Risk and Resilience Factors for Youth Homelessness in Western Countries: A Systematic Review

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Objectives: The experience of homelessness for young people can affect social, emotional, and physical development, resulting in poorer physical and mental health outcomes. To reduce rates of youth homelessness, a better understanding of both risk and resilience is needed to inform future intervention development. This article presents a systematic review of published research reporting risk or resilience factors related to homelessness among young people in Western countries.

Methods: After thorough examination for inclusion criteria, 665 abstracts of peer-reviewed quantitative studies of risk or resilience factors for homelessness among young people (ages 0–25) that included an adequate comparison group (e.g., not homeless) were selected. After abstract and full-text screening, 16 articles were reviewed. A primary prevention framework was used to create an explanatory model for the onset of homelessness using risk and resilience factors.

Results: Common risk factors for youth homelessness included difficulties with family, mental health or substance use problems, a history of problem behaviors, a history of foster care, homelessness as a child, and running away. Common protective factors included a supportive family, a college education, and high socioeconomic status. Findings were integrated into a provisional developmental model of youth homelessness risk. Clinical implications of the model for service development are discussed, and a model for monitoring homelessness risk and resilience factors is proposed.

Conclusions: Factors affecting homelessness risk among youths and adults differ, with family, foster care, and schooling playing a much more important role among youths. Findings highlight opportunities for youth homelessness prevention strategies and monitoring.

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Homelessness is a major public health problem in the United States and across the world. It affects millions of people and has a devastating impact on physical, emotional, and spiritual well-being. For young people under age 18, the impact of homelessness is particularly concerning. It is estimated that between 4% and 8% of adolescents and young adults in the United States experience homelessness and approximately 1.5 million U.S. children experience homelessness annually (1). Homelessness among youths is associated with poor health outcomes (2) and difficulties with learning, cognition, social skills, and emotion regulation (3), as well as increased risks of victimization, violence, and chronic stressors, such as hunger (4). Given that a history of youth homelessness raises the risk of future homelessness as an adult (5), understanding and preventing youth homelessness should be a priority.

Current efforts to reduce homelessness are largely tertiary prevention strategies aimed at supporting individuals who have already lost housing (6) and primarily focusing on adults who are chronically homeless. Although these efforts are valuable and improve health and housing outcomes, they do not decrease the incidence of new-onset homelessness. To reduce rates of homelessness, primary prevention is critical (7). However, our understanding of risk factors that contribute to youths becoming homeless is scattered, limiting development of primary prevention strategies. The literature lacks a systematic compilation of factors that are associated with or contribute to young people becoming homeless. In addition,

HIGHLIGHTS

- Factors affecting risk of homelessness among youths differ from those for adults.
- Family connection, foster care, poor school performance, and a history of running away or homelessness are important factors to consider for youth homelessness prevention.
- On the basis of the findings, a risk identification system is proposed to assist with directing supports to youths at risk of homelessness.

although significant research focuses on factors conveying risk of homelessness, there is limited research on factors that are protective against becoming homeless, an important consideration for primary prevention. Further, systemic societal issues, such as housing costs, are clear risk factors for homelessness (8), but the impact of individual risk factors for homelessness within these wider societal factors is also unclear.

To support the development of homelessness prevention strategies targeted toward young people, this review systematically examined risk and resilience factors associated with homelessness among young people under age 25 in Western countries. To summarize these factors within a primary prevention framework, we propose an explanatory developmental model for the onset of homelessness among young people. This model includes the identified risk and resilience factors and highlights points for the development of future interventions to prevent homelessness among youths. Clinical implications of this model are discussed, including a proposed method for monitoring homelessness risk and resilience factors in existing services: Homelessness Outreach and Monitoring of Environments (HOME).

METHODS

Definitions

Given the focus of this review on primary prevention, our definition of homelessness was designed to be as inclusive as possible to capture all persons who lack stable and safe housing and followed the definition given by the McKinney-Vento Homeless Assistance Act of 1987. This legislation defined homeless persons as those lacking a fixed, regular, and adequate nighttime residence or having a nighttime residence that is a publicly or privately operated shelter, a public or private place that provides temporary residence for those intended to be institutionalized, or a public or private place not designed for use as a regular sleeping accommodation for human beings (9). Our definition also included those exiting an institution—e.g., jail or a hospital—where they resided temporarily (who were in a shelter or place not meant for human habitation immediately prior to entering that institution); those living in overcrowded or temporary residences; those who "couch surf" or live with various friends or family members because they do not have a permanent residence (10); those experiencing frequent moves (two or more in the past 60 days); those experiencing continued difficulties maintaining housing because of disability, domestic violence, or employment barriers; and those at imminent risk of homelessness (persons forced to leave their current housing within the next 14 days, who would subsequently be left without a place to go or resources to get housing).

In the literature, homelessness is also differentiated as an acute or chronic experience. Homelessness is a transient state, and most people will experience only short-term or acute homelessness (11). Chronic homelessness is typically defined as being continuously homeless for more than 1 year or having experienced four or more episodes of homelessness in the past 3 years (12).

Search Selection and Strategy

A systematic review was completed of quantitative research articles examining risk and resilience factors for homelessness among youths. For this review, we performed a standardized search of abstracts in PubMed (1950–2019), and PsycINFO (1974–2019) databases on January 23, 2020. Search terms included risk AND/or resilience AND homelessness AND/or homeless AND youth AND/or young AND/or child AND/or adolescent in abstracts or titles. The PubMed search resulted in 543 abstracts, and the PsycINFO search resulted in 611 results (see online supplement to this article for further details). Thus the initial search yielded 1,154 articles, including 492 duplicates that were removed. Three additional articles were identified through reference lists and by speaking with field experts. The inclusion criteria were that the article was published in English and peer reviewed, it reported on a quantitative examination of risk or resilience factors for homelessness among young people (ages 0–25), and the study had an adequate comparison group (e.g., nonhomeless). Articles examining participants from non-Western countries were excluded, because there were not enough studies in this area to focus on system-level differences between Western and non-Western societies. Articles were also excluded if the factors examined occurred only subsequent to homeless experiences (i.e., if the study did not measure any factors occurring prior to homelessness episodes). After article abstracts were screened with the inclusion and exclusion criteria, 38 articles remained. The full texts of these articles were screened for the inclusion criteria, which left 16 articles for these analyses. During full-text screening, articles were primarily excluded because the study lacked an adequate comparison group or examined only factors subsequent to homelessness.

Study Quality Assessment and Data Extraction

The rigor of each study was evaluated by using the Quality Assessment Tool for Observational Cohort and Cross-sectional Studies (www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools), which considers study design, item measurement, selection bias, and detection bias. Risk or resilience factors were extracted from the articles by two independent reviewers (REG, VLT). These factors were defined as any dependent variable for which an association with homelessness was measured in the analyses. Factors that were associated with increased risk of homelessness were considered risk factors, and factors associated with decreased risk of homelessness were considered protective factors. Any disagreements were discussed, and a consensus reached. If it was not possible to extract the data from the publication, the authors were contacted for clarification.

RESULTS

Study design varied. Six of the 16 studies (38%) were considered cross-sectional in design, nine (56%) were considered longitudinal in design, and one (6%) considered retrospective in design. In terms of study rigor, 13 (81%) were considered to

have low selection bias, and 15 (94%) had low detection bias, as defined by Cochrane risk of bias (see online supplement for further details). All studies met at least 70% of the Quality Assessment Tool for Observational Cohort and Cross-sectional Studies criteria, and thus no studies were excluded because they did not meet rigor standards.

Of note, some of the study populations were specific and were not a representative sample of the general population. One study examined the lesbian, gay, and bisexual (LGB) population (13), five examined youths who were in the foster care system (14–18), one examined youths in the youth protection system in Canada (19), and one examined youths discharged from psychiatric treatment (20). Five samples were large-scale surveys of the general population (1, 21–24), one was a nationally representative household sample (2), and the remainder recruited participants from homelessness organizations alongside other control populations (25, 26).

As shown in Table 1, the studies reported specific risk and resilience factors that contributed to or protected youths from experiencing homelessness. In terms of individual factors, one of the most commonly reported risk factors was a history of homelessness (independent from the family) or of running away from home (1, 14, 15, 17, 18, 20, 21, 24). For example, the odds of youths reporting homelessness at 12-month follow-up was 1.39 times higher for those with a history of homelessness in their K–12 records (15), compared with those without such a history. Another study found that the odds of youths reporting homelessness at age 26 was 1.76 times higher for those with a history of running away (14). This risk factor was evident in the general population (1, 21, 24), youth foster care populations (14, 15, 17, 18), and for youths exiting psychiatric care (20).

Other individual risk factors included a poor academic schooling history (15, 22), not completing high school (2), and a history of delinquency or problem behavior (14, 17–19, 26). A poor schooling history was a risk for youths in the foster care system (15) and the general population (22). Those with school adjustment problems at ages 11–18 were 1.57 times more likely to become homeless between ages 18–28 (22), compared with those without such problems. Delinquent behavior was a particular risk factor for youths with a history of foster care and youths recruited from homeless services. In a sample of homeless youths, the odds of having a history of problem behavior were between 2.08 and 3.00 times higher, compared with a sample of youths in a housed control group (19, 26).

A history of substance use was also a common risk factor for homelessness (1, 13, 20, 24, 27), as was a family or peer history of substance use (26). This was evident across all populations examined. When adolescents under age 19 were discharged from psychiatric treatment, those who had a history of substance use were at 1.9 times more likely to become homeless in the subsequent 5 years, compared with those with no history of substance use (20). Although one study found that younger age at first substance use was associated with homelessness for LGB youths, it highlighted that this substance use occurred subsequent to the first episode of homelessness (13).

Another important individual risk factor for homelessness was difficulties with emotional regulation and mental health (14, 24, 25), and this was identified in the general population (24), among youths accessing homelessness services (25), and in foster youth populations (14). As with adults, mental health problems are highly prevalent among homeless youths (1). Among persons who had aged out of foster care, the odds of reporting an episode of homelessness 10 years later were 1.40 times higher among those who also reported a history of a mental disorder (14). In a population-based study, those with a past diagnosis of depression had 1.61 greater odds of homelessness at age 18–28 and those with a history of psychiatric hospitalization had 1.82 greater odds of homelessness at age 18–28, compared with youths without such histories (24).

Another common risk factor found for youth homelessness was a history of trauma, particularly physical abuse (14, 19, 20, 22), which was a risk factor in the general population (22), among youths from the youth protection system (19), among youths discharged from psychiatric treatment (20), and in youth foster care populations (14). For children ages 11–18, the odds of reporting homelessness at 6-year follow-up were 1.27 times higher for those who reported experiences of victimization, defined as the frequency in the past year of violent events (e.g., someone pulling a knife or gun on them) (22). Among young people exiting psychiatric treatment, those with a history of physical abuse were 2.58 times more likely than those without such a history to become homeless (20).

A further risk factor for youths was identifying as having a nonheterosexual sexual orientation; young people who identified as LGB had a risk of homelessness 2.20 times higher, compared with youths who did not identify as LGB (2). For the LGB population, disclosing one's sexual orientation—or "coming out"—at a younger age appeared to increase this risk. In a comparison of homeless and nonhomeless LGB youths, the homeless group had a younger mean age of coming out than did the housed group (13).

In terms of family risk factors, homeless youths from foster care backgrounds often reported a large number of foster care placements (14, 15) or not being in their biological family's care (15). Among young people from foster care backgrounds, those with a history of more than four foster care placements were 1.83 times more likely to report homelessness at 12-month follow-up, compared with those with four or fewer placements (15).

In general population samples, young people from a single-parent family, step-family, or family with nonbiological parents also appeared to be at higher risk of homelessness at age 25 (1). Youths who were unmarried and a parent were three times more likely to report homelessness, compared with youths who were not unmarried parents. Economic difficulties or low household income were also risk factors in the general population (2, 24). Adolescents with families experiencing economic difficulty in the past 12 months had

TABLE 1. Sixteen studies examining risk and resilience factors for homelessness among youths[a]

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
Prince et al., 2019 (18); longitudinal (2-year follow-up)	United States	7,449	Participants from waves 1 and 2 of the National Youth in Transition Database	17–19	30.2%	>54.6%	Risk factor for becoming homeless at age 19: African American, OR=1.41, CI=1.15, 1.72, p<.001; history of homelessness, OR=1.81, CI=1.40, 2.32, p<.001; history of substance use referral, OR=1.69, CI=1.31, 2.18, p<.001; justice system involvement, OR=1.44, CI=1.05, 1.99, p<.05; removal from home because of child behavior problem, OR=1.44, CI=1.17, 1.78, p<.001; removal from home for other reasons, OR=1.36, CI=1.15, 1.59, p<.001; history of running away, OR=3.87, CI=2.51, 5.98, p<.001; state spending on housing supports, B=−43, SE=.12, p<.001; percentage of housing-burdened renters at state level, B=−.97 SE=.07, p<.001	Resilience factor associated with lower odds of homelessness at age 19: connection to a caring adult, OR=.68, CI=.47, .98, p<.05; remained in foster care until age 19, OR=.36, CI=.28, .46, p<.001
Castaños-Cervantes et al., 2018 (25); cross-sectional	Mexico	135	Participants recruited from nine organizations serving homeless and at-risk youths	11–18	0%	NR	Risk factor for being homeless rather than at risk: depression, t=−2.10, p=.002, CI=−.71, −.02; emotion dysregulation, t=−3.12, p=.039, CI=−1.00, −.22; negative emotions intensity t=−2.97, p=.004, CI=2.49, −.49	Resilience factor against being homeless rather than at-risk: well-being t=3.55, p=.001, CI=.21, .75
Morton et al., 2018 (2); cross-sectional	United States	6,295	Participants drawn from a nationally representative sample of households with 13- to 25-year-olds	18–25	NR	NR	Risk factor for reporting homelessness: unmarried with children of their own, RR=3.00, CI=2.37, 3.76; lesbian, gay, bisexual, or transgender, RR=2.20, CI=1.67, 2.89; Black or African American, RR=1.83, CI=1.42, 2.35; did not complete high school, RR=4.46, CI=3.54, 5.57; annual household income <$24,000, RR=2.62, CI=2.10, 3.24	NR
Rosario et al., 2012 (13); cross-sectional	United States	164	Recruited from three community-based organizations focused on lesbian, gay, or bisexual	14–21	51%	78%	Risk factor for being homeless rather than nonhomeless: age at identifying as LGB: homeless, M±SD=14.1±2.7; not homeless,	NR

continued

TABLE 1, *continued*

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
			(LGB) youths and two LGB college student organizations				15.0±2.5, p<.05; age at first same-sex sexual activity: homeless, 13.8±3.5; not homeless, 15.2±3.0, p<.05; age at first alcohol use: homeless, 14.0±2.6; not homeless, 14.8±2.0, p<.05; age at first substance use: homeless, 15.0±2.7; not homeless, 16.2±2.6, p<.05	
Shah et al., 2017 (15); longitudinal (12-month follow-up)	United States	1,202	Database data for persons whose last foster care placement through the public child welfare system occurred between July 2010 and June 2012	17–21	46%	≥25%	Risk factor for becoming homeless at 12-month follow-up: youth is a parent, OR=2.16, CI=1.54, 3.03, p<.001; African American, OR=1.86 CI=1.34, 2.60, p=.002; more than four foster care placements, OR=1.83, CI=1.31, 2.56, p=.001; more than four school moves, OR=1.74, CI=1.20, 2.53, p=.003; disrupted adoption, OR=3.42, CI=1.40, 8.39, p=.007; history of homelessness in K–12 school data, OR=1.39, CI=1.02, 1.91, p=.04; more than four convictions, OR=1.57, CI=1.02, 2.44, p=.04; history of an injury in medical claims data, OR=1.35, CI=1.01, 1.80, p=.04	Resilience factor associated with lower odds of homelessness at 12-month follow-up: ever placed with a relative in foster care, OR=.68 CI=.51, .91, p=.01; high GPA, OR=.62, CI=.41, .94, p=.03
Sznajder-Murray et al., 2015 (1); longitudinal (risk factors for homelessness at age 25)	United States	8,958	Data from the National Longitudinal Survey of Youth–97 from 1997–2009	12–18	51%	Black, 15%; Hispanic, 13%	Risk factor for becoming homeless at age 25: runaway before age 17, B=.78, SD=.27, p<.01; substance use, B=.21, SD=.09, p<.05; being in a step-family, B=.90, SD=.22, p<.001; single-parent family, B=.81, SD=.20, p<.001; living with other family (not biological parents), B=1.08, SD=.29, p<.001	Resilience factor associated with lower odds of homelessness at age 25: Hispanic, B=–.51, SD=.21, p<.05; completing college by age 25, B=–1.37, SD=.36, p<.001; high level of family routine, B=–.78, SD=.39, p<.05
Dworsky et al., 2013 (14); longitudinal (risk factors for homelessness at age 26)	United States	624	Data from the Midwest Evaluation of the Adult Functioning of Former Foster Youth, which followed youths for 10 years beginning in 2002	16–26	NR	NR	Risk factor for homelessness before age 26: male sex, OR=1.45, CI=1.06, 1.99, p<.05; physical abuse, OR=1.44, CI=1.07, 1.93, p<.05; ran away at least once, OR=1.71, CI=1.27, 2.31, p<.001;	NR

continued

TABLE 1, *continued*

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
							mental disorder, OR=1.40, CI=1.05, 1.88, p<.05; total number of foster placements, OR=1.16, CI=1.04, 1.30, p<.01; delinquency, OR=1.12, CI=1.01, 1.24, p<.05	
Embry et al., 2000 (20); longitudinal (5-year follow-up)	United States	83	Participants discharged from psychiatric treatment between 1981 and 1987	<19 (M=17)	54%	22%	Risk factor for homelessness before 5-year follow-up: history of drug or alcohol use, RR=1.90, CI=1.01, 3.58; physical abuse, RR=2.58, CI=1.35, 4.19; in state custody at time of psychiatric admission, RR=2.88, CI=1.64, 5.05; history of running away, RR=2.81, CI=1.39, 5.69; no diagnosis of thought disorder, RR=4.79, CI=1.23, 18.63	NR
Tyler et al., 2011 (21); longitudinal (6- to 8-year follow-up)	United States	7,162	Data from the National Longitudinal Study of Adolescent Health	Grades 7–12	45.4%	37.3%	Risk factor for running away at 6- to 8-year follow-up: family instability, β=1.35, SE=.23, p<.001; history of running away, β=.18, SE=.03, p<.001	Resilience factor associated with lower odds of running away at 6- to 8-year follow-up: female sex, β=−.11, SE=.06, p<.05; school grade at baseline (older), β=−.14, SE=.02, p<.001
Van den Bree et al., 2009 (22); longitudinal (6-year follow-up)	United States	10,433	Data from the National Longitudinal Study of Adolescent Health	11–18 at baseline; 18–28 at follow-up	46.9%	32%	Risk factor for homelessness at 6-year follow-up: school adjustment problems, OR=1.57, CI=1.35, 1.82, p<.01; experiences of victimization, OR=1.27, CI=1.11, 1.45, p<.01	Resilience factor associated with lower odds of homelessness at 6-year follow-up: family relationship quality, OR=.79, CI=.69, .90, p<.01
Bearsley-Smith et al., 2008 (26); cross-sectional	Australia	5,747	Homeless adolescents recruited from agencies; secondary school students at risk or not at risk of homelessness recruited from randomly selected schools	M=15–17 across groups	44.2%	NR	Risk factor for homelessness, compared with those who were not at risk of homelessness: single parent or repartnered family, RR=10.59, CI=5.06, 22.16, p<.001; poor family management (rules and boundaries), RR=1.99, CI=1.40, 2.81, p<.001; family conflict, RR=2.74, CI=1.69, 4.46, p<.001; family drug use, RR=2.08, CI=1.44, 3.00, p<.001;	Resilience factor associated with lower odds of homelessness, compared with those who were not at risk of homelessness: opportunities for family involvement, RR=.47, CI=.28, .80, p<.01; enjoy family

continued

TABLE 1, *continued*

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
							peer drug use, RR=.57, CI=.38, 2.41, p<.01; antisocial peers, RR=1.79, CI=1.33, .86, p<.01; early problem behavior, RR=2.08, CI=1.50, 2.88, p<.001	involvement, RR=.47, CI=.27, .82, p<.01; opportunity for school involvement, RR=.57, CI=.41, .79, p<.01
Robert et al., 2005 (19); cross-sectional	Canada	218 (110 experienced homelessness)	Data from minors enrolled in the Youth Protection Centers of Quebec for both control and homeless groups	12–17 (M=15.68)	61%	NR	Risk factor associated with homelessness group, compared with control group: behavioral disorders, OR=3.00, CI=1.58, 5.73, p<.001; poor youth-parent relationship, OR=2.28, CI=1.20, 4.35, p<.05; high level of parent violence (abuse), OR=2.17, CI=1.13, 4.17, p<.05; prior placement in substitute environment outside the home, OR=2.15, CI=1.13, 4.09, p<.05	NR
Tyler and Bersani, 2008 (23); longitudinal	United States	1,579	Data from the National Longitudinal Survey of Youth–97	12–13 at baseline; 14–17 at follow-up	51%	African American, 22%; Hispanic, 20%	Predictors associated with increased risk of running away in midadolescence: female, B=.81, SE=.25, p≤.01; neighborhood victimization, B=.49, SE=.22, p≤.05; personal victimization, B=.31, SE=.15, p≤.05; school suspension, B=.99, SE=.31, p≤.01; delinquency, B=.58, SE=.10, p≤.01	Predictors associated with decreased risk of running away in midadolescence: higher socioeconomic status, B=−.15, SE=.07, p≤.05; African American, B=−.88, SE=.28, p≤.01; Hispanic, B=−.64, SE=.31, p≤.05; monitoring-style parenting, B=−.10, SE=.04, p≤.01
Shelton et al., 2009 (24); cross-sectional	United States	14,888	Data from wave 3 of the National Longitudinal Study of Adolescent Health	18–28	47%	33%	Variables associated with homelessness: age at follow-up, OR=1.17, CI=1.10, 1.25, p<.01; Native American, OR=2.06, CI=1.34, 3.16, p<.01; ever ran away, OR=4.03, CI=3.13, 5.19, p<.01; ordered out of home by parents, OR=3.16, CI=2.48, 4.03, p<.01; parental-caregiver neglect, OR=1.47, CI=1.09, 1.98, p=.01; adopted, OR=1.65,	Variables associated with lower odds of homelessness: Hispanic, OR=.70, CI=.50, .99, p=.04; grade when respondent left school, OR=.88, CI=.82, .94, p<.01; currently employed,

continued

TABLE 1, *continued*

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
							CI=1.05, 2.61, p=.03; foster care, OR=2.15, CI=1.34, 3.45, p<.01; biological father incarcerated, OR=1.45, CI=1.13, 1.87, p<.01; duration of welfare assistance before age 18, OR=1.14, CI=1.05, 1.25, p<.01; economic difficulty in past 12 months, OR=1.23, CI=1.11, 1.35, p<.001; ever diagnosed as having depression, OR=1.61, CI=1.17, 2.23, p<.01; psychiatric hospitalization in past 5 years, OR=1.82, CI=1.08, 3.08, p=.03; addiction problems with drugs in past 12 months, OR=1.16, CI=1.04, 1.29, p=.01	OR=.76, CI=.60, .97, p=.03
Fowler et al., 2009 (16); retrospective	United States	265	Department of Human Services records used to contact youths whose foster care ended between 2002 and 2003; interviews conducted during 2005 and 2006	19–23 (M=20.5)	48%	African American, 78%; another racial-ethnic group, 1%	Grouped into four categories of housing stability since leaving foster care: continuously stable, N=153; decreasingly stable, N=29; increasingly stable, N=31; continuously unstable, N=52. Non-White (all categories compared with continuously stable), b=−.38, SE=.12; t=−3.20; more placement transitions while in foster care (continuously unstable compared with continuously stable), b=.64, SE=.22, t=2.94; less likely transition out of foster care after independent living placements (continuously unstable compared with continuously stable), b=−.66, SE=.31, t=−2.17; younger at exit from foster care and more placements during time in foster care system (decreasingly stable compared with continuously stable), b=.77, SE=.40, t=1.99; less likely to have left foster care after restrictive placements (increasingly stable compared with continuously stable): b=−.63, SE=.31, t=−2.04	NR

continued

TABLE 1. *continued*

Study and design	Country	Sample size	Sampling strategy	Age range	Male sex (%)	Minority race or ethnicity (%)	Risk factor and effect size	Resilience factor and effect size
Dworsky and Courtney, 2009 (17); longitudinal	United States	321	Data obtained from the Midwest Evaluation of the Adult Functioning of Former Foster Youth, a longitudinal data set on foster youth	17 or 18 at baseline, 19 at second interview, 21 at final follow-up	49.2%	54.8%	Risk factor predicting homelessness after exiting foster care: physically abused by primary caregiver, OR=2.95, $p<.05$; currently placed in a group care setting, OR=4.03, $p<.05$; ran away while in care more than once, OR=7.96, $p<.001$; number of delinquent behaviors, OR=1.19, $p<.05$	Resilience factor associated with lower odds of homelessness after exiting foster care: very close to at least one adult family member, OR=.32, $p<.05$

[a] NR, not reported; OR, odds ratio; CI, confidence interval (not all CIs are 95%); RR, risk ratio.

1.23 greater odds of becoming homeless at age 18–28, compared with those who did not have families experiencing economic difficulty in the past 12 months (24). Other family risk factors in the general population included family instability (21) and having a father who is incarcerated (23). Additional risks found in populations accessing homelessness services included family conflict (26) and family drug use (26), which placed youths at higher risk of homelessness or of running away. Adolescents who were homeless were 2.74 times more likely to report family conflict at home, compared with those who were not homeless (26).

Only one study examined community-level factors, finding that among youths who were in the foster care system at age 17, those who resided in areas providing higher levels of housing supports were less likely to experience homelessness at age 19, compared with those residing in areas that provided lower levels (18). However, unexpectedly, youths residing in areas with higher housing burden (high housing costs relative to average income) were less likely to experience homelessness, compared with those living in areas with lower housing burden, even after the analysis accounted for housing supports (18).

Factors also appear to buffer youths against becoming homeless. However, less is known about these protective factors, because most studies examined in this review focused on those who had already become homeless and the risk factors for this homelessness. Of note, three studies of the general population reported that being Hispanic protected against homelessness or running away (1, 23, 24). Protective factors such as family involvement may be more prominent in Hispanic culture (28); however, this finding may also reflect the fact that people of Hispanic ethnicity often underuse housing services (29) and experience homelessness in ways that leave them undercounted (e.g., staying with family) (30). One study of the general population reported that being African American protected against running away (23); however, two other studies, one of the general population (2) and one of a youth foster care population (15), found that African Americans were more likely to become homeless. African American youths who had been in the foster care system were 1.68 times more likely than foster care youths of other races to be experiencing homelessness at 12-month follow-up (15). Another study of youths from the foster care system found that non-White participants were more likely than White participants to have unstable housing (16). These results may reflect the long-term impact of systemic racism and discrimination on young people.

In general population samples, good educational attainment, defined as completing college by age 25, was protective against homelessness (1). In addition, higher family socioeconomic status (SES) predicted a lower risk of running away (23), and both higher individual or family SES and current employment were associated with a lower risk of homelessness (24). For youths ages 18–28 who reported experiencing homelessness, only 76 were employed for every 100 who were unemployed or never employed (24).

Other protective factors in the general population included monitoring-style parenting (23), family relationship quality (family pays attention to, understands, and cares about the young person) (22), and a good family routine (spending regular time with the family at scheduled events, such as dinner) (1).

For youths in the foster care system, remaining in foster care until age 19 (18), connection to a caring adult (17, 18), a history of being placed with a relative (15), and having a high GPA (15) were all protective factors. Among former foster care youths who reported homelessness at 12-month follow-up, for every 100 who did not have a history of being placed with relatives, there were 68 who had a history of being placed with relatives, indicating that being placed with relatives was protective (15). Additionally, for youths engaged with homelessness organizations, family involvement (family members providing opportunities to do things with them) was an important protective factor (26).

The included studies varied in how the timing of the episode of homelessness was examined. Several studies examined factors related to past episodes of homelessness (2, 13, 19, 23–26). Several were prospective and examined risk factors related to the first episode of homelessness after the initial interview or examination period (1, 14–17, 20–23); however, this was not necessarily the first episode of homelessness in that person's life. Given that multiple studies noted that a prior history of housing instability or homelessness was a risk factor for future episodes of homelessness (15, 18), it remains difficult to delineate the contribution of past homelessness to these risk factors.

To aid in the comparison of risk and resilience factors across studies, we present this information in a table (see table in online supplement), noting whether each factor was a significant risk or resilience factor, whether it was examined but not found to be significant in a particular study, or whether it was not included in the study at all. Because many specific factors were examined, factors were grouped into detailed categories (see list below table in online supplement). The studies are ordered and grouped by population examined, starting with LGB population (13), foster care youths (14–18), youths in the youth protection system (19), youths discharged from psychiatric treatment (20), general population samples (1, 21–24), the nationally representative household sample (2), and the remaining participants from homelessness organizations with their corresponding control populations (25, 26). Importantly, most risk factors reported by each study were found to be independent of each other (2, 15, 16, 19, 23, 24, 26).

DISCUSSION

Proposed Model of Risk for Youth Homelessness: Moving Toward Primary Prevention

This review indicated that a number of individual and family risk factors place young people at higher risk of becoming homeless. Risk factors for homelessness in the general population identified in the review appeared to fall into six main categories: family-related factors (e.g., single-parent household and family conflict); mental health, behavioral, or substance use; a history of trauma; school or academic issues; housing instability as a child; and a history of homelessness or running away. Protective factors were not as commonly examined, but factors identified in the general population included having a supportive and high-functioning family, higher SES, and educational attainment. Family connection was important across all populations studied. In terms of demographic factors, being of Hispanic ethnicity was protective, whereas being non-White was a risk factor. The factors that led to the largest odds of homelessness included a history of running away (17, 24), being in foster care (17), and being from a single-parent family (26). These factors appeared to differ somewhat from risk factors for homelessness as an adult (31), with the family playing a much more important role.

Importantly, most risk factors reported by each study were found to be independent of each other (2, 15, 16, 19, 23, 24, 26). Of interest, household income was a risk factor that was independent of high school completion, because these risk factors were significant when the analysis controlled for the other factor (2). Mental health difficulties and substance use were also independent risk factors (24), as were economic difficulties and mental health problems (24). Family violence, placement outside the home, a poor parent-child relationship, and behavioral disorders also all independently predicted homelessness (19).

Future Directions

This review has highlighted the current state of research on factors affecting homeless experiences of youths and has identified gaps in our knowledge. The limited scope of currently available research presented a significant challenge for this systematic review. First, the research on specific populations was limited, affecting the ability to determine whether risk factors differ across sample types (e.g., foster care populations, youth accessing homelessness services, youth justice populations, and sexual minority populations). Additionally, certain populations, such as youths with serious mental illnesses, were not examined specifically by any study. Given the high rates of homelessness in the population with serious mental illnesses and given that homelessness interferes with recovery from mental illness (32), it seems vital to examine specific risk and protective factors related to homelessness for individuals affected by mental health conditions. However, excluding factors particular to specific samples (e.g., number of foster care placements for youths in the foster care system), all categories of risk highlighted by this review were present in large-scale general population studies, in addition to being found in other specific populations. This implies that the risk factors identified here contribute to homelessness more broadly and across a range of risk groups.

Second, research on protective factors was limited. Only ten of the 16 articles examined protective factors, and the protective factors were often very specific and were not examined in more than one study. Consequently, this review was able to

identify only themes of protective factors present across multiple studies, including connection to family and academic or occupational achievement. Examining resilience factors is challenging, because it is difficult to identify populations that are at risk of homelessness but that manage to remain housed. Following high-risk populations, such as LGBTIQ+ (lesbian, gay, bisexual, trans, intersex, and queer) youths or youths experiencing severe mental illness and measuring housing instability as well as possible resilience factors across shorter periods might allow a more nuanced understanding of factors that reduce the likelihood of becoming homeless.

A more comprehensive model of resilience factors would facilitate development of a primary prevention strategy. For example, we know that a youth's connectedness to his or her family and parents is a protective factor. Parents who are more responsive to their child promote development of strong self-regulation skills, which are protective against becoming homeless (3). Such protective factors represent potential elements to incorporate into prevention efforts—for example, through family-focused interventions. Other preventive efforts could identify youths whose family may not have the capacity to participate in interventions and provide programs that support them to develop other natural support networks and build on resilience factors (e.g., by supporting them to stay in school and develop financial independence).

Third, among the articles reviewed, there was little or no research examining community- and system-level factors, such as social policy, job availability, or housing availability, and their role in homelessness. Individual and family factors are clearly important to consider for homelessness, because these can often be targeted more easily by organizations aiming to prevent homelessness. For example, case managers can help individuals to build relationships with their family, get a job, and access support for mental health or substance use difficulties. However, without addressing broader community-level problems that contribute to homelessness, such as low wages or lack of affordable housing, which may be affected by systemic racism, this may be akin to swimming against the current. Because of the lack of literature examining individual factors in the context of community-level factors, it is difficult to know what role the wider societal environment plays in youth homelessness. This distinction has important policy implications, because risk would likely vary depending on what supports or safeguards against homelessness are available from the government. It would be interesting to understand how housing availability affects young people and whether current primary prevention interventions, such as rapid rehousing, are effective for youth populations. Rapid rehousing provides homeless individuals and families with short-term assistance to pay rent and with support for a quick transition into permanent housing. Further projects should aim to examine risks for youth homelessness within a more comprehensive framework.

Finally, the research examined in this review focused overwhelmingly on individual homelessness, rather than on youths who experience homelessness as part of the family unit. Family homelessness is primarily associated with parental difficulties (33), whereas individual homelessness as discussed in this review is primarily related to difficulties that the young person is experiencing individually as well as in relation to his or her family. However, it is unclear what risk or resilience factors might be common across the two situations. It is also important to understand how the experience of family homelessness by a young child may contribute to a later risk of homelessness as an adult. For example, because a history of homelessness predicts future homelessness, interventions targeting homeless families to support a quicker transition to housing may reduce later homelessness for children when they become young adults. Because homeless families account for 35% of the total homeless population, this is an important consideration (34). To comprehensively inform policy and develop effective primary prevention for youth homelessness, these issues need to be addressed by future research.

Model of Homelessness Among Youths

To summarize the current state of the literature, promote future research addressing these knowledge gaps, and provide a framework for clinicians to integrate into service delivery, a provisional model summarizing the current knowledge base of the risk and resilience factors for youth homelessness is described below (also see figure in online supplement). Where appropriate, we also integrate other known homelessness risk research that did not meet criteria for our review, to best capture the full cycle of youth homelessness. This model aims to assist in the generation of primary prevention interventions by indicating where known risk and protective factors may be important to consider in the pathway toward youth homelessness.

Known distal risk factors can occur throughout the development of homelessness risk (see figure in online supplement). These factors include individual, family, and community risk factors as discussed above. In addition, the model also includes known proximal risk factors. Because homelessness is a dynamic state, consideration of more proximal risk factors is vital. This includes risk factors discussed above that could be immediate triggers for running away or an initial homelessness episode, such as changes in mental health (25); increases in substance use (1); housing transitions, such as exiting foster care (15, 16); leaving a psychiatric stay (20); or family conflict (26). Seventy percent of homeless youths cite family conflict as the reason for their homelessness (35), which suggests that feeling disconnected from family or being forced to leave is a key reason that youths leave home. As discussed above, it is difficult to disentangle the impact of past homelessness on these risk factors, which should be addressed in future research.

Young persons' resilience factors and resources can also act to protect them against both distal and proximal risk factors. Known protective factors include high SES (23), employment (24), family support and involvement (26), good family relationships (22), and school achievement (1, 24). These factors

may indicate that, despite risks, a young person who is given support in these domains is less likely to end up homeless.

Also discussed in the reviewed literature and included in the model are factors that may support exiting homelessness or prevent entering a more chronic homelessness cycle. For example, if young people who have run away from home or are experiencing acute homelessness are able to access services (15) or family support (1), they may be able to become housed again. Additional studies of youths that did not fit review criteria suggest that those with feelings of personal control appear more resilient and able to exit homelessness (36). For some young people, becoming homeless and then housed again turns into a repetitive cycle (37). For young people who experience long-term substance use difficulties (24), have difficulty accessing services (38), or have severe mental health problems (24), this cycle may lead to chronic homelessness.

Clinical Implications

Complex public health issues such as homelessness are difficult to address because they often require broad, multifaceted interventions to manage the variety of factors involved. Similar public health issues, such as suicide prevention, have been addressed by the World Health Organization (WHO). WHO suggests key components of a comprehensive and multifaceted prevention strategy, which include clear goals or objectives so that progress can be measured; identification of relevant risk and protective factors; effective interventions based on these risk and protective measures; prevention strategies at the general population level, vulnerable group level, and individual level; research on interventions and prevention strategies; and monitoring and evaluation of outcomes (39).

In applying this model to research on youths experiencing homelessness, we suggest similar objectives and intervention strategies, including increasing awareness of risk factors for homelessness (factors that occur at population, family, and individual levels), understanding and preventing risk factors for homelessness, improving research on homelessness risk and outcomes, and improving services that enhance housing outcomes for those who are at risk of homelessness, with an overall goal of reducing incidence of new homelessness. Additionally, it is important to consider that homelessness risk differs from suicide risk in that suicide prevention is not as directly dependent on policy-related factors, such as affordable housing, economic status, and governmental support and subsidies. Thus there are more system-level variables in homelessness prevention, and these will also need to be addressed by interventions.

Despite the need for further research, the model highlights several ideal targets for existing interventions for youths and may also assist in the development of new interventions (see figure in online supplement). The Upstream program, under development by University of Chicago researchers at Chapin Hall, is a primary prevention initiative involving screening youths at schools to identify those at risk of homelessness or school dropout and then providing supportive interventions. This example highlights the methods by which we can identify and address such risk factors before young people's situations escalate to crisis (40). Another example of current state-level interventions targeting these risk factors includes state funding for housing supports for youths exiting the foster care system or extension of foster care beyond age 18. There is evidence that these strategies result in decreased odds of homelessness, which supports the idea that targeting these risk factors is effective (18, 41). Future research should examine whether these current strategies are targeting the most prominent risk factors for young people and whether changes can be made to better target key risk factors for youth homelessness, such as family conflict.

Although these strategies offer hope, many current interventions do not comprehensively address the distal risk factors that put youths at higher risk of homelessness, which highlights a need for further development of services. For example, support services for LGBTIQ+ youths should focus on community integration and support network development, whether networks involve youths' families or a wider community service; family interventions aimed at increasing positive involvement and reducing conflict; and targeted services for children who are missing school or showing problem behaviors at school. Other areas for possible research and development include services that support individuals to navigate the system and access funding assistance or affordable housing and state-level interventions that would affect service availability, affordable housing availability, and governmental assistance.

A second area of focus for interventions is proximal risk factors, such as targeting youths who are at imminent risk of running away or homelessness. This review has identified important factors that could be targeted by current systems of care—for example, by training medical, substance use, and metal health providers to assess for and intervene in homelessness risk and by integrating social services for housing support into preexisting infrastructure, such as the current health care system. A third intervention point is for youths who have run away from home or who are experiencing acute homelessness. These interventions may need to target youth drop-in centers or identify youths on the streets and could include increasing service availability and assisting youths to feel more comfortable accessing services, reintegrating youths with their families and supporting families to reach out, encouraging a sense of control and resiliency among young persons, and supporting these youths to access substance use and mental health interventions. Interventions at this final point may be able to prevent a more chronic homelessness cycle.

However, primary preventive efforts require identification of adolescents who are at risk of homelessness (26). Although this review has identified distal and proximal risk factors, it is unclear whether a combination of these factors can be used in a meaningful way to predict those at highest risk. We propose using current knowledge of risk factors through a homelessness risk monitoring system. This can provide a framework for researchers to prospectively follow youths and examine the predictive power of these factors and for current health

care or mental health care providers to provide targeted supports to young people at risk. Currently, there is no clear evidence-based way for youth services (such as mental health care, hospitals, and other social support systems, such as LGBTIQ+ services) to monitor and prevent homelessness. We propose a novel approach to monitoring these young people in clinical settings, the two-step Homelessness Outreach and Monitoring of Environments for young people or HOME assessment (see online supplement). This provides a flexible, actionable method of integrating the current knowledge of risk factors for youth homelessness into current youth services. Although HOME is based on the risk factors highlighted in this review, further research is now needed to examine the selection of risk factors, alongside this monitoring approach, and to validate whether this combination of risk factors is clinically informative and whether use of this monitoring and outreach approach reduces the incidence of homelessness among young people. In addition, we hope to expand HOME as more research is completed to better understand family and community risk alongside additional resilience factors.

CONCLUSIONS

Knowledge of risk and protective factors for homelessness among youths is expanding and suggests a major role of historical homelessness, education, and family relationships. This has clinical implications for many existing youth homelessness prevention strategies. However, current research is not yet at the stage at which these factors can be used to predict and prevent homelessness among youths. This article describes the HOME monitoring system, which summarizes current knowledge of risk factors to support examination of these factors in research and to direct homelessness services in clinical settings. However, the model is provisional, and it is vital that future research efforts focused on the timing of homelessness risk factors, systemic community factors, housing instability, resilience factors, and youths at particular risk of homelessness are used to improve and finesse these strategies.

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