13 Mental Health and Youth Homelessness: A Critical Review

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Defining Youth Homelessness

It has proven extremely challenging to accurately describe the young people whose unstable and impoverished living circumstances have left them spending large amounts of time homeless and otherwise disengaged from the ways and places of living that are associated with mainstream values and norms. Nonetheless, it is generally understood that these young people represent a distinct population with definable needs, and in response there are services and policies directed towards them. The ambiguity surrounding the definition of youth homelessness is reflected in the many terms used to describe the population. The term "runaway" was in frequent use up to the 1980s although has since fallen out of favour, possibly due to an increased recognition that nearly half of these young people did not "run away", but were in fact thrown out of their homes (Adams et al., 1985). "Homeless youth" is a frequently used term, although it is often used interchangeably with "street youth" or "street-involved youth," since many of these young people do not fall under strict definitions of homelessness (i.e. being without any form of shelter). Accurate definitions are made more complicated by the different age ranges that are applied, ranging from 12 to 24 and in some service sectors even higher. This ambiguity around the description further complicates the already difficult

task of determining accurate estimates as to the number of homeless youth. The only clear point regarding the number of homeless youth is that it is large, with a conservative estimate of the number of homeless youth in Canada being 150,000 (National Homelessness Initiative, 2006). While the lack of a systematic count strategy in Canada prevents a meaningful commentary on trends, figures from the United States suggest that the number of North American homeless youth is likely increasing (U.S. Conference of Mayors, 2010). For the purposes of this chapter I will use the term "homeless youth" in a manner intended to be inclusive of youth who are living out of doors or otherwise lacking adequate stable housing with appropriate shelter and amenities (U.S. Department of Education, 1989).

Aside from the understanding that there are large numbers of homeless youth on Canadian streets and those numbers are likely growing, the only other relatively clear fact is that the health trajectories of most homeless youth are poor and mortality rates are strikingly higher than those of housed youth. Estimates of up to 40 times the mortality rate of housed youth have been found (Shaw & Dorling, 1998), with primary causes of death identified as suicide and drug overdose (Roy et al., 2004). This chapter builds from the latter observation – that of the profound impacts of poor mental health among homeless youth – and reviews our current understanding of the impact of homelessness on the mental health and well-being of this population, and discusses future directions for research and practice.

Homeless Youth and Mental Health

In considering the mental health and addictions literature for homeless youth it becomes immediately apparent that much of our current understanding is built upon assumption. The vast majority of these studies do not use longitudinal designs (studies that gather information at more than one point in time to see what causes certain outcomes) and this greatly limits our knowledge base. We have yet to clearly understand the relationship between homelessness and mental illness and, in turn, how they are accounted for by risks and resources present in pre-street and homeless circumstances. Despite this limitation it is clear that, in a general sense, the mental health of homeless youth is poor, and across the lifespan of most homeless youth they are immersed in environments characterized by substantial risk.

In considering the social factors that impact health, this is clearly a population that has faced, and faces, numerous and severe forms of adversity. There is considerable evidence that for many young people, these challenges – which have a significant impact on mental health – begin well before they experience homelessness. Considering family contexts before youth become homeless, high rates of parental drug and alcohol abuse and criminal behaviour are consistently found (Hagan

& McCarthy, 1997; Maclean et al., 1999). The experience of poverty is another significant factor, with a high percentage of young people coming from families in precarious financial situations and with high rates of divorce (Public Health Agency of Canada, 2006). Homeless youth frequently report histories of domestic violence and a greater than average number of household moves leading to frequent changes of school (Buckner et al., 1999; Dadds et al., 1993; Karabanow, 2004). Reports of childhood physical and sexual abuse are many times that of the general population, as are histories of emotional abuse and neglect (Karabanow, 2004; Kidd, 2006; MacLean et al., 1999; Molnar et al., 1998; Ringwalt et al., 1998). A further source of adversity is apparent when considering the child welfare placement histories of a large proportion of homeless youth. Many identify these placement experiences as the major reason for their entry into street life (Karabanow, 2003; 2004; 2008; Kurtz et al., 1991), and characterize placement settings as uncaring, exploitative, and unstable (Michaud, 1989; Raychaba, 1989).

It is not surprising, given the extent of adversity reported in the lives of youth before they become homeless, that the majority of those who report mental illness on the streets describe it as having begun prior to their leaving home (Craig & Hodson, 1998; Karabanow et al., 2007). Such a trend can be directly observed in the rate of youth suffering severe mental illness who ultimately become homeless *after* the onset of their mental illness. Embry and colleagues (2000), for example, found that among the participants in their study, 15 of 83 youth with severe mental illness and who were released from residential psychiatric treatment became homeless following discharge from services.

While there would appear to be general agreement that poor mental health often occurs before homelessness, it is also clear that adversity associated with life on the streets seems to worsen existing mental illness if not cause its onset. Not only do homeless youth regularly lack shelter and go hungry (Tarasuk & Dachner, 2005), they face constant and pervasive threats to safety and wellbeing in the form of physical and sexual assaults and other types of victimization (Karabanow et al., 2007; Whitbeck et al., 2000). The link between these forms of adversity becomes clear when one considers the heightened suicide risk of youth engaged in the most extreme forms of street survival, including sex trade involvement (Kidd & Kral, 2002) and among youth who demonstrate difficulty coping with discrimination and stigma on the streets (Kidd, 2007).

Studies of mental illness among homeless youth demonstrate that the many forms of adversity occurring on the streets worsen, and sustain poor mental health. Homeless youth in general have been found to have a similar psychiatric profile to adolescents in psychiatric treatment (Shaffer & Caton, 1984), with one study finding mental illness present among homeless youth at a rate that is

three times that of housed youth (Craig & Hodson, 1998). The profiles of mental illness likewise would seem to differ substantially, as evidenced in findings such as that of Thompson and colleagues (2011), who found greater rates of depression among homeless males compared with females – the opposite of what is found in the general youth population (Canadian Psychiatric Association, 2001).

Rates of mental illness commonly found among homeless youth populations include, 31% presenting with major depression, 27% with bipolar disorder, 36% with post-traumatic stress disorder (PTSD), and 40% with alcohol and drug abuse-related disorders (Chen et al., 2006; Merscham et al., 2009) and of those with mental illness, 60% have been found to present with multiple diagnoses (Slesnick & Prestopnick, 2005a). Though findings range from comparable (McCaskill et al., 1998; Slesnick & Prsetopnick, 2005a) to rates many times that of the general population (Cauce et al., 2000; Merscham et al., 2009; Mundy et al., 1990; Kamieniecki, 2001), it is also clear that psychoses such as schizophrenia are likely more prevalent among homeless youth especially among those using methamphetamines (e.g. crystal meth) (Martin et al., 2006). Finally, thoughts of suicide and suicide attempts, another clear indication of poor mental health and one of the leading causes of death for this population, are consistently found to be present at rates many times that of the general population (Kidd, 2006).

The role street adversity plays in worsening mental illness is supported by findings that indicate that older homeless youth experience greater depression and more severe substance abuse compared to younger homeless youth (Hadland et al., 2011). Such findings are common, with many studies noting a link between the extent and severity of pre-street and street adversity with mental illness and addictions (Craig & Hodson, 1998; McCarthy & Thompson, 2010; Merscham et al., 2009; Mundy et al., 1990). Indeed, as Goodman, Saxe and Harvey (1991) proposed, homelessness itself is, for many, a process of traumatisation. As it has been repeatedly demonstrated (more so in adult homeless literature), homelessness is characterized by a repeated exposure to traumatic circumstances and chronic stress (e.g., Schuster et al., 2011). Given what is known regarding the dynamic relationship between traumatic stressors and mental health, the high rates of mental illness seen among homeless youth are not surprising, even if those linkages have yet to be clearly addressed in research.

In terms of accessing services, it is clear that the majority of youth experiencing severe mental illness are not receiving any form of treatment (Kamieniecki, 2001; Slesnick & Prestopnik, 2005a). The barriers to accessing care, though not studied thoroughly, are readily apparent in the low capacity of community service agencies to provide care for individuals with more severe forms of mental illness and the many barriers to accessing psychiatric care for homeless youth. Barriers highlighted

by Canadian providers have included a lack of identification, having no formal diagnosis, substance use, unstable housing, and long waitlists (Eva's Initiatives, 2012).

One point that frequently arises in conversations with providers, though is not accounted for in the research literature, is in regards to a perceived rise in the number of homeless youth with severe mental illness. While the literature consistently shows high rates, there is no clear evidence of an increase. This does not mean that such a trend is not occurring but, rather, could quite possibly be a phenomenon that is not being captured due to differences in study designs and locations. It is also possible that providers are becoming more aware of and sensitive to the presentation of mental illness among the youth they serve. This is certainly a point that warrants further attention as it has clear implications for the need for improved collaboration between community-based service providers and psychiatric care providers. While not widely studied, the author has received positive feedback from community service providers about strategies such as (i) education of staff regarding the signs and symptoms of major mental illnesses and effective strategies for assessing and managing short-term risk (e.g., regarding suicidal behaviour and self-injury), and (ii) education of staff about the pathways to accessing psychiatric care. Nonetheless, it is clear that the current systems and services poorly address the mental health needs of marginalized groups such as homeless youth. There is also a pressing need for the identification and creation of more effective collaborative models of care (Kidd & McKenzie, in press).

Putting Mental Health in Context: A Dynamic Process

Relative to the extensive body of work examining risk, there does exist a small segment that examines resilience and coping among homeless youth. The coping literature highlights several themes, including the importance of self-reliance, the support of other youth, spirituality, and caring for others (Karabanow, 2003; 2004; 2008; Kidd, 2003; Lindsey et al., 2000; Rew & Horner, 2003; Williams et al., 2001). There is also some emerging work that examines the deeper identity and cultural shifts that determine how homeless youth understand and experience their world which, in turn, defines and drives their coping efforts and mental health (Karabanow, 2006; Visano, 1990). In a large study examining the experiences of youth in New York City and Toronto, Kidd and Davidson (2007) studied the manner in which coping efforts were framed within youth's testing, adopting, and rejecting the various messages they are exposed to via mainstream and street interactions and cultures. The particular version of "normal" used – be it homelessness as normal or not – had important implications for both their trajectories on and off the streets and the amount of distress they experienced due to their circumstances. For a youth whose identity is one of street entrenchment, a physical assault might be considered normal and, while painful, cause little emotional

distress. For a youth whose identity is grounded in mainstream values, the same assault might prove to be severely traumatizing. For youth who did not adopt street value systems and norms, the risks of surviving on the street proved to be harsher and these youth were more likely to try to get off the street. For those who took on one or more of the value systems/subcultures available to them on the streets, they might experience less distress in the street context, but also greater exposure to risks (e.g., youths for whom sex trade work has become the norm). These youth are also less likely to seek help in getting off the street. In the face of any number of contradictions, such street identities and value systems were typically challenged many times over the course of a youth's time on the streets: friends they thought "had their back" proved untrustworthy, serious criminal charges arose, health failed, serious assaults occurred, addictions worsened, and caring and respected supports described other ways of living that seemed healthier and more meaningful. However it was described by youth, be it a shift in worldview, value systems, or culture, it was the youth's view of his or her world that set the nature and parameters of their coping and framed how context impacted their mental health.

Intervention

The formal literature on mental health and addictions intervention for homeless youth is extremely limited, as is the intervention literature in general. While this section will present the intervention literature addressing mental health and addictions there are three important qualifiers. First, given that most homeless youth have a very difficult time addressing basic needs (food, clothing, shelter) and the meeting of basic needs is closely associated with mental health, one must consider tying basic needs interventions to mental health and addictions interventions. Second, due to the varied needs of this diverse population, there is a need for commentary at a service system level on the need to be combine services to provide care tailored to the individual needs of a given youth. For example, youth who work in the sex trade have quite different service needs than traveller youth (i.e. youth who travel, hitchhiking or by rail, who typically panhandle and sleep out of doors). The existing literature provides minimal guidance in this area. Third, while the severity of the circumstances of most homeless youth does indeed suggest that they are a distinct population with distinct needs, the lack of literature addressing effective treatments for this group should not prevent the use of interventions that have been proven to work for broader populations. For example, given the high rates of post-traumatic stress disorder among homeless youth it would seem relevant to consider providing treatments for trauma that have proven effective with general adolescent and young adult populations (e.g., Foa et al., 2009).

The literature on interventions addressing the basic needs of homeless youth along with studies examining physical health interventions, such as the body

of work focusing on HIV, are beyond the scope of this chapter and have been summarized elsewhere (Kidd, 2003). The overlay with mental health interventions, however, is readily apparent in some instances, such as the recent work of Slesnick and colleagues, which demonstrated that a cognitive behavioural intervention[1] that focuses on skill building and education was more effective than treatment as usual in increasing condom use (Slesnick et al., 2008).

Looking specifically at interventions that address mental health and addictions, most advocate for the use of approaches that address both areas of concern at the same time. Slesnick has done a considerable amount of work in the area of family therapy. She has found that ecologically-based family therapy[2], with both family and individual sessions focused on decision-making, emotion-regulation or other intrapersonal factors, leads to greater reductions in substance use compared with treatment as usual (Slesnick & Prestopnik, 2005b).

Several studies have also discussed motivational intervention as a model for working with substance-using street youth, though the results suggested only modest improvements (Baer et al., 2004; Peterson et al., 2006). Slesnick and colleagues have also provided evidence that the Community Reinforcement Approach (CRA), which uses a cognitive behavioral approach to address the systematic challenges faced by youth, showed good outcomes across a number of areas including internalizing problems, social stability, and substance use (Slesnick et al., 2007).

Next Steps

Overall, the literature on the mental health of homeless youth suggests that they are a group experiencing serious mental health concerns. Further, while it is not possible to comment on the accuracy of service providers' beliefs that rates of mental illness are increasing, it would seem safe to say that they are certainly not declining in any noticeable way given similar rates observed over the past 20 years. Where the research body as a whole has done a disservice to this population is in the lack of attention given to evaluating the effectiveness of interventions.

There would seem to be four key directions available in the effort to address the high rates of mental illness and associated death among homeless youth. First, is the need to greatly expand the effort to examine the effectiveness of interventions. Therein lies a considerable challenge. For example, the criticisms of randomized

1. The premise of cognitive behavioural therapy is that changing dysfunctional thinking leads to change in effect and in behaviour.
2. Treatment developed to address immediate needs, to resolve the crisis of running away, and to facilitate emotional re-connection through communication and problem solving skills among family members.

clinical trials (studies in which participants in a treatment are compared with those who are not) are all the more applicable to homeless youth due to the severity of their circumstances. An intervention might only prove to be effective if it is provided in a program that effectively addresses other key needs such as housing, legal support, and medical care. For example, cognitive behavioural therapy will likely not be effective if the youth is living under a bridge and being victimized every other day. I have, anecdotally, observed that the positive effects of psychotherapy rapidly unravel in the face of negative circumstances such as a sudden loss of housing or a rape. As such, studies are needed that account for the programs that encompass the interventions and how they affect outcomes. For instance, the effectiveness of a psychotherapy intervention cannot be understood unless its impact is considered in light of the other services attached to it such as medical care, leisure, and employment programs.

The second area of focus should be on the ways in which services might collaborate in a given city to improve the outcomes for this population. This could include an examination of the impacts of training youth workers in mental health assessment and intervention, creating more streamlined points of access to mental healthcare in community and hospital-based services, and highlighting current practices that are working. It is a consistent challenge in community mental health sectors that highly innovative and effective practices emerge and are not clearly evaluated, articulated, or communicated such that they might be taken up in other settings (Kidd & McKenzie, in press).

The third area that would benefit from further development is that of trauma-informed care. Trauma-informed care involves the provision of services within a framework that acknowledges and understands the relevance of trauma in the lives of individuals who have faced adversity and provides access to interventions that address those issues. While service provision to homeless individuals presents unique challenges in providing care within this framework (i.e. persistent exposure to re-traumatization), there is increasing recognition of its value and relevance (Hopper et al., 2009). Regardless of whether a given homeless youth was victimized before leaving home, homelessness leads to frequent exposure to violence and chronic stress and presents a context in which trauma is a key consideration. Indeed, recent research demonstrating that the rate and severity of psychosis are directly impacted by experiences of marginalization and victimization (Bebbington, 2009) make trauma-informed care relevant beyond the more commonly understood impacts of trauma such as anxiety and PTSD.

Finally, over-emphasis on interventions geared towards individual youth is itself problematic (Kidd, 2012). Youth homelessness and the mental illness and addictions of homeless youth clearly grow from systemic problems as they flow

through failed child protection efforts, inadequate screening and prevention frameworks in schools, and criminal justice involvement. While there is certainly a need for intervention research at the individual level and, as Slesnick and others propose, family level, neglecting the systems that lead to youth homelessness will do nothing to address the task of bringing down the number of youth on the streets and the cascade of risks that are to be found in street contexts. Indeed, such work in isolation runs the risk of further stigmatizing youth, suggesting that their situation and problems are due to individual failures rather than the myriad factors that cause homelessness and mental health problems. In sum, it would seem that the task of identifying the problems of homeless youth is done. We now need to focus our efforts on generating and evaluating the solutions.

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