demonstrated heterogeneity across support aims, eligibility criteria, and service offerings. Of the ten included studies, seven presented a standard youth refuge model (Barber et al., 2005; Heinze, 2013; Peled et al., 2005; Pollio et al., 2006; Spiro et al., 2009; Thompson et al., 2002; Thompson et al., 2000) and two included strengths-based practice models (Gwadz et al., 2017; Krabbenborg et al., 2017). One study included an 'empowerment philosophy' though it was unclear whether this was a true practice model chosen by the refuge or one of interest mostly to the researchers through which they then viewed the refuge's activities (see Table 4; Dostaler & Nelson, 2009). Six of the included studies researched settings whose primary aim was

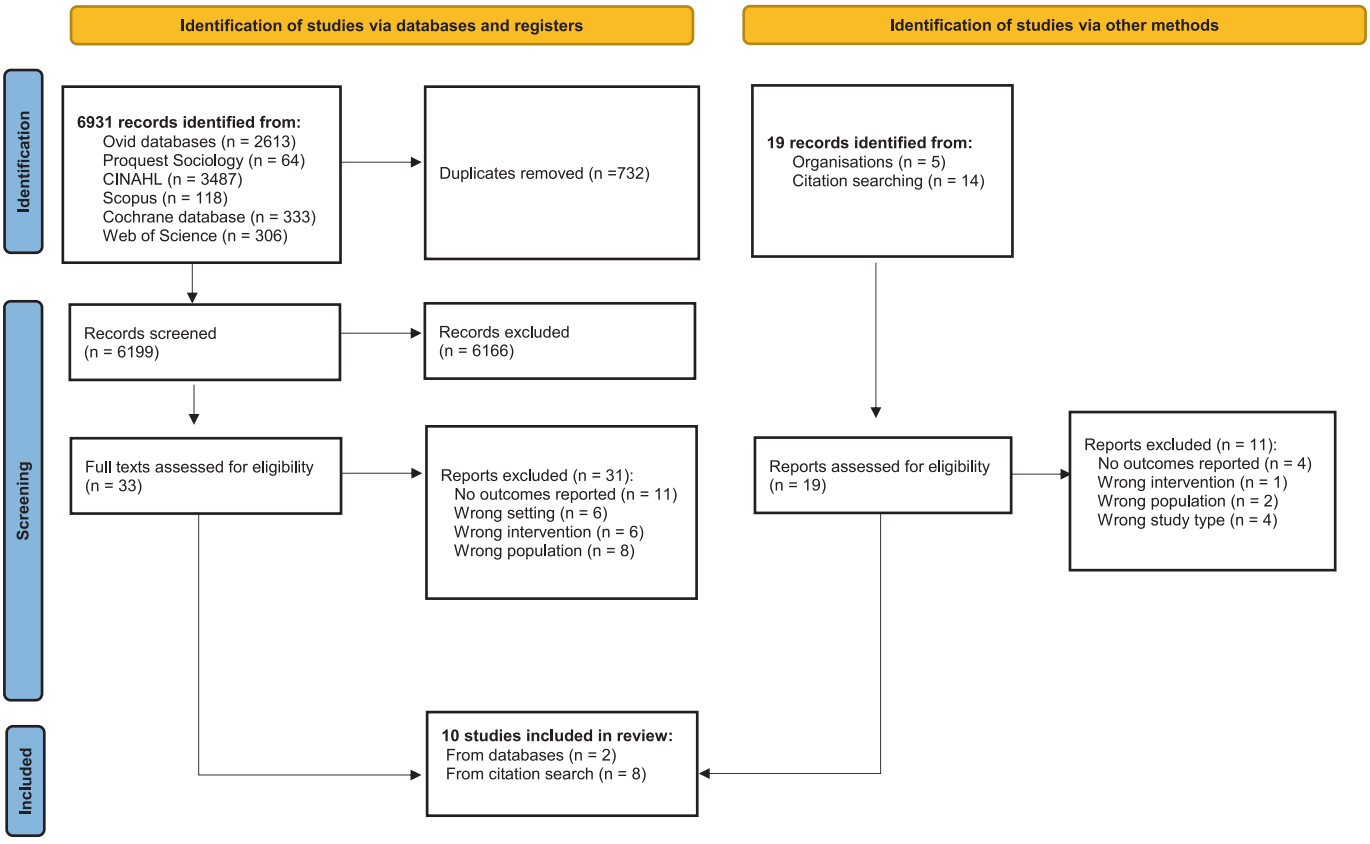

Fig. 1. PRISMA 2020 flow chart.

family reconciliation, i.e., returning youth to family (Heinze 2013; Peled et al., 2005; Pollio et al., 2006; Spiro et al., 2009; Thompson et al., 2002; Thompson et al., 2000). In contrast, the aim of the other services was different iterations of 'independence' for youth which ultimately meant enrolment in work or education to fund an independent housing option; these services described this aim as 'self-sufficiency', 'self--determination', 'independent living', being 'autonomous adults', 'healthy adult functioning', and 'social participation' respectively (Barber et al., 2005; Dostaler & Nelson, 2009; Gwadz et al., 2017; Krabbenborg et al., 2017). Only five studies reported service time frames for support, which ranged from 14 days (Heinze, 2013) to 'an average of six months' (Krabbenborg et al., 2017). Table 4 provides an overview of included settings, location, reported practice models, and any key model characteristics included.

Heterogeneity was found within participant demographics too. The eligible age range for youth refuge was 12–26 years. Refuges which focused on family reconciliation reported much younger participants than employment and education focused places (mean age range of 14.7 years–16.6 years vs. 17.5 years–20 years respectively*). Most family reconciliation refuge participants also averaged higher rates of living with family prior to entering refuge compared to education and employment focused service participants (74.75 % vs. 43 %). These findings suggest there may be two cohorts currently seeking refuge who require two different approaches: (1) those who are young and can reconcile with family with therapeutic help; and (2) older participants who can no longer reconcile and require other housing and support solutions. Across all but one study (Krabbenborg et al., 2017), participants were mainly female. Only two studies reported on transgender youth (Barber et al., 2005; Gwadz et al., 2017) who numbered 20 % and 5 % respectively of participants in those refuges. Sexual identity was only captured in one study (Gwadz et al., 2017) where 43.8 % of youth identified as lesbian, gay, bisexual, or queer. Information on ethnicity was mixed, although four of the six studies in the USA reported almost 50 % of participants were African American (Barber et al., 2005; Gwadz et al., 2017; Heinze, 2013; Thompson et al., 2000).

(* not all studies reported a mean age, hence the range of mean ages provided).

3.4. *What services are offered, and which practice models are utilised within youth refuge?*

All refuges, regardless of the practice model employed, stated their aim was to provide youth with independent living skills necessary to function as autonomous adults. If outlined, funding or policy obligations were the main reasons offered for choice of practice model. There were two clear objectives found: family reunification or obtaining employment/income to fund an independent living option. In pursuit of this aim, one refuge shut residents out of their premises during business hours (9am–4 pm) as they required individuals to be actively job-seeking or house-hunting during these times (Dostaler & Nelson, 2009).

3.4.1. *Standard refuge models*

The seven studies (Barber et al., 2005; Peled et al., 2005; Pollio et al., 2006 Spiro et al., 2009; Thompson et al., 2000; Thompson et al., 2002) which examined a standard refuge model reported many similarities between refuges. Youth refuges were typically limited to less than 20 beds, set tight timeframes for support (all <30 days when reported) and all included case management/staff support. Some refuges housed male and female residents whilst others were gender exclusive. Counselling (individual or family) and education and employment assistance was provided across all but one service. Dostaler and Nelson (2009) refuge provided no services but food, accommodation, and case management in-house; other services were via referral to community agencies to 'foster independence'. Perhaps relatedly, this refuge reported the lowest average duration of stay (5.7 days). Three studies utilised the same agency network which further increased similarities between reported

Table 2
Risk of bias of included studies as assessed by the Mixed Methods Appraisal Tool (MMAT).

Types of mixed methods study components	Methodological quality criteria	Krabbenborg et al., 2017 Cluster RCT	Gwadz et al., 2017 Cross-sectional study	Barber et al., 2005 Cross-sectional study	Thompson et al., 2000 Cross-sectional study	Thompson et al., 2002 Case-control study	Pollio et al., 2006 Cross-sectional study	Spiro et al., 2009 Cross-sectional study	Peled et al., 2005 Cross-sectional study	Dostaler & Nelson, 2009 Mixed-methods study using cross-sectional survey	Heinze, 2013 Cross-sectional study
Screening questions	Are there clear research questions?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
	Do the collected data address the research question?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
2. Quantitative RCT	2.1 Is randomisation appropriately performed?	**Yes**									
	2.2 Are the groups comparable at baseline?	**Yes**									
	2.3 Are there complete outcome data (>80 %)?	**No**									
	2.4 Are outcome assessors blinded to the intervention provided?	**Yes**									
	2.5 Did the participants adhere to the assigned intervention?	**No**									
3. Quantitative non-RCT	3.1 Are the participants representative of the target population?		**Yes**	**Yes**	**Yes**	**No**	**Yes**	**No**	**No**	**Yes**	**Yes**
	3.2 Are measurements appropriate regarding both the outcome and intervention (or exposure)?		**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**No**
	3.3 Are there complete outcome data (>80 %)?		**Yes**	**Yes**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
	3.4 Are confounders accounted for in the design and analysis?		**Yes**	**Yes**	**No**	**Yes**	**No**	**Yes**	**Yes**	**Yes**	**Yes**
	3.5 During the study period, is the intervention administered as intended?		**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Total		**3/5 60 %**	**3/5 60 %**	**4/5 80 %**	**2/5 40 %**	**2/5 40 %**	**2/5 40 %**	**2/5 40 %**	**2/5 40 %**	**3/5 60 %**	**2/5 40 %**

Table 3
Participants, service focus, outcomes and results for included studies.

Outcome type	Gwadz et al., 2017	Krabbenborg et al., 2017	Heinze 2013	Dostaler & Nelson, 2009	Spiro et al., 2009	Pollio et al., 2006	Barber et al., 2005	Peled et al., 2005	Thompson et al., 2002	Thompson et al., 2000
No. of participants	$n = 463$.	$n = 251$ at baseline, $n = 198$ at 6-months or post-discharge, whichever came first.	$n = 82$ at baseline, $n = 73$ at second survey mid-stay, $n = 50$ at two days post-discharge.	$n = 40$ at admission, $n = 30$ at 3-months.	$n = 102$.	$n = 371$.	$n = 202$ at intake, $n = 163$ at 2-weeks, $n = 141$ at 3-months, $n = 183$ at 6-months.	$n = 495$. Proxy Interviews: $n = 191$ parents, $n = 192$ social workers.	$n = 368$ at intake, $n = 261$ at 6-weeks.	$n = 70$.
Service focus	Independence	Independence	Family rec.	Independence	Family rec.	Family rec.	Independence	Family rec.	Family rec.	Family rec.
Housing	–	–	–	Housing type, i.e., private house/ apartment, staying with a friend, living with family/ relatives, group home/shelter/ boarding home, street*	–	Days on the run**	– Housing type, i.e., independent/peer, family, stable supported living, short-term shelter/ hotel/hospital, street/ incarcerated[a] – Safety rating of current housing[a]	– Housing type at exit and follow-up, i.e., parent's home, out of home placement, with relatives/ friends, indepen-dent living on street/shelter/ other, unknown[a] – Housing type desired at exit[a] – Social worker assessment of whether housing type meets needs[a]	Days on the run*	– Home at discharge[a] – Living with parents[a] – Average number of days on the run[a]
Substance Use	Alcohol or drugs used in past 3 months[a]	– Alcohol use – Soft drug use – Hard drug use	–	–	–	Currently using substances**	–	–	–	– Not drunk or high post-exit[a] – Number of times drunk post-exit[a] – Used drugs (various specific drugs listed)[a] – Used alcohol[a]
Health	–	Satisfaction with health*	Engagement in health behaviours (e.g., nutrition, exercise, relaxation)*	Self-rating of health improvement	–	–	–	–	–	–
Vocational Status	Currently in school, job training or have a job[a]	Employed or in school*	– Self-report of estimated average grades[b] – Self-report of estimated frequency of school attendance[b]	Self-report of improvement in education/ employment	–	– Suspended from school* – Expelled from school* – Detention at school* – Currently employed* – Fired since last survey**	Current vocational status[a]	–	– Suspended from school* – Expelled from school – Detention at school* – Currently employed** – Fired from a job**	– Currently attending school – Currently employed
Psychological	Resilience[a]	– Resilience* – Quality of life* – Depression* – Autonomy* – Competence * – Somatisation	– Life satisfaction** – General distress** – Internal developmental assets*	Life satisfaction**	–	Self-esteem**	Total Problems subscale of Youth Self-Report**	–	Self-esteem**	–

(*continued on next page*)

Table 3 (*continued*)

Outcome type	Gwadz et al., 2017	Krabbenborg et al., 2017	Heinze 2013	Dostaler & Nelson, 2009	Spiro et al., 2009	Pollio et al., 2006	Barber et al., 2005	Peled et al., 2005	Thompson et al., 2002	Thompson et al., 2000
		– Anxiety – Relatedness								
Behavioural	Involved in 'street economy' in past 3 months[a]	–	–	–	–	Currently sexually active*	Number of arrests[a]	–	Currently sexually active**	– Had sex after exit[a] – No. of sexual partners[a] – In trouble with the police[a]
Family and social relations	–	– Satisfaction with family relations* – Satisfaction with social relations*	Self-ratings of how well 'getting along with' primary male[b] and primary female caregiver**	–	Self-reported change in relations with parents[a]	– Family contact** – Perceived family support**	–	Change in family relations[a]	– Family contact[a] – Perceived family support**	– Contact with parents[a] – Have close friends[a] – Involved in social activities (church, sports, extracurricular)[a]
Other	–	–	–	Income type	Self-reported effect of stay, e.g., for better or for worse	–	Type of services received in refuge	–	–	Types of services used after exit

Note. $^{*}p < 0.05$, $^{**}p < 0.01$, [a] only reported descriptive statistics, [b] no analyses reported.

standard models (Pollio et al., 2006; Thompson et al., 2000; Thompson et al., 2002). Within this network, the standard refuge model included short-term accommodation, short-term case management, access to school-based education, crisis and family counselling, life skills training, food and clothing provision, and referral services. Barber et al. (2005) study included the same standard refuge model outlined above in addition to a full medical clinic and health screenings for every resident. This refuge concentrated on employment, so services were focused to support this, i.e., job interview coaching, resume preparation, clothing for interviews, and brief vocational training programs (e.g., security and food service certificates).

The two refuges located in Israel (Peled et al., 2005; Spiro et al., 2009) also outlined short-term accommodation provision and family reunification goals (termed 'normative housing'). They prioritised 'normal' routines such as school attendance, however differed from other refuges in that they also aimed to provide a 'home-like' environment to their 'youngsters'. A 'housemother' was employed who reportedly cuddled and provided affection to the residents, cooked for them, and scolded them like a parent. These were the only refuges across all studies to link service delivery to home-like conditions, with all others prioritising either a quick return to family or the quick procurement of employment and independent living conditions, with support to achieve these aims provided by trained staff who championed self-sufficiency rather than acting as parental-like figures. Similarly, these were the only studies to discuss the 'needs' of individuals versus 'outcomes'. No time limits were reported for these two refuges which also seems to align more closely with the 'warm home environment' they aimed to provide.

3.4.2. *Practice models*

There were similarities in approach for two of the three practice models. Houvast and Positive Youth Development (PYD) were both adjunct to a standard refuge model, and both were strengths-based approaches that championed: (1) resilience; (2) self-sufficiency; and (3) the active agency of young people in goal setting and attainment (Gwadz et al., 2017; Krabbenborg et al., 2017). More specifically, Houvast was co-designed with professionals and youth to determine the key characteristics of an efficacious model (Krabbenborg et al., 2017). These were found to be: (1) a constructive working relationship based on trust and mutual respect; (2) high-quality communication; (3) fostering hope; (4) a positive nonjudgmental approach; (5) problem solving; (6) the need to always provide a second chance; and (7) a strengths-focus (Krabbenborg et al., 2017). Staff were trained to use a structured form with which to collaborate with youth to set goals in ten life domains (e.g., finances, social relationships). Staff and youth noted any strengths (i.e., talents, opportunities, resources, or social connections) the young person currently had that could be capitalised (Krabbenborg et al., 2017). Krabbenborg et al. (2017) found no significant differences on outcomes between services who used Houvast and services who employed a standard refuge model, hence it is unclear exactly what this strengths-based approach offered that was beyond the standard level of care. The authors concluded that a strengths-based focus was common to case management in other refuges hence a lack of differentiation between interventions (Krabbenborg et al., 2017). This conclusion also highlights that Houvast appears to be mostly applied to how individual staff collaborate with youth rather than a whole-of-organisation approach.

Similarly, Positive Youth Development (PYD) did not outline how it specifically informed service delivery. All that was reported was that PYD was mandated by U.S. government legislation to be incorporated into youth refuge practice (Gwadz et al., 2017). Likewise, no further detail about the empowerment philosophy was outlined by Dostaler and Nelson (2009) above what is included in Table 4. As such, there is no conclusive evidence about how these practice models are implemented. All appear to be approaches for case management practice rather than models that inform the policies, ideology, and procedures of an entire organisation.

Table 4
Setting location, setting types, definitions, and practice model information as provided within included studies.

Author, Year	Location	Number of and type of Setting	Definition of Setting and Average Length of Stay	Practice Model	Key Model Characteristics
Gwadz et al., 2017	New York state, USA	29 settings: **Transitional Living Program (TLP):** $n = 11$ **Drop-in Centres (DIC):** $n = 9$ **Dual/multi program:** $n = 9$	**TLP:** supported residences where youth can reside for up to 18 months. Provide counselling in basic life skills, interpersonal skill building, educational advancement, job attainment skills, and physical and mental health care. Average length of stay was 147 days. **DIC:** take a 'low threshold' approach, providing a safe and supportive space that is easy to access. Youth can socialise and rest, receive tangible services, mental health counselling, health services and street outreach. No accommodation is provided in this setting, hence no average duration of stay. **Dual/multi program:** no definition provided. Average length of stay was 64.52 days.	Positive Youth Development (PYD) approach: A strengths-based model for encouraging resilience and self-sufficiency among youth, emphasising the importance of youth's engagement in their own development and goals.	No further information provided on model.
Krabbenborg et al., 2017	Netherlands	10 shelter facilities	**Shelter facility:** provides crisis or residential services to individuals aged 18 and above. All facilities aim to improve the living conditions of homeless youth by teaching them independent living skills. Professionals offer support on different living domains, such as housing, social network, education, and finances. Average length of stay was 157 days, ranging from 27 to 238 days.	Houvast: A strengths-based intervention developed to improve the quality of life of homeless young adults by focusing on their strengths and stimulating their capacity for self-reliance. Informed by theoretical concepts of resilience, self-determination theory, the concept of citizenship and the model of social quality. Co-designed with homeless youth and professionals via focus groups, interviews, and workshops.	▪ A constructive working relationship based on trust and mutual respect and fostering hope ▪ High quality communication ▪ A positive non-judgemental approach ▪ Problem-solving ▪ The need to always provide a second chance ▪ Focus on strengths and what individual can do rather than problems and what they can't do ▪ Young person is the director of their recovery process and the focus is on achieving goals they have set for themselves
Heinze, 2013	USA, Southeast Michigan	3 emergency youth shelters	**Emergency youth shelter:** provides accommodation for up to 14 days, material aid (e.g., food, beds, clothing, transportation), individual and family counselling, medical care, and educational support. Parental permission was required for children under 18 to receive shelter services. Family reconciliation is the main goal. Average length of stay was 11.87 days.	Standard refuge model	No further information.
Dostaler & Nelson, 2009	Canada, Ottawa	1 shelter	**Emergency shelter for young women:** provision of emergency shelter, medical and dental treatment, and short-term counselling for females aged 12–20 years. Objectives are to offer stability for residents and reduce stress by temporarily meeting their needs for shelter, food, safety, and health care. Achievable goals are set which focus on: (1) increasing women's knowledge of resources; (2) increasing their connection to community services to assist with housing, education, employment, social assistance, or longer-term	Empowerment philosophy: Empowerment-based practice has a goal of helping individuals to gain control over their lives. Empowerment encourages self-determination, choice, and independence.	**'Formalised set of values':** • Be woman positive and respectful • Be accessible to residents 24 h a day in both official languages (French and English) • Staff are accountable for their interactions and support of young women • A safe environment is provided • Power differentials between staff and residents are recognised and reduced where possible • The right for residents to make their own choices is upheld

(*continued on next page*)

Table 4 (*continued*)

Author, Year	Location	Number of and type of Setting	Definition of Setting and Average Length of Stay	Practice Model	Key Model Characteristics
			medical treatment; and (3) increasing independence and enhancing support. The shelter has two floors. The top floor contains an office, a common room with a couch, books and TV, and a room with a computer and telephone for resident use. Downstairs houses seven bedrooms, a bathroom, laundry, and a private room for counselling. Two staff members are on shift 24/7, and there are 18 staff in total. Residents must be off-site between 9 am–4 pm, though they may return at 12 pm for lunch. Dinner is served daily at 5 pm and residents are expected to complete chores before having access to the phone and TV. Monthly resident feedback meetings are held. Average stay was 5.7 days per admission.		
Spiro et al., 2009	Israel, Tel Aviv	1 shelter	**Shelter:** offers 22 beds for adolescents aged 13–20 years, split evenly for males and females with daily occupancy rates between 6–18 people per night. Staff include a director, a social worker, a housemother, and eight part-time counsellors. Stated goal is to remove young people off the streets and return them to a normative housing arrangement, typically back to family or residential care. Average length of stay not reported.	Standard refuge model	No further information.
Pollio et al., 2006	USA, Missouri, Iowa, Nebraska, and Kansas	11 crisis shelters	**Crisis shelter:** assists adolescents aged 12–18 years, is limited in size to less than 20 beds, and restricts stays to fewer than 15 days. Partially funded by US Department of Health and Human Services. Providing material aid is the main service. Agencies are mandated to attempt family reunification or to provide training and employment readiness activities designed to develop independent living skills. Average length of stay not reported.	Standard refuge model	No further information.
Barber et al., 2005	USA, New York City	1 crisis program	**Crisis program:** provides short-term housing, health, vocational, and counselling services for individuals aged 18–21 years in separate units for men, women, and mothers with children. All residents receive a health screen and health risk information as well as access to a medical centre. Emphasis is placed on vocational pursuits, with brief vocational training programs, job interview coaching and resume preparation offered. Length of stay is less than 30 days, and youth workers make daily contact whilst social workers and medical staff provide specialist services. There are specialised programs for men with substance use concerns and men and women with mental illness. Average length of stay was	Standard refuge model	No further information.

(*continued on next page*)

Table 4 (*continued*)

Author, Year	Location	Number of and type of Setting	Definition of Setting and Average Length of Stay	Practice Model	Key Model Characteristics
			18 days, with a range of 1–188 days. Ninety percent of individuals stay <62 days.		
Peled et al., 2005	Israel, Tel Aviv and Jerusalem	2 shelters	**Shelter:** provides 13–18-year-old "youngsters" who are unable or unwilling to live at home with a safe space, "time-out", a "warm home" and an opportunity to reorganise, mediate between them and their parents or other services, and help them to "find a normative living arrangement that fits their needs" (p. 262). Residents are provided with required therapy and are re-socialised to normative living habits in terms of daily functioning, schooling, and work. Each shelter has approximately 20 beds with daily occupancy ranging from six to 18 residents with a mix of males and females. Average length of stay was 24.81 days and ranged from 1 to 97 days.	Standard refuge model	No further information.
Thompson et al., 2002	USA, Missouri, Iowa, Nebraska, and Kansas	11 emergency shelters	**Emergency shelter:** provide crisis shelter and services, including short-term, temporary, residential services; short-term case management; access to school-based education; crisis and family counselling; life skills training; referral services; and discharge planning. Some are freestanding shelters whilst others are part of large service networks. Some support both male and female residents whilst others are gender exclusive. Average stay of 2–4 weeks.	Standard refuge model	No further information.
Thompson et al., 2000	USA, St Louis, Missouri	3 crisis shelters: Two provided a broad range of services to children and families while the third provided services for runaway, homeless, abused, and neglected women.	**Crisis shelter:** provides emergency and crisis services for youth and is federally funded by the U.S. Department of Health and Human Services.Average stay not reported.	Standard refuge model	No further information.

3.5. What are the health, behavioural, psychosocial or housing outcomes for youth in youth refuge?

3.5.1. Health

Health related outcomes showed improvement following a refuge stay. Of the ten included studies, three measured self-reported improvements in health (Dostaler & Nelson, 2009; Heinze, 2013; Krabbenborg et al., 2017). Krabbenborg et al. (2017) reported a significant improvement in satisfaction with health, whilst Heinze (2013) found significant increases in health behaviours from mid-stay to discharge. Heinze (2013) concluded that once residents were settled within the refuge and had developed a good working relationship with staff, they then felt more capable within themselves and were empowered to create positive change. Participants then engaged more with supports outside of the refuge, hence these improvements were found towards the end of their stay. These findings support qualitative reports from Dostaler and Nelson (2009). Participants reported that the cumulative stress of housing instability, poor nutrition, and living in poverty prevented better health and resulted in depressive symptoms. Once housing stability was achieved, health improvements were reported.

Unlike Altena et al. (2010) finding that substance use is one of the most common treatment outcomes investigated with youth, this review found that only four out of ten studies examined it (Gwadz et al., 2017; Krabbenborg et al., 2017; Pollio et al., 2006; Thompson et al., 2000). Where substance use was measured, overwhelmingly, alcohol and marijuana were the main substances (Gwadz et al., 2017; Krabbenborg et al., 2017; Pollio et al., 2006; Thompson et al., 2000). Only two of four studies analysed differences in use postintervention and only one found significant change. Pollio et al. (2006) reported significant decreases in use at three time points versus baseline (six-weeks, three-months, and six-months). However, there were increases in substance use between three-month and six-month follow-up, resulting in no significant difference in substance use rates between six-week and six-month follow-up (Pollio et al., 2006). These results may be due to a short intervention period (<15 days) or a reduction in refuge support. For example, Gwadz et al. (2017) reported that 50 % of their cohort felt the refuge setting helped them to manage/avoid substance use whilst other participants reported that a lack of support and increased independence was 'stressful' (Dostaler & Nelson, 2009). Pollio et al. (2006) also reported that participants receiving support for substance use were significantly more likely to report decreases in 'days on the run', indicating that managing substance use may be a precursor for increased housing stability or that housing stability is needed before substance use can decline.

3.5.2. Behavioural

Behavioural outcomes fell into three categories: individual behaviour (i.e., sexual activity and involvement in the street economy), police contact, and vocational status. Results for individual behaviours and police contact were mainly descriptive and lacked context, hence it was difficult to ascertain whether they improved. For example, Barber et al. (2005) only reported arrest rates postintervention. Similarly, Thompson et al. (2000) reported number of sexual partners postintervention without an explanation of how this related to a refuge stay or what constituted an improvement on this outcome.

Of the eight studies that measured vocational status, all reported increased education and employment enrolments postintervention. Thompson et al. (2002) and Pollio et al. (2006) examined the same outcomes: (1) school behaviour: suspended, expelled, received detention; and (2) employment: currently employed, fired in last 6 weeks. In Thompson et al. (2002) study, significant improvements were found on each of these outcomes at six-weeks postintervention. Moreover, when compared to day treatment users who were receiving longer-term care (i.e., upwards of six-weeks versus less than 30 days), no significant differences were demonstrated between the groups suggesting a refuge stay can positively impact this outcome within relatively short intervention periods. Pollio et al. (2006) reported that negative school events significantly decreased between six-week and three-month follow-up though there were no further decreases after six-months. More context is needed to understand if education improvements were not sustained, or if the maximum amount of potential change was reached.

Results for employment rates were mixed, and it was difficult to compare studies or interpret results due to a lack of standardisation and limited sophistication of measures. One study found that employment rates increased at six-weeks and three-months versus baseline but had significantly decreased by six-month follow-up (Pollio et al., 2006). The refuges included in this study restricted stays to less than 15 days, thus intervention duration may have been too short to impact vocational rates long-term. In addition, all participants in this study were under 18 years of age, and at six-month follow-up, over 88 % of this cohort had family contact and reported significantly improved family support. Thus, this reduction in employment rates at six-months may have been due to no longer needing to work to afford housing as most participants were living with family. In support of this, Barber et al. (2005) found that vocational status continued to significantly improve six-months postintervention, and unlike Pollio et al. (2006), Barber et al. (2005) study focused on an older population who needed their own independent housing option without family support. At three-month follow-up, 45 % ($n = 141$) were engaged in work or study. By six-month follow-up, 52 % ($n = 183$) of participants were engaged in work or study. However, as this study grouped education and employment rates together and had different participant numbers at different time points, it is unclear which rate improved and/or why. Krabbenborg et al. (2017) also found significant improvement in vocational status by six-month follow-up, with no significant differences found between the Houvast group and those receiving the standard refuge model.

Some predictors for success were found. Youth with residential care histories were less likely to be enrolled in school or working, whereas individuals with a work history in the year prior to admission were more likely to secure employment or to enrol in school (Barber et al., 2005). Krabbenborg et al. (2017) also found a higher probability of being enrolled in school or working at follow-up if youth were already doing so at intake. These outcomes may be moderated by other personal characteristics and/or environmental factors. Heinze (2013) reported that youth who rated themselves higher on 'commitment to learning' had higher grades and frequency of school attendance. Similarly, Dostaler and Nelson (2009) qualitative analysis found many participants wanted to prioritise finishing school over finding employment as they knew the positive role that education could play in improving their futures. However, many reported facing discrimination in workplaces and from educators who "just don't have any ideas about what it is like trying to concentrate… when you are worrying about housing…" (Dostaler & Nelson, p.107). This result indicates a need for housing stability before other outcomes can be sustained, and education of the systems who intersect with youth about the traumatic impacts of homelessness and how best to offer support. Moreover, the differences in vocational achievement demonstrate the cumulative impact of trauma and the heterogeneity within the youth population. Across the studies included in this review there was a strong indication of multiple subgroups with distinct support needs; some youth with shorter homelessness histories (meaning less traumatic experiences over time) may be able to engage successfully in school/employment quickly once housing stability is achieved, whilst others (those with care histories or longer homelessness histories meaning more potential for traumatic impact) require enhanced support for longer periods to achieve similar results.

3.5.3. Psychosocial

Findings show that a refuge stay may improve family relations, regardless of service focus. All studies which included a family reconciliation focused refuge investigated a family focused outcome, with all reporting increased contact and higher ratings of perceived support (Heinze, 2013; Peled et al., 2005; Pollio et al., 2006; Spiro et al., 2009; Thompson et al., 2000; Thompson et al., 2002). Thompson et al. (2000) found 98.6 % of their participants had contact with their parents postintervention, and 87.8 % were living with them. Whilst Heinze (2013) did not obtain enough data to investigate male caregivers, relationship ratings for female caregivers improved significantly during a refuge stay. Whilst their refuge focused on independence for youth, Krabbenborg et al. (2017) also found a significant improvement in satisfaction with family relations.

Psychological outcomes varied widely but results trended positively across all studies. Two studies investigated self-esteem, and both reported significant increases at six-week follow-up (Pollio et al., 2006; Thompson et al., 2002). However, these increased ratings had reversed by six-month follow-up in one study (Pollio et al., 2006). Barber et al. (2005) found improvements on the 'Total Problems' subscale of the 'Youth-Self-Report' of the Achenbach System of Empirically Based Assessment (ASEBA; Achenbach, 1997) at both three- and six-month follow-up. Krabbenborg et al. (2017) focused on a wide range of psychological outcomes, including: (1) quality of life; (2) depression; (3) anxiety; (4) somatization; (5) autonomy; (6) competence; (7) relatedness; and (8) resilience. All measures improved by follow-up regardless of whether participants were receiving Houvast or the standard refuge model, though only quality of life, depression, autonomy, competence, and resilience improved significantly. Gwadz et al. (2017) also included resilience and found it positively related to setting quality although the mechanism underlying this relationship was unclear. Life satisfaction scores significantly improved postintervention, with participants qualitatively reporting that these improvements correlated with more stability (Dostaler & Nelson, 2009).

Heinze (2013) investigated internal developmental assets and found some interesting patterns. Individuals with higher ratings on most internal developmental assets (support, commitment to learning, social competence and personal identity) reported generally more favourable results across all outcomes, e.g., less distress, greater life satisfaction, more satisfaction with refuge experience, better relationships, more school attendance. There were further patterns to these changes; from admission to mid-stay (a stay averaged 11.87 days), distress significantly lessened, and life satisfaction increased. From mid-stay to discharge, relationship with female caregiver, commitment to learning, positive values, and positive identity scores all significantly increased. These results indicate that increased stability results in the ability to focus on other aspects of self, correlating with better individual outcomes for youth. Individuals with greater internal developmental assets – and consequently a greater capacity for resilience – may therefore experience homelessness in a way that is distinct from youth with lower internal developmental assets. This would then translate into one group

having more ability to 'bounce back' from adversity, resulting in more improvements following service engagement.

3.5.4. Housing

Housing outcomes were examined in six of ten studies, with results further highlighting the heterogeneity of youth (Barber et al., 2005; Dostaler & Nelson, 2009; Peled et al., 2005; Pollio et al., 2006; Thompson et al., 2000; Thompson et al., 2002). For some, a return home was feasible and successful, whilst others needed and wanted other solutions. Younger individuals (aged under 17) and those from two parent families had the most successful return home, whilst a significant proportion of individuals aged over 18 (58 %) needed other options (Peled et al., 2005). Thompson et al. (2000) reported positive associations between returning to a parental home post-discharge, and: (a) reduced police contact; (b) increased school engagement; (c) increased engagement with religious services; and (d) increased interpersonal relationships. This study excluded participants over 18 and had a cohort with a mean age of 14.8 years. Two other studies of participants under 18 found significant reductions in 'days on the run' at six-week and three-month follow-up (Thompson et al., 2002) though these decreases had reversed by six-month follow-up (Pollio et al., 2006). In fact, 'days on the run' significantly increased at six-months in comparison to both other follow-up periods. This contrasts with two studies of older participants that found housing outcomes were maintained and increased at six-month follow-up (Barber et al., 2005; Dostaler & Nelson, 2009). These results suggest two distinct cohorts within refuge: (1) younger participants who would benefit from a return home after intervention and with therapeutic support; and (2) older participants who need more independent, sustainable options other than family.

The existence of two distinct cohorts is supported by the findings of Peled et al. (2005) where a return home was rated by social workers as 'not at all' meeting the individual's needs (40 %) or only meeting the individual's needs 'to a slight extent' (27 %). In contrast, a lower proportion of youth who exited the program to living on the street or in a shelter were rated as not having their needs met (33 %) or only slightly having their needs met (10 %) through their respective housing outcome. Further, a higher proportion of youth living on the street or in shelters at exit were rated as having their needs met 'to a great extent' compared to youth who returned home (18 % vs 10 %, respectively). Furthermore, Peled et al. (2005) asked youth to name their desired housing exit – 32 % wanted to go home, 18 % preferred residential care, and 17 % preferred independent living or the army. These results suggest that a return home is not always the most preferred or suitable option, hence increases in 'days on the run' after six-months may simply confirm unsuitability of family as the only housing choice. Further, these results point to the importance of working holistically with youth and their families wherever possible, particularly when the client group is very young.

4. Discussion

The aim of this review was to: (1) identify what services youth refuges provide, and which practice models are used; and (2) explore the impact these services have on any health, behavioural, psychosocial, or housing outcomes for youth. This review found many similarities between services, and little by way of practice or outcomes that distinguished a practice model from a standard refuge model. Consequently, a key finding of this review is a lack of research into the efficacy of standard youth refuge models and the absence of evidence to support specific practice models. None of the practice models included in this review provided strong evidence in achieving improved outcomes for youth over and above a standard youth refuge model. This finding was due to several reasons: (1) practice models were not clearly articulated; (2) the quality of evidence was low (see Table 2 for risk of bias analyses); and (3) included practice models (e.g., Krabbenborg et al., 2017) were more akin to case management approaches rather than a whole-of-organisation model, leading to a lack of differentiation between practice models and comparison conditions which offered similar, if not the same, interventions.

A lack of rigorous evaluation of youth refuge is somewhat understandable considering that conducting RCTs (considered the 'gold standard' of research evidence) is often not feasible or appropriate in human services where interventions are: (1) complex; (2) include a diverse range of participants and activities; (3) are typically run by professionals with varying levels of education and training who are mostly unskilled in research; and (4) include conditions that are unable to be tightly controlled and/or the use of comparison/control groups is unethical because it withholds services from people in need (Pinnock et al., 2015). The transient nature of this cohort also makes participation and follow-up difficult. Furthermore, human services are often reliant on philanthropy or small budgets which means they are not typically able to employ external research teams, nor are they frequently engaged with universities or other academic institutions. The crisis-driven nature of these services also prioritises service delivery over research priorities. These factors may explain the lack of peer-reviewed evaluations of more real-life settings.

Within these studies, youth refuge, regardless of practice model employed, contributed to short and medium-term improvements across several health and wellbeing outcomes. Moreover, youth rated their experience of and satisfaction with refuge positively and noted the ability of services to help them manage and avoid unhelpful behaviours and increase their resilience (Gwadz et al., 2017; Peled et al., 2005). While some attenuation in gains was found by six-month follow-up, this likely reflects the very short intervention periods, impacts of the withdrawal of refuge support, and/or environmental circumstances of the young people rather than a deficit of the service setting. For example, a quick return home to an unsustainable family environment where therapeutic supports have not been provided or maintained in the longer-term results in housing instability which then erodes previous gains made.

Of all outcomes, vocational status appears most amenable to change, however many studies acknowledged that federal mandates required services to provide vocational assistance which increased focus and effort on this domain. Family relationships also improved which demonstrates a possibility to intervene successfully with youth and their families under the right circumstances. Younger participants had more success reconciling with family as did youth from two parent households, indicating the importance of early intervention, triage and primary prevention. Substance use decreased as did psychopathology in relatively short periods of time. These findings reinforce the idea that homelessness itself results in numerous deleterious impacts for those who experience it, and once it is addressed, a reduction in other health, psychosocial and behavioural issues will occur. However, as some of these positive changes were not sustained long-term, more research is needed to understand these results with more context so that the individual, structural and systemic factors which hinder or support positive gains can be understood, and viable support solutions which also take into consideration various subcategories of youth (e.g., those with care histories, LGBTQIA + identifying individuals) can then be developed.

The outcomes chosen for inclusion in many studies prevented adequate comparisons between models and limited an in-depth understanding of youth. For example, some studies (e.g., Pollio et al., 2006; Thompson et al., 2000; Thompson et al., 2002) reported success across the following outcomes: (1) youth returning to parental homes; (2) increased contact with family; (3) increased attendance at religious services; and (4) disengaging from sexual activity. These studies disregarded youths' characteristics, preferences or needs and weighted outcomes subjectively, focusing more on outcomes the researchers perceived as 'good' or 'normative'. For example, Spiro et al. (2009, p.262) stated that returning home, being placed in a foster home or institution, or exiting refuge to a placement chosen by staff were positive outcomes postintervention, and any other housing exit was considered

"a failure". These variables can be considered 'subjective' measures of success due to the unique developmental stage of adolescence, the heterogeneity of the broader youth population, and personal and cultural differences. For example, sexual activity is increasingly prevalent during adolescence, and research shows that healthy romantic relationships are vital during this time to learn interpersonal skills such as emotional and sexual intimacy, emotional self-regulation, and the provision and receipt of emotional support (Shulman, Seiffge-Krenke, & Walsh, 2017). Similarly, reasons for engaging in faith can be personal and/or cultural, and the choice to engage in faith services is not better nor worse than non-engagement. Finally, given family violence and relationship breakdown are two of the most common reasons for youth homelessness (see: Institute, 2021; MacKenzie et al., 2016; OECD 2020c), for a large percentage of youth, a return to their parental home would be considered impossible or unsafe. Thus, family reunification is skewed to the minority of youth for whom this is feasible. The reason for the inclusion of subjective measures could be that in some studies (e.g., Pollio et al., 2006; Spiro et al., 2009; Thompson et al., 2000; Thompson et al., 2002) youth were mainly referred to youth refuge by their families, and the use of refuge was an attempt to return young people to 'pre-crisis behaviours' or 'normal' functioning, i.e., to behaviour prior to whatever situation resulted in their family making the referral to crisis services, or to behaviour necessitated by the family for a return home (Thompson et al., 2000). Thus, these study design characteristics reduce the ability to accurately assess the efficacy of youth refuge and limit the generalisability of results. Standardised measures investigating relevant outcomes are needed in future, and youth should be consulted to understand which outcomes they believe most accurately reflect efficacy of support for them.

Across all studies, it was clear that housing stability predicated the successful achievement of other outcomes. Youth also noted that withdrawal of support was experienced as 'stressful' which aligns with their developmental stage and needs. Despite the resourcefulness and independence they may exhibit – which are necessary characteristics to survive homelessness – it is important to remember that youth are on the cusp of adulthood. Research shows that they still need support, both due to their developmental stage as well as simply because they value it (Dostaler & Nelson, 2009; Gwadz et al., 2018). However, this developmental need seemed to be overlooked by most refuges who focused on quick outcomes in <30 days. The influence of neo-liberal ideologies on policies and service provision in the human services sector may be a factor here.

Neo-liberal policies view individuals as rational, responsible, and autonomous, and emphasise individual responsibility for success (Kuskoff, 2018). Where there is failure to achieve expected goals (such as employment or education), this is viewed as an individual's failure, and systemic and structural causes are typically neglected (Kuskoff, 2018). As such, youth are positioned as young adults with agency despite their substantial developmental and support needs and are held responsible for their homelessness (Kuskoff, 2018). Language within the research literature to date supports this – runaways, throwaways, delinquents – all imply some level of personal agency and individual fault in young peoples' homelessness. Further, there were two clear objectives found for youth refuge: return youth home or get them employed so they can fund their own housing option. There was little recognition of trauma symptoms or developmental or safety needs. The inclusion of youth perspectives was limited to satisfaction with the service or rudimentary enquiries about housing. Only Dostaler and Nelson (2009) qualitatively enquired about youth experiences, and overwhelmingly these responses showed individuals who were stressed and depressed by their circumstances and who wanted and needed help. Neo-liberalist influence may also be why independence and vocational pursuits were championed and included practice models focused on strengths and empowerment rather than trauma recovery, which is counterintuitive to research conducted on trauma and homelessness to date (e.g., Hopper et al., 2010, McKenzie-Mohr et al., 2012). Current timelines for support, expectations of youth, and service provision need to be reviewed through a trauma-informed lens to determine how service delivery may retraumatise youth and how best to appropriately support youth and their development to achieve sustainable outcomes. Policy and funding obligations and organisational procedures and ideologies should also be reviewed in this way.

The results of this systematic review also identified a predominant research emphasis on examining health burdens and undesired behaviours whilst excluding housing as an outcome. This is consistent with previous reviews (Altena et al., 2010; Morton et al., 2020; Slesnick et al., 2009; Wang et al., 2019) and further highlights the narrow focus of homelessness interventions on changing individuals' behaviour to reduce homelessness. Only three out of ten studies measured housing status separate from investigating whether youth had returned home (Barber et al., 2005; Dostaler & Nelson, 2009; Peled et al., 2005). Even then, studies simply measured housing type at exit. Three studies included 'runaway behaviour (i.e., number of days on the run)' which, in addition to its mildly pejorative implication that youth are choosing to run, does not meaningfully investigate whether homelessness had been addressed. Further, the studies which measured 'days on the run' included multiple measures of family contact and perceived family support (Thompson et al., 2000; Thompson et al., 2002; Pollio et al., 2006), underlining the emphasis on family reunification as the primary, or most valued, housing outcome. These studies found that 'days on the run' increased at six-month follow-up, suggesting a failure to find a sustainable solution in pursuit of family reconciliation goals.

Only one study attempted to determine contextual factors needed for housing. Barber et al. (2005) investigated predictors of successful housing outcomes and found that no background, individual, or service factors were significant however low methodological quality prevented accurate and meaningful interpretation of these results. In comparison, qualitative investigation found various structural causes that seemed to maintain homelessness. Participants reported low-income rates, living in poverty, and discrimination from workplaces and educators as barriers to housing sustainability (Dostaler & Nelson, 2009). These reports align with other research that has found that unemployment and income rates are associated with homelessness, and that this type of social exclusion maintains homelessness for youth (Heerde, Bailey, Toumbourou, Rowland, & Catalano, 2020). Taken together, these findings demonstrate that current homelessness interventions are grounded in the assumption that the individual and their family are responsible for creating a pathway out of their homelessness, and neglects to recognise other important developmental, service-level, or systemic-level changes needed to truly prevent youth homelessness. A focus only on the individual is too narrow to adequately address youth homelessness long-term.

The results of this systematic review highlight the importance of implementation science to bridge the research-practice gap in social work, with less reliance on programs written by researchers and tested with RCTs (Munro, Skouteris, Newlands, & Walker, 2021). Implementation science encourages researchers to move beyond focusing solely on intervention efficacy to consider the public health impact of interventions by identifying: (1) service reach; i.e., who is serviced by the intervention; (2) adoption, i.e., who applies the intervention; (3) generalisability; (4) adaptations of the intervention; (5) implementation personnel and conditions; (6) fidelity; (7) costs; and (8) the interplay between setting-level factors, context and individual characteristics (Glasgow et al., 2019). The inclusion of qualitative as well as quantitative data to capture the perspectives of staff and youth is also necessary to determine the efficacy of interventions, and to really understand why they work (Thomas, Ciliska, Dobbins, & Micucci, 2004). This was true of Dostaler and Nelson (2009) study where qualitative enquiry added context to quantitative results, offering a richer understanding of youth experience and outcomes. A richer understanding can lead to better service delivery, increased service uptake, and more positive, longer-term outcomes, further resulting in reduced individual, social, and

economic burdens that arise from youth homelessness.

4.1. Limitations

This review summarised current research evaluating youth refuge services and has revealed significant limitations of research to date. Firstly, studies were found from only a few OECD countries (i.e. USA, Canada, Israel, and the Netherlands) reflecting the lack of global data and understanding of youth refuges currently available. The studies included in this review were also predominately rated as low methodological quality based on the MMAT. Further, many of the study authors also recognised that the outcomes measures they had utilised were unvalidated, too simple, too broad, and/or were limited to quantitative measures which restricted the richness of data and broader understandings of the complexities of youth (e.g., Barber et al., 2005; Gwadz et al., 2017; Krabbenborg et al., 2017; Thompson et al., 2000; Thompson et al., 2002; Pollio et al., 2006). Results were therefore ambiguous, simplified, lacked context, and prevented true comparison of refuge models. Furthermore, some results were not collected from the youth who experienced the refuge intervention. Three studies used proxy interviews with family members or social workers in cases where youth could not be located at follow-up (Thompson et al., 2002; Peled et al., 2005; Pollio et al., 2006). Missing data and high attrition rates were common across all studies, and in four out of ten studies, only those youth whose parents gave permission to be included in the research were eligible. Further, most of these participants were living at home when they completed the follow-up interview resulting in limited generalisability to the broader youth population (Heinze et al., 2013; Pollio et al., 2006; Thompson et al., 2000; Thompson et al., 2002).

In terms of understanding the models themselves, incomplete and limited descriptions of interventions meant it was difficult to ascertain what was provided to youth, intervention adherence, or to adequately compare practice models. Moreover, comparison conditions tended to offer similar if not the same interventions, further reducing the ability to assess the efficacy of youth refuge settings specifically. Most of the included data is roughly 25 years old at the time of writing this review – six studies collected data between 1995 and 1999 (Barber et al., 2005; Peled et al., 2005; Pollio et al., 2006; Spiro et al., 2009; Thompson et al., 2002; Thompson et al., 2000) and the most contemporary data is nearly a decade old (Gwadz et al., 2017). A lack of recent evaluation could explain why some more modern practice models have been excluded.

Overall, these limitations impact the reported efficacy of youth refuge, and suggest that more rigorous, standardised, longitudinal, mixed-methods research that addresses these methodological concerns is needed. Despite these limitations, this research base shows promise for youth refuge and helps highlight improvements needed within future research to meaningfully understand the complex, multi-layered interventions necessary to end youth homelessness.

5. Conclusions and implications for future research

Youth refuges receive considerable public expenditure and are an integral part of global homelessness strategies. The results of this review suggest that youth refuge can have short- to medium-term positive impacts across a broad range of health, behavioural, psychosocial, and housing outcomes in relatively short periods of time. However, the existing research base is limited to a select few countries, is not sufficiently rigorous, nor does it adequately address long-term outcomes or, importantly, evaluate trauma-related needs or outcomes. When working with homeless populations, trauma-informed practice models are increasingly recognised as important to address perpetuating factors that prevent sustained housing or achievement within other health and wellbeing domains. This review highlights that there is currently no research evidence that trauma-informed practice models are being utilised within youth refuge. Practice models included in this review were more akin to case management approaches than whole- of-organisation models, were narrowly focused on strengths and building independence, and offered no greater benefits to youth above a standard refuge model.

These results indicate that more rigorous, mixed-method evaluations of youth refuge that include both staff and youth voices are needed to not only determine whether positive changes can be maximised and sustained, but to ensure services: (1) meet the developmental needs of adolescents; (2) address the experience of trauma; and (3) prioritise the creation of sustainable pathways to permanently exit homelessness. Future research should focus on enhancing understanding and measurement of the factors that predict improved outcomes to determine what aspects of service delivery and implementation help or hinder progress. Few studies were found to meaningfully measure housing as an outcome which, considering the evidence that homelessness is traumagenic and leads to numerous health and wellbeing difficulties across the lifespan, means future research must prioritise this important goal of service delivery. Additionally, there is no guidance on how to deliver programs effectively in these unique settings and contexts. It is important that future evaluations not only examine individual-level outcomes but also consider service-level and system-level characteristics across a range of global contexts. This knowledge and its subsequent translation into practice has the potential for large economic savings and a significant reduction of individual health and wellbeing costs. Developing a more nuanced understanding of what works through implementation science, without a reliance on RCT evaluations and including the voice of both practitioners and homeless youth, will help determine evidence-based best practice that can be implemented and replicated in the real world.

CRediT authorship contribution statement

Anda Jaman: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft. **Tatiana Corrales:** Writing – review & editing, Supervision. **Rachael Green:** Methodology, Writing – review & editing, Supervision. **Emma Galvin:** Validation, Formal analysis. **Melissa Savaglio:** Validation, Formal analysis. **Claire Edmanson:** Writing – review & editing. **Helen Skouteris:** Conceptualization, Methodology, Validation, Writing – review & editing, Supervision.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2025.108487.

Data availability

Data will be made available on request.

References

Achenbach, T. M. (1997). *Manual for the Young Adult Behaviour Checklist and Young Adult Self-Report.* Burlington: Department of Psychiatry, University of Vermont.

Altena, A. M., Brilleslijper-Kater, S. N., & Wolf, J. R. (2010). Effective interventions for homeless youth: A systematic review. *American Journal of Preventive Medicine, 38*(6), 637–645. https://doi.org/10.1016/j.amepre.2010.02.017

Australian Bureau of Statistics [ABS]. (2012). 4922.0 - Information Paper - A Statistical Definition of Homelessness [https://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4922.0]. Accessed 18 December 2021.

Australian Institute of Health and Welfare [AIHW] (2021). *Specialist homelessness services annual report 2020–21*. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/about. Accessed 18 January 2022.

AIHW (2020). Australia's children. Cat. no. CWS 69. Canberra: AIHW. https://doi.org/10.25816/5ebca4d0fa7dd.

AIHW (2025). *Specialist homelessness services annual report 2023–24*. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/young-people-presenting-alone. Accessed 28 April 2025.

Barber, C. C., Fonagy, P., Fultz, J., Simulinas, M. A., & Yates, M. (2005). Homeless near a thousand homes: Outcomes of homeless youth in a crisis shelter. *American Journal of Orthopsychiatry, 75*(3), 347–355. https://doi.org/10.1037/0002-9432.75.3.347

Bender, K. A., Thompson, S. J., Ferguson, K. M., Yoder, J. R., & Kern, L. (2014). Trauma among street-involved youth. *Journal of Emotional and Behavioural Disorders, 22*, 53–64. https://doi.org/10.1177/1063426613476093

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence, & Abuse, 10*(4), 375–388. https://doi.org/10.1177/1524838009339757

Centrepoint (2024). Hidden in Plain Sight: Understanding youth homelessness in the UK 2023-2024 [Research report]. https://centrepoint.org.uk/ending-youth-homelessness/what-youth-homelessness/stats-and-facts#:~:text=Across%20the%20United%20Kingdom%2C%20we,107%2C000%20young%20people%20faced%20homelessness. Accessed 28 April 2025.

Christie, D., & Viner, R. (2005). Adolescent development. *BMJ, 330*(7486), 301–304. https://doi.org/10.1136/bmj.330.7486.301

Crosby, S. D. (2015). An ecological perspective on emerging trauma-informed teaching practices. *Children & Schools, 37*(4), 223–230. https://doi.org/10.1093/cs/cdv027

DeChants, J., Bender, K., & Stone, K. (2019). Incorporating youth voice into services for young people experiencing homelessness. In H. Larkin (Ed.), *Homelessness Prevention and Intervention in Social Work* (pp. 335–338). Switzerland: Springer Nature. https://doi.org/10.1007/978-3-030-03727-7_16.

Dostaler, T., & Nelson, G. (2009). A process and outcome evaluation of a shelter for homeless young women. *Canadian Journal of Community Mental Health, 22*(1), 99–112. https://doi.org/10.7870/cjcmh-2003-0007

Glasgow, R. E., Harden, S. M., Gaglio, B., Rabin, B., Smith, M. L., Porter, G. C., & Estabrooks, P. A. (2019). RE-AIM planning and evaluation framework: Adapting to new science and practice with a 20-year review. *Frontiers in Public Health, 7*, 64. https://doi.org/10.3389/fpubh.2019.00064

Grey, C. N., Woodfine, L., Davies, A. R., & Azam, S. (2019). Childhood adversity in those with lived experiences of homelessness in Wales: A cross-sectional study. *The Lancet, 394*, S45. https://doi.org/10.1016/S0140-6736(19)32842-9

Goodman, L. A., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*(11), 1219–1225. https://doi.org/10.1037/0003-066X.46.11.1219

Gwadz, M. V., Cleland, C. M., Leonard, N. R., Bolas, J., Ritchie, A. S., Tabac, L., & Powlovich, J. (2017). Understanding organizations for runaway and homeless youth: A multi-setting quantitative study of their characteristics and effects. *Children and Youth Services Review, 73*, 398–410. https://doi.org/10.1016/j.childyouth.2017.01.016

Gwadz, M., Freeman, R. M., Kutnick, A. H., Silverman, E., Ritchie, A. S., Cleland, C. M., & Bolas, J. (2018). Do programs for runaway and homeless youth work? A qualitative exploration from the perspectives of youth clients in diverse settings. *Frontiers in Public Health, 6*, 112. https://doi.org/10.3389/fpubh.2018.00112

Hadland, S. E., Wood, E., Dong, H., Marshall, B. D., Kerr, T., Montaner, J. S., & DeBeck, K. (2015). Suicide attempts and childhood maltreatment among street youth: A prospective cohort study. *Pediatrics, 136*(3), 440–449. https://doi.org/10.1542/peds.2015-1108

Haigh, R., Harrison, T., Johnson, R., Paget, S., & Williams, S. (2012). Psychologically informed environments and the "Enabling Environments" initiative. *Housing, Care and Support, 15*(1), 34–42. https://doi.org/10.1108/14608791211238412

Heerde, J. A., Bailey, J. A., Toumbourou, J. W., Rowland, B., & Catalano, R. F. (2020). Prevalence of homelessness and co-occurring problems: A comparison of young adults in Victoria, Australia and Washington State, United States. *Children and Youth Services Review, 109*, Article 104692. https://doi.org/10.1016/j.childyouth.2019.104692

Heinze, H. J. (2013). Beyond a bed: Support for positive development for youth residing in emergency shelters. *Children and Youth Services Review, 35*(2), 278–286. https://doi.org/10.1016/j.childyouth.2012.10.018

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information, 34*(4), 285–291. https://doi.org/10.3233/EFI-180221

Hopper, E., Bassuk, L. E., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1). https://doi.org/10.2174/1874924001003010080

Johnson, R., & Haigh, R. (2010). Social psychiatry and social policy for the 21st century-new concepts for new needs: The 'psychologically-informed environment'. *Mental Health and Social Inclusion, 14*(4), 30–35. https://doi.org/10.5042/mhsi.2010.0620

Johnstone, M., Jetten, J., Dingle, G. A., Parsell, C., & Walter, Z. C. (2015). Discrimination and well-being amongst the homeless: The role of multiple group membership. *Frontiers in Psychology, 6*, 739. https://doi.org/10.3389/fpsyg.2015.00739

Kahan, D., Lamanna, D., Rajakulendran, T., Noble, A., & Stergiopoulos, V. (2020). Implementing a trauma-informed intervention for homeless female survivors of gender-based violence: Lessons learned in a large Canadian urban centre. *Health & Social Care in the Community, 28*(3), 823–832. https://doi.org/10.1111/hsc.12913

Kidd, S. A. (2007). Youth homelessness and social stigma. *Journal of Youth and Adolescence, 36*(3), 291–299. https://doi.org/10.1007/s10964-006-9100-3

Krabbenborg, M. A., Boersma, S. N., van der Veld, W. M., van Hulst, B., Vollebergh, W. A., & Wolf, J. R. (2017). A cluster randomized controlled trial testing the effectiveness of Houvast: A strengths-based intervention for homeless young adults. *Research on Social Work Practice, 27*(6), 639–652. https://doi.org/10.1177/1049731515622263

Kuskoff, E. (2018). The importance of discourse in homelessness policy for young people: An Australian perspective. *Journal of Youth Studies, 21*(3), 376–390. https://doi.org/10.1080/13676261.2017.1380789

MacKenzie, D., Flatau, P., Steen, A., & Thielking, M. (2016). The cost of youth homelessness in Australia: research brief. doi: 10.4225/50/5722A58AE5600.

McKenzie-Mohr, S., Coates, J., & McLeod, H. (2012). Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention. *Children and Youth Services Review, 34*(1), 136–143. https://doi.org/10.1016/j.childyouth.2011.09.008

Milburn, N. G., Rosenthal, D., & Rotheram-Borus, M. J. (2005). Needed: Services research with homeless young people. *Journal of Health & Social Policy, 20*(3), 1–9. https://doi.org/10.1300/J045v20n03_01

Minnery, J., & Greenhalgh, E. (2007). Approaches to homelessness policy in Europe, the United States, and Australia. *Journal of Social Issues, 63*(3), 641–655.

Morton, M. H., Kugley, S., Epstein, R., & Farrell, A. (2020). Interventions for youth homelessness: A systematic review of effectiveness studies. *Children and Youth Services Review, 116*, Article 105096. https://doi.org/10.1016/j.childyouth.2020.105096

Munro, E. R., Skouteris, H., Newlands, F., & Walker, S. (2021). Guest editorial. *Journal of Children's Services, 16*, 177–183. https://doi.org/10.1108/JCS-09-2021-083

O'Donnell, M., Varker, T., Cash, R., Armstrong, R., Di Censo, L., Zanatta, P., ... & Phelps, A. (2014). The trauma and homelessness initiative. *Report prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health and Vincent Care Victoria*.

Organisation for Economic Co-operation and Development—Social Policy Division—Directorate of Employment, Labour and Social Affairs. (2020b). HC3.2 national strategies for combating homelessness. https://www.oecd.org/els/family/HC3-2-Homeless-strategies.pdf. Accessed 15 December 2021.

Organisation for Economic Co-operation and Development—Social Policy Division—Directorate of Employment, Labour and Social Affairs. (2020c). Better data and policies to fight homelessness in the OECD. [Policy Brief]. http://oe.cd/homelessness-2020. Accessed 20 January 2022.

Ortiz-Ospina, E. & Roser, M. (2017). *Homelessness*. https://ourworldindata.org/homelessness. Accessed 17 November 2022 [online resource].

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*. https://doi.org/10.1136/bmj.n71

Peled, E., Spiro, S., & Dekel, R. (2005). My home is not my castle: Follow-up of residents of shelters for homeless youth. *Child and Adolescent Social Work Journal, 22*(3), 257–279. https://doi.org/10.1007/BF02679472

Pinnock, H., Epiphaniou, E., Sheikh, A., Griffiths, C., Eldridge, S., Craig, P., & Taylor, S. J. (2015). Developing standards for reporting implementation studies of complex interventions (StaRI): A systematic review and e-Delphi. *Implementation Science, 10*(1), 1–10. https://doi.org/10.1186/s13012-015-0235-z

Pollio, D. E., Thompson, S. J., Tobias, L., Reid, D., & Spitznagel, E. (2006). Longitudinal outcomes for youth receiving runaway/homeless shelter services. *Journal of Youth and Adolescence, 35*(5), 852–859. https://doi.org/10.1007/s10964-006-9098-6

Rew, L. (2008). Caring for and connecting with homeless adolescents. *Family & Community Health, 31*, 42–51. https://doi.org/10.1097/01.FCH.0000304017.13255.12

Shulman, S., Seiffge-Krenke, I., & Walsh, S. D. (2017). Is sexual activity during adolescence good for future romantic relationships? *Journal of Youth and Adolescence, 46*(9), 1867–1877. https://doi.org/10.1007/s10964-017-0699-z

Slesnick, N., Dashora, P., Letcher, A., Erdem, G., & Serovich, J. (2009). A review of services and interventions for runaway and homeless youth: Moving forward. *Children and Youth Services Review, 31*(7), 732–742. https://doi.org/10.1016/j.childyouth.2009.01.006

Spiro, S. E., Dekel, R., & Peled, E. (2009). Dimensions and correlates of client satisfaction: An evaluation of a shelter for runaway and homeless youth. *Research on Social Work Practice, 19*(2), 261–270. https://doi.org/10.1177/1049731508329395

Taylor, K. M., & Sharpe, L. (2008). Trauma and post-traumatic stress disorder among homeless adults in Sydney. *Australian & New Zealand Journal of Psychiatry, 42*(3), 206–213. https://doi.org/10.1080/00048670701827218

Thomas, B. H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: Providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing, 1*(3), 176–184. https://doi.org/10.1111/j.1524-475X.2004.04006.x

Thompson, S. J., Pollio, D. E., & Bitner, L. (2000). Outcomes for adolescents using runaway and homeless youth services. *Journal of Human Behavior in the Social Environment, 3*(1), 79–97. https://doi.org/10.1300/J137v03n01_05

Thompson, S. J., Pollio, D. E., Constantine, J., Reid, D., & Nebbitt, V. (2002). Short-term outcomes for youth receiving runaway and homeless shelter services. *Research on Social Work Practice, 12*(5), 589–603. https://doi.org/10.1177/1049731502012005001

Vitopoulos, N., Cerswell Kielburger, L., Frederick, T. J., McKenzie, K., & Kidd, S. (2017). Developing a trauma-informed mental health group intervention for youth

transitioning from homelessness. *Professional Psychology: Research and Practice, 48*(6), 499. https://doi.org/10.1037/pro0000168

Wang, J. Z., Mott, S., Magwood, O., Mathew, C., Mclellan, A., Kpade, V., & Andermann, A. (2019). The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: A systematic review. *BMC Public Health, 19*(1), 1–22. https://doi.org/10.1186/s12889-019-7856-0

Woodcock, J., & Gill, J. (2014). Implementing a psychologically informed environment in a service for homeless young people. *Housing, Care and Support, 17*(1), 48–57. https://doi.org/10.1108/HCS-12-2013-0024