# Evidence Summary

## Individual Counseling and Related Interventions for Youth Homelessness

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### Highlights

- Evidence suggests individual counseling and treatment interventions can improve mental health and reduce substance use and sexual risk behaviors among youth experiencing homelessness.
- Rigorous replication studies with longer follow up periods are needed to understand how well these interventions work in different contexts and for youth with different characteristics.
- We also need more research into which youth choose to participate and remain engaged in these types of interventions to inform better targeting and implementation models.

### Overview

The **Voices of Youth Count** initiative's systematic evidence review is the most comprehensive synthesis of evaluation evidence on programs and practices related to youth homelessness to date.[1] This document is one in a series of seven topical evidence summaries derived from the longer evidence review brief. Here, we summarize evaluations of Individual counseling and treatment interventions for youth experiencing homelessness. The evidence here includes only impact evaluations designed to assess measurable changes in outcomes due to specific programs and practices. Other kinds of evaluation, including assessments of program implementation, processes, or participant experiences, will be summarized and reported elsewhere.

**Individual counseling and treatment interventions** typically involve non-housing, non-family-based interventions primarily focused on delivering therapeutic or health-related counseling or treatment to youth experiencing homelessness. These interventions complement crisis services, such as drop-in centers, shelters, or street outreach. We broadly subgroup these interventions as brief interventions (involving fewer than six sessions or less than one month of duration), more intensive health-risk reduction treatment, and more intensive mental health treatment. Of the 62 studies of 51 programs included in this evidence review, 24 studies evaluated 21 individual counseling and treatment programs, generally focused on mental health, substance use, or sexual risk.

### Evidence Summary

These evaluations showed promising results for therapeutic and counseling interventions complementing crisis services. Brief motivational interventions tended to yield short-term improvements in attitudes concerning risk-behaviors and some aspects of social-emotional wellbeing. More intensive health-risk reduction interventions tended to focus on HIV and substance use behaviors, and all showed at least some success. For example, the Community Reinforcement Approach (CRA) showed increases in condom use and reductions in substance use and depression.

1. For detailed information about our evidence review methods and findings, please refer to Morton, M.H., Kugley, S., Epstein, R.A., & Farrell, A.F. (2019). Missed Opportunities: Evidence on Interventions for Addressing Youth Homelessness. Chicago, IL: Chapin Hall at the University of Chicago.

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More intensive mental health treatments, such as cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) approaches, showed reductions in symptoms associated with mental health problems like post-traumatic stress, depression, hopelessness, anxiety, and anger. Notably, there were no randomized evaluations of more intensive mental health interventions, specifically with youth experiencing homelessness in the U.S.

## Included Studies of Individual Counseling and Related Interventions

| Description | Study design* | Results |
|---|---|---|
| **Brief interventions** | | |
| **Brief motivational intervention (BMI)** (Peterson et al., 2006; Baer et al., 2007) | | |
| A brief feedback and motivational intervention for substance use among homeless adolescents (14-19). | Randomized evaluations (two evaluations; n=285, n=117) | First evaluation: reduced illicit drug use at one-month follow-up; effects faded by 3-month follow-up. Second evaluation: no effects on drug use, but improved service utilization at 1-month follow-up; effects faded by 3-month follow-up. |
| **AWARE** (Tucker et al., 2017) | | |
| A group-administered motivational interviewing brief intervention to reduce risk behaviors among homeless young adults (18-25). | Randomized evaluation (n=200) | Reduced alcohol use and unprotected sex; improved attitudes related to drug and condom use. |
| **Project SAFE** (Bender et al., 2016) | | |
| A group-administered brief risk detection skills intervention among homeless youth (18-21). | Randomized evaluation (n=97) | Randomized evaluation (n=97) |
| **A brief, street-based intervention for homeless female youth** (Rew et al., 2016) | | |
| A brief street-based group intervention to increase psychological capital and health outcomes among homeless young women (18-23). | Partially randomized evaluation (n=80) | Improved safe sex self-efficacy; other psychological capital outcomes (e.g., hope, resilience) improved for both treatment and control groups. |
| **Becoming a Responsible Teen (BART)** (Carmona et al., 2014) | | |
| A brief HIV prevention and substance abuse treatment group intervention for youth (14-20) administered along with either the Community Reinforcement Approach, Motivational Enhancement Therapy, or case management. | Pre-post evaluation, no comparison group (n=270)* | Increased condom use and reduced sex partners. |
| **Nurse-led brief HIV/AIDs prevention Hepatitis Health Promotion (HHP) intervention** (Nyamathi et al., 2012; 2013) | | |
| A brief 3 session nurse-led interactive group intervention for homeless youth (15-25). | Pre-post evaluation, no service-as-usual comparison group (n=154)* | Reduced alcohol and drug use. Improved HIV, HBV, and HCV-related knowledge, and psychological wellbeing. |
| **Artist-led brief Art Messaging (AM) program** (Nyamathi et al., 2012; 2013) | | |
| A brief 3 to 4 session art faculty-led group intervention for homeless youth (15-25) using different forms of art to address health-related topics. | Pre-post evaluation, no service-as-usual comparison group (n=154)* | Reduced alcohol and drug use. Improved HIV, HBV, and HCV-related knowledge. |

| Description | Study design* | Results |
|---|---|---|
| **Brief intervention (BI) to reduce alcohol use and sexual risk** (Thompson et al., 2017) | | |
| A brief motivational intervention (BI) to reduce both alcohol use and sexual risk behaviors among homeless young adults (17-22) vs. a brief educational comparison (EC) intervention involving sharing normative information. | Pre-post evaluation, no comparison group (n=210)* | Improved mental health, employment, and housing stability. No improvements in education. |
| **Drug Prevention in Youth** (Fors & Jarvis, 1995) | | |
| A group-administered, peer-led drug abuse risk reduction program for runaway and homeless youth (12-17). | Non-randomized evaluation comparing youth in shelters assigned to peer-led, adult-led, and non-intervention groups. Shelters self-selected into the intervention group.* | Improved knowledge and intention outcomes related to substance use, but not actual substance use outcomes. |
| **More intensive health-risk reduction treatment** | | |
| **Community Reinforcement Approach (CRA)** (Slesnick 2013a; 2013b; Guo et al., 2014) | | |
| A comprehensive cognitive-behavioral intervention for the treatment of substance abuse problems, including with people with co-occurring disorders (evaluated with runaway adolescents, 12-17). | Pre-post evaluation, no service-as-usual comparison group (n=61)* | Reduced substance use but not depressive symptoms. |
| **Community Reinforcement Approach (CRA) plus HIV prevention** (Slesnick et al., 2007; Slesnick & Kang, 2008b; Grafsky et al., 2011) | | |
| CRA (see above) plus 4 sessions that covered AIDS education and assessment of risk, risk reduction, and skills practice with street-living youth (14-22). | Randomized evaluation (n=180) | Reduced substance use and depression and increased social stability. |
| **Community Reinforcement Approach (CRA) plus mentoring** (Bartle-Haring et al., 2012) | | |
| CRA (see above) plus 12 mentoring sessions with homeless youth (14-22). | Pre-post evaluation, no comparison group (n=48)[2]* | Reduced problem consequences associated with substance use. |
| **Project Legacy** (Minority AIDS Initiative, 2013) | | |
| A group-administered HIV risk prevention motivational intervention for homeless young adults (18-24). | Pre-post evaluation, no comparison group (n=288)* | Improved attitudes and knowledge related to HIV and safe sex, along with social hope about future work and social support. |
| **More intensive mental health treatment** | | |
| **Cognitive behavioral therapy for trauma in street children (CBT-TSC)** (Shein-Szydlo et al., 2016) | | |
| 12 weekly cognitive behavioral therapy sessions with trauma-related treatment adaptations for street adolescents (12-18) reporting at least moderate PTSD in Mexico. | Randomized evaluation (n=100) | Reduced a broad range of mental health symptoms. |

2. Although this evaluation was initially designed as an RCT, the service-as-usual comparison group data are not used in the analysis due to incomplete data. Because the control group was not used in the analysis, we only include the 48 intervention group participants in the sample size in this table.

| Description | Study design* | Results |
|---|---|---|
| **Cognitive behavioral therapy (CBT)** (Hyun et al., 2005) | | |
| Cognitive behavioral group therapy for runaway adolescents in South Korea. | Randomized evaluation (n=27) | Reduced depression and increased self-efficacy; no effects on self-esteem. |
| **Youth Education in Spiritual Self-Schema (YESSS) program** (Grabbe et al., 2012) | | |
| A mindfulness meditation intervention to enhance resilience among homeless youth (17-23) at high risk for mental health problems and substance abuse. | Pre-post evaluation, no comparison group (n=39)* | Increased spirituality, mental wellness, psychological symptoms, and resilience; no changes in impulsiveness. |
| **Traumatic incident reduction (TIR)** (Descilo et al., 2010) | | |
| A trauma resolution method conducted with urban at-risk youth and unaccompanied minor refugees (11-18). | Pre-post evaluation, no comparison group (n=31)* | Reduced post-traumatic stress. |
| **Relationship-based group intervention** (McCay et al., 2011) | | |
| A six-session program focused on strengthening relationships that would guide, support, and nurture street-involved youth (16-24) in Canada. | Non-randomized evaluation comparing youth who chose to participate in the intervention to those who chose not to (n=15).* | Improved social connectedness; no significant between-group differences for hopelessness, self-esteem, resilience, suicidality, or substance abuse. |
| **Dialectical Behavior Therapy (DBT)** (McCay et al., 2015) | | |
| A 12-week behavioral therapy involving both individual- and group-based sessions conducted with high-risk street-involved youth (16-24) in Canada. | Non-randomized evaluation comparing youth who chose to immediately participate to the wait-list (later start) (n=139). | Reduced mental health symptoms and improved resilience, self-esteem, and social connectedness. |

* High risk of bias: All evaluations, even the most rigorous, have some risk of bias. Bias is especially likely when an evaluation lacks a credible comparison group to assess what would have happened without the intervention. Without such a comparison group, we can't know if changes occur (for example) because youth got older, they were already motivated to improve, or due to other influences in the young person's life. We indicate evaluations as "high risk of bias" if they lack a "usual services" comparison or control group, or if the group was created without specific efforts (like statistical matching) to create comparable groups. Without similar comparison groups, findings are interpreted with additional caution. In some cases, it is necessary to rely on less rigorous studies to inform interventions while we await additional evidence.

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