14 The Need for Early Mental Health Intervention to Strengthen Resilience in Street-involved Youth

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Background

Street-involved or homeless youth face dramatic threats to their physical and mental health: they are at increased risk for suicide attempts (McCay, 2009; McCay et al., 2010; Roy et al., 2004), substance abuse and injection drug use (Steensma et al., 2005), and unwanted/survival sex, as well as a wide range of other health concerns, compared to housed youth of a similar age (Dachner & Tarasuk, 2002; Kelly & Caputo, 2007). Further, it is well known that mental health challenges are extremely common among youth who are street-involved (Adlaf & Zdanowicz, 1999; McCay et al., 2010; Yonge Street Mission, 2009). These youth have very high levels of mental health challenges compared with young adults who are housed (Boivin et al., 2005; McCay et al., 2010; Saewyc et al., 2009; Smith et al., 2007; Rhode et al., 2001). There is evidence to suggest that providing housing, combined with supports, for individuals who are living with severe mental illness may be effective in improving their well-being (Goering et al., 2011). Even so, it has been observed that the mental health challenges of youth who are street-involved may interfere with their ability to access services that will improve their overall circumstances. Improving the life circumstances of street-involved youth requires a broad range of social services, including a much needed focus on housing. Further, improving the mental health of these youth is a critical factor in enabling them to participate in available services and programs that are designed to support adaptation to challenges and re-integration into society.

In response to the profound level of mental health need among street youth, our research team carried out a comprehensive assessment of mental health challenges. It was expected that a more in-depth understanding of the mental health challenges of street-involved youth could help to identify appropriate approaches to address these needs (McCay, 2009; McCay et al., 2010). This study used both quantitative (numeric questionnaires) and qualitative (interactive interviews) methods, and also engaged participants in individual and group discussions (see below) throughout the study to ensure their voices were heard. Seventy participants were recruited from four agencies serving homeless youth in Toronto. The participants completed a series of questionnaires to evaluate mental health symptoms such as depression, self-harm, suicide risk, alcohol and substance use, and experiences of physical and sexual abuse, as well as resilience (ability to overcome challenges) and self-esteem. Nine of these youth also participated in individual qualitative interviews to discuss views of their own mental health challenges and strengths. Youth were also recruited from two community agencies to participate in two focus groups to discuss mental health needs and resilience.

Our results indicated that these youth (ages 16–24) had extremely high levels of mental health symptoms when compared with studies involving youth adults who were housed (Meyer & Hautzinger, 2003; Brausch & Muehlenkamp, 2007). These results were comparable to findings from other studies of the mental health symptoms of homeless youth (Boivin et al., 2005; Fisher et al., 2005; Whitbeck et al., 2004). Specifically, the youth in our study exhibited extremely high levels of depression, anxiety, hostility, paranoia, psychotic symptoms, and emotional sensitivity. Sixty-one percent of participants in our study had experienced physical abuse, while just over 25% reported being sexually abused, and 31% expressed some form of suicidal thinking. Forty-one percent of the participants engaged in some form of self-harm and virtually all identified issues with drug and alcohol use. Even with these exceedingly severe levels of mental health symptoms and emotional distress, our participants displayed moderately high levels of resilience and self-esteem (McCay, 2009; McCay et al., 2010).

Overall, the themes that emerged from the interviews with the youth illustrated their resilience and determination, and included: *Surviving life on the street* (negotiating street-life); *Living with mental health challenges* (wide range of mental health problems and stress of being homeless); *Finding strength in the midst of challenges* (striving for a better life, despite obstacles) and *Seeking supportive relationships* (positive connections with family; understanding peers; and relationships with staff). In the next phase of the study, participants suggested that they would like to take pictures (photovoice) (a research method that combines photographs and verbal descriptions) to illustrate what it meant for them to be mentally and emotionally healthy. Underlying themes were derived from discus-

sions with the youth and guided the focus of the youths' photographs. These themes reflected the value of positive mental health from the youth's perspective and included: 1) knowing yourself; 2) recognizing self-worth; 3) being stable, adaptable, positive, and balanced within society and among other people; and 4) trying to cope and get through every day, knowing that you will be okay.

Overall, the qualitative findings mirrored the quantitative findings, specifically regarding the high levels of mental health symptoms. Participants described a number of mental health issues, which they identified as either a consequence of being street-involved or as related to pre-existing illness or challenges. Despite the challenges and sadness experienced by these youth, they also frequently talked about their determination to strive for a better life. It was striking that despite the challenges they faced, the goals of the youth who participated in the study included attending college or university or finding a job, as is typical of the developmental phase of young adulthood (McCay, 2009). Their determination to strive for a better life translated into a number of practical coping strategies to deal with emotional distress, such as thinking positively, learning from past mistakes, helping others, and pursuing goals in order to move ahead, as illustrated by the following quotation from one young male participant.

> *I found out my things the hard way, right, and I'm still young. I've learned from my mistakes. And I find that even though it's the hard way I'm kinda glad I learned that way you know. Because I learned about my mistakes and I'm not going to make those mistakes again now you know. Well [I was] just goin' down all the bad roads... and with the wrong people, doing the wrong things, wrong mentality...Now I'm like wow, wait a minute what am I doin' here, you know. If I would have just smartened up, buckled down and just focused on just a few short term goals I would have my life set up the way I wanted to right now.*

Previous studies have also found high levels of resilience among street youth (Adlaf & Zdanowicz, 1999; Rew et al., 2001; Rew, 2003). In addition, without exception, all of the youth who participated in qualitative interviews identified the central importance of supportive relationships in becoming mentally healthy and strong. Indeed, recent findings have encouraged researchers to move beyond simply describing mental health problems among street youth to focusing attention on developing and evaluating approaches that strengthen positive relationships and build resilience (Karabanow & Clement, 2004; Kidd, 2003; Kidd & Davidson, 2007; Johnson et al., 2005).

The Urgent Need for New Effective Approaches

Despite the dramatic level of mental healthcare need, these vulnerable youth are far less likely to access mental health care, healthcare and/or social services for a variety of complex reasons, including issues of stigma and discrimination associated with homelessness and mental health problems, as well as other barriers to accessing services (Hughes et al., 2010; McCay, 2009; Slesnick et al., 2001). Understandably, street-involved youth are frequently suspicious of adults, authority and social structures (Karabanow & Clement, 2004; Meade & Slesnick, 2002), posing significant challenges to care providers who are responsible for intervening with these youth to support positive change. Although it is accepted that there is a profound need for more effective interventions with homeless youth, strategies for effective intervention must accommodate all factors that prevent youth from accessing supports that can help them in their journey to achieve more stability, secure housing, and ultimately to lead satisfying and successful lives.

The selection of approaches to address the mental health needs of street youth is problematic, since so few interventions have been specifically designed for this population. As yet, there is a lack of evidence regarding interventions to address the specific mental health needs of homeless youth (Altena et al., 2010). Kidd (2003) reviewed the mental health literature and located 42 articles from 1987-2003 that could be considered relevant to intervention programs for street youth. Although the articles reviewed highlighted issues to be considered in the design of mental health intervention programs, such as early intervention and the need to assess mental health issues, virtually all of the studies reviewed were descriptive and focused on symptoms of mental illness, with little attention given to intervention approaches based on research evidence (Kidd, 2003).

Few studies have evaluated the impact of mental health programs on street youth. An early study by Cauce and Morgan (1994) compared the effects of an intensive mental health case management program with a standard case management model. Standard case management is a collaborative process intended to address the youth's needs for service and support. In addition to standard case management, intensive case management allows for: smaller caseloads resulting in increased time with youth; higher educational requirements for case managers; along with scheduled supervision for case managers with experienced experts. Participants who received intensive mental health case management showed lower aggression and greater life satisfaction than those receiving standard case management, benefits which the authors attributed to a positive therapeutic relationship with the case manager. Slesnick et al.'s (2007) study compared regular treatment, which included an average of three to four case management sessions, with an intensive community reinforcement approach which involved 12 individual therapy ses-

sions designed to meet a range of health, social and occupational needs, along with four educational HIV sessions. Youth participating in the 12-week intervention reported reduced substance use and depression, as well as increased social stability, as assessed by the degree of stability in housing, education, work and health. The authors concluded that, for street youth, interventions must be able to disrupt a downward spiral of behaviours and interactions, while providing support and skills to further positive relationships (Slesnick et al., 2007). Both of these studies demonstrate the importance of positive social relationships for the participants' outcomes. Further, Slesnick et al., (2009) reviewed community-based treatment interventions for homeless youth and concluded that, in order for interventions to be effective, it is essential that community agency staff be trained in the therapeutic relationship skills necessary to keep youth engaged in interventions over time.

It is evident from this review of available research literature that there is a large knowledge gap related to research-based interventions to reduce emotional distress, promote positive relationships, and support overall positive functioning among street youth. A pilot study conducted by our group (McCay et al., 2011) suggests that a relationship-based intervention for street-involved youth may be promising. Youth who participated in a 6-week relationship-based group intervention experienced higher levels of social connectedness (a sense of belonging and fitting in) and experienced less hopelessness (a core symptom of depression), compared with youth who did not receive the intervention. This finding is important since it reinforces that there may be benefits to providing psychologically-based interventions for street youth that are directed toward strengthening resilience and, in this case, positive relationships, rather than focusing on mental health symptoms. Addressing the mental health problems of street youth, including their very high levels of psychological distress, should enable youth to engage in opportunities for social reintegration through the transition to stable housing and/or employment programs.

An extensive qualitative study of 128 street youth and 50 service providers (Karabanow & Clement, 2004; Karabanow, 2008) has been used to create a theoretical model to describe the process of exiting the street and finding stable housing. Central to successful "exiting" were characteristics such as personal motivation and positive self-esteem. These observations are consistent with the findings of Kidd and Shahar (2008), who found that self-esteem was the strongest factor protecting against thoughts of suicide and loneliness amongst a similar group of street-involved youth in New York City. Taken together with our study findings, it seems that interventions that concentrate on strengthening mental health and resilience, as well as self-esteem, hold great promise in supporting street-involved youth to achieve independent, healthy and successful lives.

Critical Periods for Intervention

The longer youth spend on the street, the greater the chance that they will engage in high risk behaviours, such as survival sex, suicide attempts (McCarthy & Hagan, 1992), substance use, and injection drug use (Steensma et al., 2005), and the less likely they are to seek regular healthcare (O'Toole et al., 1999). As youth spend more time on the street, the risk of chronic homelessness increases (Goering et al., 2002) suggesting that there is a critical window of opportunity for intervention (Auerswald & Eyre, 2002). By far the largest barrier to improving the circumstances of street-involved youth is the profound difficulty of engaging marginalized youth in helping relationships and services (Slesnick et al., 2000). Although difficult to define, engagement can be thought of as the degree to which youth are able to access and trust in the relationship with their primary service provider. It is evident that for street-involved youth, challenges associated with engaging in healthcare and social services are linked to mental health. Accessing mental health services, as well as health and social services, requires a capacity for effective engagement. There is an overwhelming need to meaningfully engage youth who are at critical periods in their journey in order to end their homelessness. Two critical periods for intervention include: 1) first engagement/contact with service providers and 2) transition to independent housing.

Initial Contact as an Optimal Time for Engagement: Engaging Youth through Motivational Interviewing (MI)

It is generally accepted that overwhelming mental health issues, such as those described earlier, frequently prevent youth from fully engaging in a range of healthcare services (including mental health services), as well as educational or employment programs that could ultimately lead to independent and healthy lives. Difficulties engaging in health and social service programs can be been attributed to highly complex psychological needs (e.g. trauma) and the associated lack of trust necessary to engage in helping relationships. As well, challenges associated with life on the street, such as substance use, also interfere with the formation of trusting relationships and engagement in programs (Darbyshire et al., 2006; Slesnick et al., 2008). A study examining the participation of at-risk youth in mental health services highlights the need to understand the demanding nature of engaging vulnerable youth (French et al., 2003). These authors emphasize that rigid practices are likely to limit youth's engagement, and advocate for participatory processes that clearly place youth's concerns at the centre of relationships with service providers. Further, an extensive literature review by Paterson and Panessa (2008) concludes that surprisingly little attention has been paid to engagement processes in harm-reduction strategies and argues that youth engagement is a critical factor in supporting youth to make healthy behavioural choices. Given the

profound problems of engaging youth so negatively affected by life on the street, there is a need for intervention strategies to enable care providers to: develop trusting relationships with youth; motivate youth to adopt healthy behaviours for change; and to ultimately engage youth in services to obtain stable housing and achieve life goals. An effective strategy for engaging youth in making positive changes in their lives is an approach called Motivational Interviewing or MI.

Motivational Interviewing (MI) is a highly interactive and client-centred counselling style for supporting and motivating clients who may be interested in changing their health behaviours (Miller & Rollnick, 2002). MI is particularly effective when working with individuals who are not yet thinking about change or who are unsure about whether they want to change (SAMHSA, 2010), and, in this way is well suited to street-involved youth. Peterson et al., (2006) argue that MI is "well matched" for working with homeless and marginalized populations who may find it especially difficult to think about and follow through with changes given all of the challenges and barriers they face. MI recognizes that therapy can be used to strengthen an individual's personal motivation and abilities, resulting in behavioural change and positive health outcomes (Frey et al., 2011; Naar-King et al., 2009). The role of the service provider is to work collaboratively with clients in order to help them begin to understand and put into words how they feel about their own behaviour, how motivated they are to change their behaviour, and when ready, to consider specific steps towards changing behaviour. Creating a safe setting, so that the client can share their true feelings and motivations regarding a specific behaviour, is one of the most important characteristics of the service provider's role in MI.

MI follows four guiding principles: (1) expressing empathy, (2) developing discrepancy, (3) rolling with resistance, and (4) supporting self-efficacy (Miller & Rollnick, 2002). Expressing empathy involves communicating support and acceptance of clients as they are, regardless of the choices they make, which builds clients' trust in the counsellor and in themselves and, in turn, facilitates change. Developing discrepancy aims to help clients recognize that their current behaviours are in conflict with important personal goals or personal values, thereby helping clients identify their own reasons for change. By rolling with resistance, the provider lets the client know that uncertainty about changing is natural. Finally, to support self-efficacy (one's belief that one is capable of making changes), the provider communicates confidence that change is possible and helps the client develop the necessary skills to achieve such change (Jackman, 2011).

The benefits of a trusting and accepting bond between client and counsellor have been recognized in the research for decades (Angus & Kagan, 2009). MI emphasizes the need for care providers to communicate non-judgmental, unconditional

acceptance to highly vulnerable youth, while at the same time inviting youth to consider the need for change, such as moving away from harmful behaviours and toward life goals. MI has been shown to be effective in addressing the different kinds of mental health problems experienced by homeless youth, such as substance abuse, anxiety and depression (Arkowitz et al., 2007; Westra & Dozois, 2006), and eating disorders (Arkowitz et al., 2007; Burke et al., 2003). It also shows promise for addressing non-suicidal self-harming behaviour (Kress & Hoffman, 2008), as well as for conditions like schizophrenia and bipolar disorder, by building commitment to treatment (Rusch & Corrigan, 2002). In the same way, MI helps to overcome the basic difficulties in engaging street-based populations, as limited client engagement and lack of follow-through continue to be the major factors limiting the effectiveness of current interventions, holding back positive behavioural change. In this way, the bulk of the current evidence points to the value of MI in the treatment of a broad range of mental health problems by increasing engagement with treatment and improving outcomes overall (Arkowitz et al., 2008). Recognizing the potential of MI, a resilience- and strength-based approach, which focuses on moving toward client-centred goals, while respecting where clients are, at any given moment in their journey, our research group is currently engaged in a study funded by the Canadian Institutes of Health Research (CIHR). The study's aims are to develop, carry out and evaluate an innovative intervention, which includes motivational interviewing, to meaningfully engage youth who are at the beginning of their journey to end homelessness. Through meaningful engagement, we hope to help youth adopt healthy behaviours for change and ultimately support them in becoming healthy, independent young adults.

Mental Health Intervention to Support the Transition to Independence: Dialectical Behaviour Therapy (DBT)

As youth continue on their journey towards independence, there is a need for services and programs to support them in building the skills and experience necessary to become independent young adults. The need to engage in career-oriented activities, such as education or employment programs, is particularly urgent when youth are preparing to transition to independence. Programs such as transitional housing, which support youth's transition to independence, can be found in most large urban centers. Within these programs, youth live in stable, independent housing and are provided with support to acquire skills (such as money management and cooking), as well as the opportunity to engage in education or employment-related opportunities, all necessary for independent living. Despite the availability of these transitional programs, experience suggests that youth are often unable to stay engaged in these programs. Frequently, profound mental health issues, such as depression, anxiety, self-harm and suicidality, as well as issues related to drug abuse and other self-defeating behaviours, dramatically harm the young person's capacity

to engage in opportunities for social re-integration. Transitioning to independent living is another critical period where mental health intervention may maximize youth's capacity to stay in transitional programs to achieve successful independence.

Dialectical Behaviour Therapy (DBT) (Linehan, 1993) is supported by research evidence and includes both individual and group components and is well suited to street-involved youth experiencing a range of mental health challenges. Originally, DBT was developed to reduce self-harming behavior common among individuals with severe challenges in coping, such as those with borderline personality disorder (Linehan, 1993). Over the past number of years, DBT has been adapted for a wide range of mental health challenges, specifically suicidal and non-suicidal self-harming behaviour, addictive behaviour, and other impulsive behaviours, as well as mood disorders in adults and youth, all of which are common in street-involved youth and involve problems with emotion regulation (Katz et al., 2009; Goldstein, Axelson et al., 2007; Harley et al., 2008; Linehan, 1993 & 2000; Miller et al., 2007). Emotion regulation refers to the individual's capacity to have control over their emotions (e.g. – limit emotional outbursts), particularly in social situations, and is thought to be related to overall emotional well-being, including the quality of relationships (Lopes et al., 2005). DBT is based on the understanding that a lack of emotion regulation (aggressive behaviour in response to anger) is related to a range of difficulties in coping with life challenges. Emotional dysregulation or extreme emotional sensitivity may be a result of biological vulnerability (emotional sensitivity) and/or traumatic interpersonal relationships (Koerner & Dimeff, 2007). It is recognized that individuals who struggle with emotional regulation also have profoundly negative perceptions of themselves, to the point of self-loathing. DBT intervention emphasizes the need for therapeutic unconditional acceptance of the client, as well as the need to focus on changing ineffective coping mechanisms, such as self-harm and/or addiction, which are frequently used by street youth to avoid painful emotions and perceptions of themselves.

As a multi-component intervention, DBT is designed to enhance individuals' capacity to cope with challenging circumstances (such as past & current traumas) in their lives by learning to regulate their emotions, cope with emotional distress, be more mindful of strengthening the core self (genuine sense of self), and become more effective in interpersonal relationships. Thus DBT offers promise in improving the mental health and overall functioning of street youth in two important ways: 1) DBT is directed towards actively engaging youth in weekly individual psychotherapy and group skills training sessions focused on learning to cope with emotional distress, thus decreasing the intensity of emotional distress and ineffective coping mechanisms over a relatively short time frame, which often can take many months or years; and 2) DBT emphasizes problem-solving and relationship skills, which youth are able to transfer to other life situations. Given the poten-

tial of DBT to reduce emotional distress, build emotion-based coping skills, and increase interpersonal skills for street youth, our research group (funded by the Canadian Institutes of Health Research) is currently providing and evaluating the adolescent version of DBT (Miller et al., 2007) to street youth aged 16-24. The adolescent version of DBT is closely aligned with Linehan's model (1993) and addresses core issues such as unstable moods, impulse control, intense relationship issues (coping with feelings of abandonment), and identity disturbance (confusion regarding the core self) (Rathus & Miller, 2002), all common problems during the transitional phase of adolescence, particularly for street-involved youth.

Our 12-week adolescent version of DBT addresses each of the mental health challenges described above through individual psychotherapy, skills training in a group setting, development of a 24-hour crisis plan, and staff training to enhance therapists' DBT capabilities. Currently, staff working within two community agencies in Canada are administering the DBT intervention. Staff received DBT training using a variety of methods which included the following: (1) online DBT training; (2) a series of eight DBT training sessions/webinars led by a DBT expert; and (3) a written manual outlining the 12-week DBT program. In order to evaluate the effectiveness of the DBT training methods listed above, staff were asked to complete pre- and post-training questionnaires testing their knowledge of DBT. DBT individual and group therapists in this study also participate in ongoing weekly one-hour consultation meetings via teleconference during which they receive support and consultation regarding the implementation of DBT. The consultation team meetings help to ensure that the therapists are following the DBT model. To assess the effectiveness of the intervention, participants are asked to fill out a number of questionnaires, which measure mental health challenges and strengths, as well as overall functioning at different points in time. Some of the participants will also be invited to participate in interviews to discuss their views of the DBT intervention. The study is ongoing, and recruitment and youth engagement in the intervention is encouraging. Informal feedback from youth and staff alike indicates that this is a promising intervention for youth who are transitioning to independence.

Recommendations for Policy Makers

Overall, there is an urgent need for increased access to mental health services for street-involved youth. Research findings from our study, designed to gain a deeper understanding of the mental health challenges and strengths of street-involved youth, illustrates that despite their high level of mental health care need, they are far less likely to access mental health care, healthcare and/or social services for a variety of complex reasons, including stigma and discrimination (McCay et al., 2010). Accessible mental health services should be non-stigmatizing, which may be accomplished by offering these services at sites that

youth already frequent, such as shelters or drop-in programs. Mental health services for street-involved youth need to be offered in a non-threatening environment where help is offered in a non-judgmental and accepting manner, so that youth can readily trust providers and be willing to engage in services. It is clear that youth are unlikely to use traditional mental health services.

In addition, our findings suggest that multi-component mental health programs and interventions are needed to address youth's strengths and challenges in order to better help street-involved youth achieve social re-integration and improved quality of life (McCay et al., 2010). Emerging findings indicate that youth may benefit from participating in interventions focused on their mental health. Specifically, street-involved youth who participated in a 6-week relationship-based intervention experienced higher levels of social connectedness, along with decreased hopelessness, compared with youth who did not receive the intervention (McCay et al., 2011). Such interventions and programs have the potential to build youth's resilience and capacity to cope with challenging circumstances, to cope with emotional distress, and to build on existing strengths to pursue practical, personal goals towards an improved quality of life. The mental health challenges of street-involved youth are severe and complex. Skillful intervention requires working from both positive and negative perspectives, emphasizing positive self-acceptance and resilience while focusing on the need to move away from negative coping strategies, such as self-harm and/or addiction, toward more effective strategies, such as building positive relationships. Providing evidence-based mental health interventions on-site within agencies providing services to street-involved youth (like the two studies in progress described in the chapter), is an approach that promises to increase access and suitability to youth of much needed interventions to address their profound mental health needs.

From a policy perspective, it is essential to recognize that evidence-based mental health interventions have the potential to help youth negotiate critical crossroads on their path to recovery, specifically when they first enter or seek services, as well as during their transition to independence. These are ideal times to provide effective mental health interventions within the context of services for street-involved youth. Early data from our study that looks at providing and evaluating DBT for street-involved youth suggest that it is indeed possible to engage these youth in services, as well as in helpful relationships with service providers. These interventions are complex and require that training be accessible for service providers to attain adequate training and support to sustain effective implementation. There is an urgent need to recognize the mental health needs of street-involved youth and for policy makers to direct their attention to the implementation of evidence-based mental health interventions and practices in youth friendly settings in order to support these youth to achieve health and independence.

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