3.2 RESPONDING TO MENTAL HEALTH CONCERNS ON THE FRONT LINE: BUILDING CAPACITY AT A CRISIS SHELTER FOR YOUTH EXPERIENCING HOMELESSNESS

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INTRODUCTION

It is well established that youth experiencing homelessness face many challenges with their mental health. For example, a literature review of the topic found that 30%–40% of youth who are homeless experience major depression, bipolar disorder, posttraumatic stress disorder, and substance use (Kidd, 2013). A small number also experience psychotic disorders such as schizophrenia, although this incidence is believed to be larger than that found in the general population (Kidd, 2013). Moreover, an alarming number of youth face some form of emotional distress regardless of whether they have a formal diagnosis. Our administrative data at Covenant House Toronto, Canada's largest youth-serving agency, show that about 30% of the young people we serve in our emergency shelter have a serious mental health concern, and of a sample of 164 youth using our drop-in, shelter, and transitional housing programs, over 70% reported experiencing at least one symptom of depression, anxiety, hearing or seeing things that others could not, distress from past trauma, sleep disturbances, and/or suicidal ideation in the past three months. Sadly, over 30% thought about ending their lives over the past three months. These numbers were even higher for vulnerable subpopulations, particularly LGBTQ2S youth, of whom over 90% experienced at least one symptom and 59% thought about ending their lives in the past three months.

Despite their high levels of need, few youth who are homeless use mental health services (McCay et al., 2010), and there is a dearth of literature exploring promising mental health practices with this population, particularly in a drop-in or emergency setting (Coren et al., 2013). At Covenant House, we have seen several behavioural manifestations of the youth's distress, including self-harming behaviour, substance abuse, and even suicide attempts. This chapter outlines the steps we have undertaken to build our capacity to respond to the mental health challenges of our young people.

CHALLENGES IN SUPPORTING YOUTH WHO ARE HOMELESS

Toronto's emergency shelter system, including Covenant House, has historically not been equipped to address the vast mental health issues that our young people face. We face numerous challenges providing the supports the youth require, although five challenges stand out:

- Our youth present with a wide continuum of symptoms ranging from anxiety, depression, and posttraumatic stress to hallucinations and paranoia. The supports they require therefore vary tremendously.
- When young people come to Covenant House, they are generally seeking help securing their basic needs, not necessarily to address their mental health concerns. As such, their desire to engage around these issues may be minimal.
- Unless youth are aware and articulate their struggles, it can be challenging for us to understand the precise nature of their difficulties. Services for youth who are homeless are designed to be low barrier, which means there are not comprehensive screening or assessment procedures in place prior to providing service. We often see the behavioural manifestations of mental health concerns but do not know the cause, as it could be the result of any number of factors including trauma, substance use, or a serious disorder.
- Some youth who are homeless tend to access services sporadically over a long period of time, and move frequently between shelters and other temporary accommodations. This impedes our ability to develop and execute a consistent plan of care.
- Most of our staff members are youth workers who lack the expertise and skill set necessary to identify and address most mental health concerns. This may be the most significant challenge.

Drop-in and emergency services fulfill a very significant role in the continuum of supports to youth who are homeless and marginalized. Considering the many challenges we face in providing mental health services, we have attempted to provide these services in this setting in several ways: by having staff available onsite in a flexible capacity, by providing staff training and practising self-care, and by building strategic partnerships with other agencies and universities. This chapter discusses each of these approaches, as well as lessons we learned while undertaking these initiatives.

PROVIDING MENTAL HEALTH CARE IN A DROP-IN SETTING

Within our drop-in and emergency services, staff must balance the need to establish sanctuary in the space while being responsive to the very complicated mental health and substance use needs presented by some of the youth. Much of their work involves crisis intervention in the role of first responder. Our workers are continually assessing immediate safety needs, and when required are calling mobile crisis units to respond. As in all our work, the most important component is the connection and trust that is developed between the youth and the staff. This is used as a tool to engage youth in service whether it is safety planning or referrals to treatment. Within this setting, it is important to keep barriers to service provision low by allowing youth to access services in a flexible way. We do this by having a dedicated mental health staff onsite, and by having professionals work out of our drop-in on a part-time basis.

We have established a new full-time staff position, the mental health and substance use counsellor, whose job is to support the mental health, wellness, and substance use issues of our youth. Young people using any of our programs or from the community can access the counsellor simply by phoning, texting, or emailing to make an appointment, or they can drop in when she is available. The counsellor provides general supports and skills development to youth who are contemplating engaging in long-term supports but perhaps are not ready to do so, or who have not been able to access formal supports in the community for one reason or another (e.g., no formal diagnosis, on a waiting list, prohibitive cost). The continued presence of the counsellor allows youth who may be highly transient to have a consistent and accessible mental health professional available when they are willing to engage, and they can make appointments as frequently or infrequently as possible. Youth do not need to identify that they have a mental health or substance use problem, but can merely indicate that they "have a lot going on" in their lives, which will prompt an invitation to talk to our counsellor. This is likely a very different experience from their past connections with mental health providers who create hurdles by requiring youth to identify their mental health needs, to attend scheduled appointments, and to be on time.

We have also formed strategic partnerships that allow mental health professionals to spend some time at our agency. For example, a psychiatrist comes to Covenant House once a week. This provides the opportunity for youth to be assessed, to access medication supports, and for treatment plans to be developed. Each month, the psychiatrist provides

time for a clinical consultation session where particularly challenging cases are presented. Program staff benefit from this process by either learning about a new strategy to address a challenging behaviour or by getting affirmation that they are doing the right thing.

We also have a youth worker from Central Toronto Youth Services who works out of our drop-in space. As a mental health specialist, she works with youth to enhance their coping skills and safety plan if need be. Having professionals available at the drop-in is extremely useful because it allows young people to visit whenever they would like rather than having to make a series of fixed appointments, which is difficult for some youth to commit to. The mental health worker's continued presence in a youth-friendly, familiar environment also allows youth to gradually build their comfort level and trust, which promotes access to supports if need be, including in the event of a crisis.

INCREASING TRAINING OPPORTUNITIES

Having trained staff that is equipped to address the challenges our youth face is crucial given the high incidence of mental health concerns. Staff members undergo various trainings, including applied suicide intervention skills training, which helps workers identify and respond to suicidality among our youth. They also attend trainings co-created with the Paloma Foundation on a variety of topics pertaining to youth and mental health (visit palomafoundation.com to view training videos). Below we describe our largest training initiative, the implementation of a strengths-based resilience model of care across all of our programs.

RESILIENCE: A STRENGTHS-BASED APPROACH

At Covenant House Toronto, we have implemented a strengths-based philosophy of care, largely informed by Ken Ginsburg's model (Ginsburg & Jablow, 2015; Ginsburg & Kinsman, 2014). The model draws on the notion of resilience—the ability to persevere through challenging times. Resilience models promote protective factors that allow young people to develop in a healthy way while avoiding risky behaviour in the face of hardship. Our approach facilitates development of the 7 Cs: the traditional 5 Cs from positive youth development theories—confidence, competence, connection, character, contribution—plus two more—control and coping (see sidebar) (Ginsburg & Kinsman, 2014). At

Covenant House, staff uses the 7 Cs in interactions with youth. For example, to foster a sense of control, staff intentionally offers choices to help youth set, redefine, and evaluate their goals as they see fit, and before offering suggestions or advice, staff asks the youth's permission to do so.

7 Cs model of resilience

1. **Confidence:** youth gain confidence through acting in a competent manner that is reinforced by staff. It is the staff's job to draw attention to the young person's strengths.
2. **Competence:** this quality is acquired through skills development. Staff model and work with youth to develop necessary skills.
3. **Connection:** developing a connection with adults is one of the most important protective factors in developing resilience among youth.
4. **Character:** building character involves developing morals and self-awareness. It is important that this is modelled by staff.
5. **Contribution:** youth who develop the first four Cs are able to make contributions to themselves, their families when applicable, their communities, and society in general.
6. **Coping:** youth develop adaptive and healthy strategies for managing stress and life's challenges.
7. **Control:** youth feel they are in control of their behaviour and can avoid risky behaviour.

A resilience-based approach is paramount to working with youth who are homeless because most of them have undergone tremendous hardship such as family conflict, or abuse, in addition to the experience of homelessness itself. In the face of these challenges, being able to move forward in their lives and thrive, or taking advantage of life's opportunities that are necessary to build a promising future (e.g., education and employment), requires a tremendous amount of resilience. All of our youth demonstrate resilience to some degree, but many face challenges because they have acquired maladaptive coping mechanisms such as substance use. As a result of their histories, many youth have difficulty believing they have any strengths, and require the loving guidance of someone who accepts them unconditionally and believes in their ability to move forward. As many of the youth we see do not have a strong support system, staff must provide this critical link by developing a meaningful relationship with the youth.

At Covenant House Toronto, we have invited Dr. Ginsburg to deliver full-day trainings to our staff, and have followed up by using his training guide *Reaching Teens* (Ginsburg & Kinsman, 2014). The guide discusses a range of topics, including how a strengths-based model promotes change, how trauma affects development, how to incorporate a trauma-informed model into practice, and what strategies to use to address specific emotional and behavioural health concerns such as depression, anxiety, and substance use. The guide also describes how workers can practise self-care to avoid burnout and best serve their clients. All program staff meets monthly for training on a particular topic in the guide. The primary focus of these sessions is to give staff practical tools to support them in their daily interactions with youth. For example, in a session on stress reduction, staff created a wellness box that could be offered to youth struggling with substance use or emotional regulation. It included colouring books, stress balls, headphones for listening to music, play dough, and other aids. Each of these sessions allots time to addressing the self-care needs of our staff, which is critical to being effective in working with youth.

BUILDING PARTNERSHIPS

Responding to the mental health concerns of our young people requires a continuum of options that are administered by a multi-disciplinary group of professionals. While we have a limited number of clinical professionals at Covenant House, the level of need demonstrated by our youth means this is not something we can address on our own. In this sense, partnerships with other organizations and institutions are pivotal. Two of the most beneficial partnerships we have forged involve university-based researchers and professionals from Youthdale Treatment Centres.

PARTNERSHIPS WITH UNIVERSITIES

There are often researchers and mental health professionals at local universities who are interested in testing the effectiveness of particular intervention strategies on specific populations, including youth who are homeless.[1] We partnered with researcher Elizabeth McCay (and colleagues) at Ryerson University to test the effectiveness of dialectical

[1] Some of these techniques are also available through local training centres such as the Toronto Hostels Training Centre (thtcentre.com).

behaviour therapy (see chapter 1.2) and motivational interviewing as counselling interventions for our youth. This allowed several of our staff to get training in two techniques they continue to use long after the original research concluded.

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) is a multi-component therapeutic intervention that has demonstrated effectiveness treating a range of concerns relating to difficulties in emotional regulation, including substance use, self-harming behaviour, mood disorders, and suicidality (McCay, Quesnel, & Aiello, 2014). Given the high volume of emotional turmoil many of our youth face, DBT was seen to be a good fit for our agency. Consultation at the front end between the researchers and senior staff at the agency ensured that the intervention was modified to reflect the unique needs of youth who are homeless. For example, the number of sessions was reduced to promote better outcomes around youths' sustained engagement in the intervention. McCay and colleagues developed a training curriculum that was delivered to a cross-section of our staff, including youth workers and case managers. They participated in a series of eight DBT training sessions and additional online training, and received a DBT skills training manual. The study found that DBT significantly improved symptoms of depression, anxiety, and hopelessness, and increased resilience, self-esteem, and social connectedness among youth participants (McCay et al., 2015).

This training required a huge investment of time and often was challenging for staff to complete given the demands of their daily responsibilities. Some staff received the training and then were unable to sustain their commitment to the project. A core group, however, remained involved and continues to offer DBT groups to our youth, as well as incorporating DBT emotional regulation techniques in their individual practice, such as offering ice packs, sour candy, and colouring activities.

Motivational interviewing

We also partnered with McCay and colleagues at Ryerson University to study the effectiveness of motivational interviewing (the results are forthcoming) because we were concerned about the transience of our youth and our challenges in engaging them in the change process. Three of our caseworkers and later our mental health and substance use counsellor were trained in motivational interviewing. This client-centred technique aligns philosophically with the transtheoretical model (stages of change) and strengths-based and resilience theories of care (McCay et al., 2015). Motivational interviewing was seen to be an effective tool for our staff to reframe "resistance to engage" as an opportunity

to join with youth to help them more comfortably consider and embrace change. The caseworker's main duties are to create a safe and non-judgemental atmosphere, develop a plan of care that is unique to each youth, and continually point out the young person's strengths and resilience through previous hardship (McKay et al., 2015).

PARTNERSHIP WITH MENTAL HEALTH ORGANIZATIONS

In addition to training our staff, we have sought to increase partnerships with community mental health agencies that can work with our youth directly. Of particular note is the partnership we developed with Youthdale Treatment Centres, a local mental health centre for youth, with whom we share not only office space, but also staff. Staff from Youthdale comes to our shelter during the week for four hours, where they spend time with the youth in our open space. They build relationships with the young people and give them additional one-on-one time to discuss anything that might be bothering them. The partnership is structured in a way that facilitates reciprocal learning: Youthdale staff learns more about young people who are homeless and struggling with mental health concerns (often without the support of their families), and our staff learns concrete strategies for working with young people struggling with their mental health, or current strategies are reinforced.

KEY MESSAGES FOR PRACTITIONERS

The young people who access our services present with myriad mental health concerns ranging from anxiety, depression, and posttraumatic stress to symptoms such as hallucinations and paranoia. We have attempted to build our internal capacity to address this in several ways: by providing informal services onsite, by implementing a resilience-based model of practice, and by forming partnerships with academics and community-based mental health agencies. We have learned a lot from this process, but would emphasize five of the most important learnings, which are described in the following section.

Understanding trauma, strengths, and resilience is paramount to working with youth who are homeless. Many, if not most, of our youth have complex histories of trauma and continued hardship. In many cases, some of the behaviours they have adopted such as substance use and self-harming behaviour have been adaptive in the sense that they have

helped youth survive through tough times. By focusing on the strengths of our young people, we avoid stigmatizing and even retraumatizing them, allowing them to build the confidence and resilience necessary to move forward in their lives.

Supports must be in place that meet youth where they are at. In many cases, youth are not in a position to commit to a regular series of appointments with a mental health professional. While it is important to have structured supports in place for youth who are able to access them (such as the DBT and motivational interviewing interventions discussed above), it is also crucial that informal services be in place for youth in a drop-in setting. This allows youth to come and go as they need or require, knowing the supports are there when they need them.

Start by securing basic needs and developing relationships. In order to work with youth on their mental health concerns, their basic needs must be met and they must feel safe. Providing basic needs is obviously necessary for survival and provides a foundation for all other work to occur, but it also is a starting point for staff to build rapport and develop a relationship with the youth. Once rapport is established, using informal ways to discuss mental health can be very useful. For example, our partners at Youthdale Treatment Centres develop rapport with youth by engaging them in activities such as board games or cards. The activity provides an opportunity to talk with youth in an informal and non-confrontational manner.

Partnerships are critical. No one agency can do this important work alone. Responding to the needs of our young people requires a variety of professionals with different expertise and credentials. Yet building effective partnerships can be challenging and is inevitably a lot of work. Having dedicated staff to manage these partnerships is important, as is ongoing communication and compromise. It is also important that partnerships are situated as a "win-win" for both sides—that both parties benefit from the partnership.

The prevalence of mental health concerns and distress among youth experiencing homelessness is alarmingly high. While forming partnerships and increasing our internal capacity to respond to these concerns is important, we must not shift attention from the need for increased community-based supports for our youth, and from the need to prevent the factors that place young people at increased risk of mental health struggles, such as homelessness. Youth homelessness is generally caused by many of the same factors that lead to the high levels of distress our young people face, including family conflict and breakdown, abuse, discrimination (including colonization, racism, transphobia, and

homophobia), and a breakdown of various systems such as child welfare and corrections. The experience of homelessness itself adds to this distress. We cannot respond to the challenges of our young people without acknowledging what causes them. While as a sector we have become much better at responding to the mental health challenges our youth face, the homeless sector cannot and should not take on this social concern by itself. If we truly want to respond to the mental health challenges of our youth, we must do the best we can to prevent them from falling into situations that harm them in the first place.

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