

CHILD AND YOUTH MENTAL HEALTH IN THE COMMUNITY





Experience of
Emotional Stress
and **Resilience**
in **Street-Involved Youth:**

The Need for Early Mental Health Intervention

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Mental illness left untreated in adolescence and young adulthood can readily become a chronic illness in adulthood, seriously hampering the capacity of individuals to become healthy contributing members of society. Mental health challenges are of paramount importance to the health and well-being of Canadian adolescents and young adults, with 18% of Canadian youth, ages 15–24, reporting a mental illness (Leitch 2007). However, it is unlikely that this statistic accounts for those invisible youth (Rachlis et al. 2009) who are disconnected from families and caregivers, bereft of stable housing and familial support – in other words, youth who are street-involved. Mental health risk is amplified in street-involved youth and, as such, must be recognized as a priority for policy development that commits to accessible mental health programming, in order to realize the potential of these vulnerable youth.

Youth who are compelled to survive on the street can be found in all major urban centres worldwide (Ensign and Ammerman 2008). In Canada, it is estimated that 8,000–11,000 are homeless each night (Canada Mortgage and Housing Corporation 2001). Typically, street-involved youth live and work in urban centres (Boivin et al. 2009). Although definitions of *street-involved youth* are highly varied, there is general agreement that these youth are precariously housed; have residential instability (e.g., live in shelters, abandoned buildings or on the street); and are emotionally and psychologically vulnerable (Public Health Agency of Canada 2006; Roy et al. 2009). Youth frequently leave home due to conflict, abuse and extreme deprivation within the home environment (Kidd 2009; Miller et al. 2004; Public Health Agency of Canada 2006). Many youth come to be on the street through the child welfare system; they often wish to escape the frustrations of foster care, such as feeling overburdened by inappropriate rules or frequent moves between homes. Others have had to leave foster homes or group homes to escape abuse or simply because they have reached the age of 16 (Karabanow 2008; Serge et al. 2002). There is some indication that the proportion of children from the child welfare system is increasing within the street youth population (Serge et al. 2002).

Mental Health Challenges

It has been well established that mental health challenges are ubiquitous to youth who are street involved (Adalf and Zdanowicz 1999; McCay et al. 2010; Yonge Street Mission 2009). Researchers have documented exceedingly high levels of mental health symptoms, such as depression, hopelessness, anxiety and psychosis, among street-involved youth (McCay 2009; Stuart and Arboleda-Florez 2000). Mental illness in youth is a significant risk factor for homelessness (Ensign and Ammerman 2008) and can emerge as a result of the adverse conditions of life on the street, such as exposure to violence, a

lack of basic necessities, participation in survival sex and drug use (Kipke et al. 1997; McCay et al. 2010; Morrell-Bellai et al. 2000). Addiction on the part of youth or their families and caregivers has been identified as a significant issue that leads to homelessness (Kidd 2009; Mallet et al. 2005). Parents may feel overwhelmed by their child's use of substances and the associated behavioural patterns, leading to a breakdown of the relationship, at which point the child may be impulsively kicked out. Alternatively the parents may be incapable of providing physical and psychological nurturance for their child due to their own addictions (Kidd 2009). For Aboriginal youth, mental health challenges, such as addictions and unhealthy family relationships, have been identified as factors that contribute to youth homelessness (Baskin 2007). However, underlying structural issues, such as poverty and overrepresentation of children in the child welfare system, are thought to be of major importance in understanding homelessness in Aboriginal youth (Baskin 2007).

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It is not surprising that the conditions associated with living on the street may exacerbate pre-existing mental illness (Whitbeck et al. 2004) or precipitate the emergence of mental health symptoms in these young people. A great number of youth are predisposed to mental health symptoms due to the occurrence of physical or sexual abuse in the home environment, which may lead to symptoms of post-traumatic stress disorder, such as flashbacks, anxiety and anger. Youth living on the street are also exposed to dangerous conditions where they may be physically or sexually assaulted, which may also result in trauma-related symptoms (McManus and Thompson 2008; Stewart et al. 2004) or the exacerbation of prior trauma symptoms. The prevalence of trauma-related symptoms ranges from 18–24% among youth who are homeless and is substantially higher than in non-homeless youth, with transience between cities increasing the occurrence of trauma symptoms (Bender et al. 2010; McManus and Thompson 2008).

High levels of substance abuse have been documented for the majority of street youth cohorts, with more than 50% of youth study participants reporting drug and alcohol use suggestive of a serious level of abuse (Goering et al. 2002; Klein et al. 2000; McCay et al. 2010). The use of substances can be a means of coping with the ongoing emotional turmoil and stress associated with life on the street (McCay et al. 2010; Rachlis 2009; Rew 2003). Youth have been found to use crystal methamphetamine to cope with distress, to stay awake for long periods in order to

protect themselves and as a substitute for prescribed psychiatric medications (Bungay et al. 2006). In addition, street-involved youth are engaged in injection drug use at alarmingly high rates. For example, studies in Vancouver and Montreal indicated that 41% and 60% of youth, respectively, reported prior injection drug use (Kerr et al. 2009; Roy et al. 2007). Factors found to be associated with increased injection drug use included being older than 22 years, involvement in survival sex and hepatitis C infection (Kerr et al. 2009), suggesting that the length of time on the street leads to a hierarchy of increasingly risky behaviour and heightened difficulty stopping behaviours such as injection drug use (Steensma et al. 2005). Substance use, in particular, is very common form of risky behaviour and is associated with high rates of mortality in street youth populations (Roy et al. 2004).

Youth who are highly engaged in substance abuse to cope with the stress of life on the street and who have a history of physical and sexual abuse have been found to experience high levels of mental health symptoms (Adalf and Zdanowicz 1999). It is not surprising that mental health problems such as loneliness, a lack of social connectedness, self-harm behaviours, depression, anxiety and suicidality are experienced by street youth who must not only cope with past and current traumas but also survive on the street. Of most concern is the fact that suicide has been found to be the leading cause of death among street-involved youth (Roy et al. 2004). In a major study (Molnar et al. 1998) of suicide and abuse, suicidal behaviour was found to be closely linked to physical and sexual abuse prior to leaving home. In another recent study, about one half of the participants engaged in some form of self-harm and approximately one third reported at least one suicide attempt (McCay 2009). Overall, a pervasive sense of loneliness, hopelessness, despair and low self-esteem places homeless youth at risk for suicide (Kidd 2006; Kidd and Shahar 2008; McCay 2010).

Not only do youth have to cope with the extreme challenges of their circumstances, they also have to deal with the existence of social stigma toward homelessness, generally, and toward mental health issues, specifically. Youth perceive the existence of social stigma and identify that living a life associated with homelessness, illustrated by negative labels such as “squeegee kids,” can result in a profound sense of shame and worthlessness. Further, the burden of stigma associated with mental health challenges is thought to exceed the experience of stigma associated with homelessness (McCay et al. 2010). For youth, feeling doubly stigmatized can profoundly influence behaviour, so much so that youth report that they avoid seeking help for fear of being further stigmatized. Not surprisingly, perceived social stigma has been found to contribute to feelings of low self-esteem, loneliness and suicidality (Kidd 2009). It is the propensity to internalize the negative views of others that is most closely related to mental health indicators, such as those noted above. Youth are particularly vulnerable to the internaliza-

tion of external stigma, given the fluid and sensitive nature of self-definition at this transitional developmental phase.

Resilience in Spite of Distress

Life for these young people is frequently complex and composed of paradoxes. Experiences of tension, challenge and sadness frequently associated with victimization are often juxtaposed with the determination to strive for a better life. Studies have demonstrated the will of youth to move beyond life on the street (McCay 2009; Rew and Horner 2003). Leaving the home environment to escape abuse and surviving life on the street can be viewed by youth as an important independent first step in taking care of themselves and gaining self-respect (Rew 2003).

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Even with exceedingly severe levels of mental health symptoms and emotional distress, there is some evidence that street youth possess moderately high levels of resilience (the capacity to overcome adversity) and self-esteem (Adalf and Zdanowicz 1999; McCay et al. 2010; Rew et al. 2001). For example, youth demonstrate strengths such as the capacity to take care of themselves, including the need to take a break from drug use and finding water and food (Bungay and Malchy et al. 2006). Additional strengths include seeking resources and focusing on self-improvement through gaining emotional maturity, learning skills, focusing on the positive and adopting healthier behaviours (McCay 2009; Rew 2003).

Supportive relationships with others such as family (immediate or extended), peers and shelter staff have also been identified as resources that are adopted by youth. The description of family relationships as supportive differs considerably from the description of problematic unstable home environments frequently identified as the cause of youth homelessness (Kidd 2003; McCay 2009). This observation suggests that in some cases it may be possible to repair strained difficult relationships to the benefit of some youth. On the other hand, youth may derive most of their support from friends in the shelter system or on the street (Karabanow and Clement 2004; Kidd 2003; McCay 2009). Peers are frequently described as “street family.” The importance of positive, caring relationships with shelter staff is also critical for some youth (Karabanow and Clement 2004; McCay 2009). Positive relationships with staff may have long-lasting effects that go well beyond the pursuit of a particular goal, transferring to a fundamental belief in the self as a valued and capable young person.

In addition to being determined to leave the street (Miller, 2004), it is noteworthy that youth describe goals for the future such as going to college or finding a job (McCay 2009). This is consistent with the developmental stage of emerging adulthood, where youth prepare themselves for adult careers and relationships (Arnett 2007).

Barriers to Accessing Services

There is clearly an urgent need to significantly increase access to mental health services in order to address the severe and complex mental health problems of street-involved youth. However, at the present time only a small percentage of youth are using mental health services, suggesting problems with access to and availability of appropriate services (Bungay et al. 2006; McCay et al. 2010; Rachlis et al. 2009). One obstacle to the use of existing services is the degree of stigma associated with disclosing mental health challenges. Feelings of uncertainty associated with the disclosure of mental illness are consistent with those experienced by the general population. For some youth, there seems to be a great deal of skepticism regarding psychiatric treatment, as well as the fear of discrimination associated with the disclosure of mental health challenges to staff (McCay et al. 2010). The labelling of services as mental health services also seems to be problematic to youth, primarily due to social stigma and a fear of long term labelling (Kidd et al. 2007; Yonge Street Mission 2009). Youth also appear to be highly sensitive to whether staff really care about them or are just doing a job. This is a highly salient issue given the number of youth who have experienced physical and emotional trauma in their home environment or have grown up in transient foster homes. As such, issues of trust and engagement with staff are paramount (Collins and Barker 2009).

A striking barrier with regard to accessing mental health services is the lack of evidence-based interventions to address the mental health problems of street youth (Slesnick et al. 2007). The literature suggests that insufficient attention has been given to protective factors for and strengths of street-involved youth (Bender et al. 2007). Interventions that focus on developing protective factors as well as the critical relationship between self-esteem and resilience can enhance youths' abilities to face challenges and solve problems (Bender et al. 2007). Kidd (2003) undertook an extensive review of the literature relevant to intervention programs for street youth. Virtually all of the studies reviewed were descriptive and focused on psychopathology, with little attention given to evidence-based interventions. Clearly, there is a critical need for intervention research directed toward the implementation and evaluation of effective strategies pertaining to the mental health challenges of homeless youth (Klein et al. 2000; Nyamathi et al. 2005; Slesnick et al. 2007).

Policy Implications

The longer the time that youth spend on the street, the greater

the chance that they will engage in high-risk behaviours, such as prostitution, suicide attempts (McCarthy and Hagan 1992), substance abuse and injection drug use (Steenma et al 2005); these behaviours ultimately increase the risk of chronic homelessness (Goering et al. 2002). Further, the longer youth stay on the street, the more they are likely to experience mental health challenges and to define themselves as street youth with limited opportunities for the future and diminishing expectations of leaving the street (Yonge Street Mission 2009). Nonetheless, a significant number of youth do view their situation as temporary. For example, one in five youth using the services of a downtown drop-in program were homeless for less than three months, and a number of these youth were able to exit the street within this time frame. This highlights the existence of a critical window of opportunity for intervention (Yonge Street Mission 2009).

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Given the significant immediate and long-term risks associated with prolonged life on the street, policy needs to be directed toward programs that support early intervention for youth while they remain open to the possibility that life on the street may be a short interruption in their development to adulthood, rather than an indentured state of hopelessness and chronic homelessness. Challenges associated with entering and exiting life on the street are inextricably linked to mental health. Mental health challenges, such as pre-existing mental illness, substance use and abuse for youth, parents and guardians, have been identified as a primary cause of youth homelessness. Youth who grow up within the child welfare system and have been subjected to highly transient and disruptive childhoods are particularly vulnerable to the negative consequences of life on the street.

The mental health challenges of youth are severe and complex. These challenges include pervasive issues of depression, anxiety, psychosis, addictive behaviours, self-harm and suicidality. Even with these severe mental health symptoms, youth also demonstrate a range of strengths, as well as the capacity for resilience. The interface between psychological resilience and acute distress offers a critical perspective for identifying evidence-based interventions, such as dialectical behaviour therapy (DBT), which offers great promise. DBT focuses on interrupting the negative emotional spiral that is associated with a range of self-harm behaviours, including addiction, while at the same time providing opportunities for

support and to acquire the emotional skills necessary to assume a healthy independent adult life. As new therapeutic programs are developed, it is imperative that the strengths of these youth be recognized and encouraged within the context of supportive relationships, while concurrently coaching youth to deal with the realities of hopelessness and despair.

From the perspective of youth (McCay, 2009), accessible mental health services should be offered on site, such as at shelters where they reside or at drop-in programs. Youth are unlikely to access traditional mental health services, which are located in institutional settings. This seems to be linked to a general mistrust of the system and to the perceived stigma associated with mental health challenges. According to youth, effective mental health services would be non-stigmatizing and non-threatening with careful attention given to engaging youth in therapeutic relationships (Karabanow and Clement 2004; McCay 2009). As such, the development of multi-faceted mental health programs within existing services for street youth could incorporate a range of services, including assessment and treatment, case management with an emphasis on relationship building and mental health promotion. Immediate attention could also be given to acute risk factors such as suicidality, self-harm, emotional distress and substance abuse, while also addressing ongoing treatment issues. On-site mental health programming would go a long way toward increasing accessibility and decreasing stigma for street-involved youth, providing an ideal milieu for implementing evidence-based interventions, as described above.

Peer mentorship programs could also be offered within the context of existing programs for street youth, enabling staff to work closely with youth. Peer mentors would provide an opportunity for youth who are overcoming challenges to acquire a critical understanding of supporting strengths in others in order to overcome vulnerability. The availability of peer mentors offers an effective modality to engage youth who have a great deal of difficulty trusting staff, given their traumatizing backgrounds (Karabanow and Clement 2004; Kidd 2003).

At the level of the community, strategies are required to reduce the negative or stigmatized attitudes toward street-involved youth to create a climate of greater understanding and acceptance for youth in the community. As noted previously, youth are vulnerable to the internalization of external stigma, given the fluidity of self-definition at this transitional developmental phase. Strategies that target attitudes toward both street youth and mental health issues would be most helpful in supporting the development of this group that is frequently “doubly stigmatized.” Of critical importance is the need for programs in the schools that target the prevention of youth homelessness. Given that issues such as substance abuse create considerable strain for families during the adolescent period, programs are required for both youth and their parents. These

programs could be based on a resilience perspective and could include mental health promotion skills for youth and their families, such as effective communication, conflict resolution and understanding risk taking. In addition, increased awareness in primary healthcare settings with regard to identifying youth who are at risk of entering street life is required, particularly for youth living within the context of troubled families or the child welfare system. It is recognized that the transition out of care for youth who have never had a real home is highly sensitive and requires the development and evaluation of programs that allow for gradual independence (Serge et al. 2002).

Policy needs to be directed toward programs that support early intervention for youth while they remain open to the possibility that life on the street may be a short interruption in their development to adulthood.

Conclusion

Given the pervasiveness of mental health challenges and, in particular, the high suicide rate among street-involved youth, it is imperative that programs directed toward the treatment of mental health and addiction problems be identified as a public health priority (Roy et al 2009). Mental health programs that are embedded within broader programs of support that effectively address the social determinants of health are essential to assist vulnerable adolescents to navigate the transition to adulthood (O’Sullivan and Lussier-Duynstee 2006). The At Home/Chez Soi program sponsored by the Mental Health Commission of Canada is an exemplary model, where housing in addition to mental health support is provided for adults living with mental health challenges (Goldbloom 2010). From a policy perspective, it is important to keep in mind that street-involved youth are part of our national community of children and youth who require mental health services. Although child and youth mental health services have been severely underfunded, decision-makers are now recognizing the urgency of financially supporting child and youth mental health in order to support the health and well-being of future generations (Haddad 2010). The urgent mental health needs of street-involved youth need to be recognized as a top priority within the funding envelope of child and youth mental health. It is only through directing our attention and resources to the mental health and resilience of all children and youth within our communities that will we realize our goal of supporting the entire youth population to achieve a healthy, productive and satisfying adulthood. **HQ**

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