*Résumé*

# Les défis et les forces chez les jeunes vivant dans la rue, sur le plan de la santé mentale : le besoin de mettre en place une approche multi-déterminée

**Elizabeth McCay, John Langley, Heather Beanlands, Linda Cooper, Naomi Mudachi, Andrea Harris, Rebecca Blidner, Karen Bach, Colin Dart, Carol Howes, Susan Miner**

Les activités sociales des jeunes sans-abri et les milieux qu'ils fréquentent entraînent souvent un mode de vie nocif menant à la toxicomanie, au sexe de survie, à des comportements autodestructeurs et à des tendances suicidaires. Dans le cadre de cette étude, une approche à méthodes mixtes a été utilisée pour évaluer les défis et les forces chez les jeunes vivant dans la rue, sur le plan de la santé mentale. Un échantillon de commodité composé de 70 jeunes sans-abri a répondu à une série de questionnaires normalisés, lesquels visaient à évaluer l'état de santé mentale, la résilience et l'estime de soi de ces jeunes. Les chercheurs ont aussi tenu deux groupes de discussion avec pour but de cerner les perceptions qu'ont les jeunes vivant dans la rue quant à leurs besoins en santé mentale. L'étude a révélé chez cette population (âgée de 16 à 24 ans) d'importants taux de troubles mentaux, comparativement à d'autres groupes de jeunes adultes. Toutefois, ces jeunes affichaient des taux de résilience et d'estime de soi modérément élevés. Par conséquent, la mise en place de programmes et d'interventions en santé mentale tenant compte à la fois des forces et des défis pourraient aider les jeunes vivant dans la rue, dans leur démarche pour réintégrer la société et, en bout de ligne, améliorer leur qualité de vie.

Mots clés : santé mentale

# Mental Health Challenges and Strengths of Street–Involved Youth: The Need for a Multi–determined Approach

**Elizabeth McCay, John Langley, Heather Beanlands, Linda Cooper, Naomi Mudachi, Andrea Harris, Rebecca Blidner, Karen Bach, Colin Dart, Carol Howes, Susan Miner**

The social environments and activities of homeless youth frequently create a downward spiral, leading to drug abuse and survival sex as well as self-harm behaviours and suicidality. This study employed a mixed-methods approach to assess the mental health challenges and strengths of street-involved youth. A convenience sample of 70 homeless young people completed a series of standardized questionnaires evaluating mental health symptoms as well as resilience and self-esteem. Two focus groups were also held to capture the perceived mental health needs of street-involved youth. These young people (aged 16–24) were found to have high levels of mental health symptoms compared to other groups of young adults. However, they also exhibited moderately high levels of resilience and self-esteem. Therefore, multi-component mental health programs and interventions that address both strengths and challenges may well help street-involved youth to work towards social re-integration and, ultimately, improved quality of life.

Keywords: determinants of health, mental health/pyschosocial, vulnerable populations, youth health

## Introduction

Nearly two decades ago, Kurtz, Jarvis, and Kurtz (1991) made the observation that the underlying causes of homelessness in youth (e.g., the need to escape abuse; being thrown out of the home) are frequently linked to mental health challenges. For youth living on the street, mental illness may be a major risk factor for homelessness or may emerge in response to the need to cope with the multitudinous stressors associated with life on the street (Adalf & Zdanowicz, 1999). These stressors include exposure to violence, pressure to participate in survival sex, and drug use (Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Morrell–Bellai, Goering, & Boydell, 2000; Rew, Taylor–Seehafer, Thomas, & Yockey, 2001). Researchers have made the observation that living on the street

may in fact exacerbate existing mental illness in these young people (Whitbeck, Johnson, Hoyt, & Cauce, 2004), with a number of studies documenting high rates of mental health problems in street-involved youth (Boivin, Roy, Haley, & Galbaud du Fort, 2005; Sleegers, Spijker, Van Limbeek, & Van Engeland, 1998). Other studies document significant levels of mental illness in homeless and runaway youth (including major depressive disorder, post-traumatic stress disorder, and substance abuse) in US cities (Fietal, Margetson, Chamas, & Lipman, 1992; Rhode, Noell, Ochs, & Seeley, 2001; Whitbeck et al.). McCaskill, Toro, and Wolfe (1998) compared samples of homeless and housed youth in the Detroit area and found elevated levels of disruptive behaviour and alcohol abuse in the homeless sample. While a review of mental health needs in adult homeless populations is beyond the scope of this article, it is worth noting that there is literature indicating that mental health challenges and symptoms are associated with chronic homelessness, further demonstrating the need to address the mental health requirements of street-involved youth (North, Pollio, Smith, & Spitznagel, 1998).

It is evident from the literature that youth who are living on the street are highly vulnerable and are predisposed to mental health problems. The social environments of these young people frequently create a downward spiral, leading to drug abuse and survival sex (Slesnick, Prestopnik, Meyers, & Glassman, 2007) as well as chronic homelessness and suicide (Kidd & Kral, 2002). Further, McManus and Thompson (2008) report that homeless adolescents are particularly vulnerable to trauma-related symptoms given their high level of exposure to dangerous conditions such as impoverishment and constant threats to survival. What is particularly disturbing is the extremely high rate of suicide and attempted suicide amongst homeless youth; the rate of attempted suicide in this group is 10.3 times the average for Canadian youth (Kidd & Kral), while suicide has been found to be the leading cause of death amongst homeless youth (Roy et al., 2004).

Despite the pervasive hardship experienced by homeless youth, there are indications that a strong sense of psychological resilience may exist in the midst of the chaos experienced by homeless adolescents and young adults (Adalf & Zdanowicz, 1999; Kidd & Shahar, 2008). Rew (2003) interviewed 15 homeless young people in a qualitative study of attitudes towards self-care. The findings revealed that these youth regarded leaving home as an important first step in taking care of themselves and gaining self-respect. Life on the street entailed forming relationships with peers and learning how to manage many obstacles. A secondary content analysis of data obtained from several qualitative studies (Rew & Horner, 2003) demonstrated the will of youth to move beyond life on the street. Specific actions included seeking resources, focusing on self-improve-

ment, gaining emotional maturity, acquiring skills, and adopting healthier behaviours. In addition, a quantitative study with 208 homeless youths in New York City and Toronto (Kidd & Shahar) identified a critical relationship between self-esteem and resilience, further indicating the need to pay attention to these protective factors amongst this vulnerable population.

Notwithstanding the current literature related to the mental health of homeless youth, there is an urgent need for careful assessment of the level of unmet mental health needs amongst this population (Rhode et al., 2001). The purpose of the present study was to conduct a comprehensive mental health assessment of homeless youth to increase our understanding of the challenges and strengths pertaining to street-involved youth. Although a number of studies have described the mental health challenges of street-involved youth, the present study is unique in that it employed a mixed-methods approach to describe both mental health challenges and strengths. Ultimately, it was expected that the results would provide direction for a targeted mental health intervention to strengthen mental health and support the overall functioning and capacity of homeless young people to engage in social re-integration.

The terms homeless youth and street youth are used interchangeably in the literature (Hwang, 2001). However, the term street-involved youth will be used throughout this article and refers to people between the ages of 16 and 24 who have been without a home for a minimum of 1 month.

## Methods

### Study Design

The study employed a mixed-methods approach (quantitative and qualitative methods). This article reports on the quantitative findings as well as a component of the qualitative findings — specifically, those pertaining to two focus groups of eight to ten participants each. The quantitative component of the study used a cross-sectional descriptive design. Focus group questions targeted self-perceptions of the mental health needs of street-involved youth as well as identification of services and strategies that could be helpful in meeting those needs. The focus groups were audiorecorded and the recordings were transcribed verbatim.

### Procedures

A convenience sample of young people was recruited from four community agencies in Toronto for either the quantitative or the qualitative component of the study. The community agencies all provided a range of services to street youth, including shelter, drop-in services, and sexual

health services. Approval was obtained from the appropriate institutional ethics review board. Inclusion criteria were as follows: (a) aged 16 to 24; (b) being without a home or place of one's own for at least 1 month; (c) ability to read, comprehend, and speak English; and (d) capacity to give informed consent. Staff in the community agencies invited eligible young people to participate in the quantitative component of the study. If a youth expressed interest in the study, research assistants obtained informed consent and administered the questionnaire for the quantitative component (described below), which took approximately 60 to 90 minutes. Two experienced research assistants administered the questionnaires in a supportive interview format. The participants were encouraged to take a break if they found the process arduous and the research assistants checked with them at the end of the interview to inquire whether they needed additional support. The majority of young people stated that participating in the study gave them a feeling of accomplishment. Those who expressed suicide ideation were referred directly by the research assistant to agency staff members, who were readily available to the participants.

On a separate occasion, different young people who met the same inclusion criteria were recruited to participate in the two focus groups to give their perspective on mental health needs. The focus groups were conducted in a supportive manner, with additional support available as required.

Participants were paid $20 for taking part in the quantitative component and $10 for taking part in a focus group. The data were collected between 2005 and 2007.

### Study Measures

The questionnaires were selected in accordance with the overall purpose of the study, to assess both mental health challenges and strengths for the participants. The questionnaires have demonstrated satisfactory levels of reliability and validity in youth populations and require a Grade 6 to Grade 8 reading level. Sample characteristics include indicators of suicidality, self-harm, and sociodemographic factors in order to provide a comprehensive description of the sample.

***Mental health challenges.*** The Symptom Checklist 90 (SCL–90) (Derogatis, 1994) is a self-report scale that measures symptoms of major mental illness. It has consistently demonstrated sound levels of reliability with favourable evaluations of content, concurrent, and discriminant validity (Groth–Marnat, 2009). The SCL–90 allows for assessment of severity of symptoms rather than just the presence or absence of a particular diagnosis.

The Centre for Epidemiologic Studies Depression Scale (CES–D) (Radloff, 1977) is a 20-item measure of psychological distress and depression that has been used in studies with street-involved young people and adults. This measure of depression has high reported levels of internal consistency as well as excellent concurrent and construct validity (Radloff).

The Beck Hopelessness Scale (BHS) (Beck, Weissman, Lester, & Trexler, 1974) is a 20-item measure designed for the detection and assessment of hopelessness in a variety of populations. The BHS has demonstrated high levels of internal consistency and a high degree of correlation with clinical and self-report measures of hopelessness (Beck et al.).

***Mental health strengths.*** The Resilience Scale (RS) (Wagnild & Young, 1993) is a 25-item self-report scale that measures resilience, a positive personality characteristic that enhances individual adaptation. The RS has demonstrated high levels of internal consistency and concurrent validity (Wagnild & Young).

The Rosenberg Self-Esteem scale (RSE) (Rosenberg, 1979) is a well-validated 10-item self-report inventory developed to measure global self-worth. The RSE has been shown to have consistently high levels of internal consistency as well as convergent and discriminate validity (Sinclair et al., 2010).

***Characteristics of the sample.*** The Juvenile Victimization Questionnaire (JVQ) was used in this study to assess level of physical and sexual abuse. The JVQ was originally developed to provide a comprehensive inventory of childhood victimization (Finkelhor, Ormrod, Turner, & Hamby, 2005).

Items were adopted from the Deliberate Self-Harm Inventory (SHQ) (Gratz, 2001) to assess deliberate self-harm behaviours without suicidal intent. These items asked participants to report on deliberate self-harm behaviour in general over a range of time periods. The purpose was to determine whether participants engaged in self-harm in a minimally intrusive manner.

The Depressive Symptom Index: Suicidality Subscale (DSI–SS) is a brief measure containing four items from the Hopelessness Depression Symptom Questionnaire (Joiner, Pfaff, & Acres, 2002).

The Michigan Alcoholism Screening Test (MAST) is a tool widely used to screen for alcoholism in adults. The original MAST was modified by Snow, Thurber, and Hodgson (2002) for use with adolescents regarding the use of substances as well as alcohol. This revised adolescent version of the MAST scale has had limited psychometric testing and therefore was used to obtain an overall indication of the degree of harmful substance use amongst the participants.

Participants in the quantitative component of the study were asked to report their age, gender, current living situation, relationship status, use of mental health services, and length of time in their current living circumstances.

## Data Analysis

For the quantitative component of the study, descriptive statistics (measures of central tendency and dispersion; frequency distribution) were used to exemplify characteristics of the sample and to provide mean scores for measures of mental health challenges and strengths. These scores were compared to relevant mean scores obtained from several studies in the literature (see Table 1). In keeping with the purpose of this study — to increase our understanding of mental health challenges and strengths amongst street-involved youth — Pearson product moment correlations were computed between measures of mental health challenges and strengths as well as with continuous variables descriptive of

Table 1   *Means and Standard Deviations for Mental Health Variables Amongst Study Sample and Comparative Sample*

| | Study Sample Mean (SD) | Comparative Sample Mean (SD) |
|---|---|---|
| **SCL–90 Dimensions** | | |
| Somatization | 1.24 (0.87) | 0.70 (0.53)[a] |
| Obsessive-compulsive | 1.55 (0.89) | 1.16 (0.65) |
| Interpersonal sensitivity | 1.19 (0.96) | 1.17 (0.74) |
| Depression | 1.40 (0.90) | 1.29 (0.69) |
| Anxiety | 1.20 (0.91) | 1.10 (0.62) |
| Hostility | 1.28 (0.99) | 1.75 (0.81) |
| Phobic anxiety | 0.82 (0.92) | 0.78 (0.52) |
| Paranoid ideation | 1.37 (1.02) | 1.63 (0.73) |
| Psychoticism | 0.94 (0.85) | 1.08 (0.61) |
| Depression (CES-D) | 20.57 (12.68) | 15.75 (9.28)[b] |
| Hopelessness (BHS) | 4.77 (4.43) | 3.51 (4.16)[c] |
| Resilience Scale (RS) | 130.27 (24.54) | 111.98 (17.6)[d] |
| Rosenberg Self-Esteem Scale (RSE) | 29.40 (6.18) | 30.26 (5.86)[e] |

[a] McCaskill, Toro, & Wolfe (1998).
[b] Meyer & Hautzinger (2003).
[c] Brausch & Muehlenkamp (2007).
[d] Rew, Taylor-Seehafer, Thomas, & Yockey (2001).
[e] Chubb, Fertman, & Ross (1997).

the sample. A thematic analysis (Boyatzis, 1998) of the focus group transcripts was conducted to identify themes that might extend our understanding of quantitative data related to mental health needs from the perspective of the participants. The focus group transcripts were read and reread independently by a subset of the research team to identify themes, as described above. After extensive discussion, the coding scheme was developed by consensus. The transcripts were then coded by experienced research assistants and the first author. The first author (EM) validated all coding by the research assistants.

## Quantitative Results

### Characteristics of the Sample

In total, 70 youths participated in the study and completed the questionnaires. The participants ranged in age from 16 to 24, with a mean age of 20.21. The majority were male ($n = 48$). The participants reported a range of living situations: shelters ($n = 39$), transitional housing ($n = 4$), rough on the street ($n = 13$), couch surfing ($n = 6$), or a variety of unstable housing arrangements ($n = 8$). The mean length of time living in the current situation, which included shelters or rough on the street, was 456 days (15 months). The mean number of years of education reported by participants was 10.5. The majority of participants ($n = 55$) reported being unemployed at the time of the study. When asked if they had ways of making money other than employment, approximately a third of the participants indicated a range of activities, including: receiving a personal needs allowance from the shelter ($n = 9$); receiving welfare ($n = 3$); selling drugs ($n = 2$); panhandling, escorting, and working the street ($n = 4$); or receiving some help from parents ($n = 2$). A majority of participants identified relationships, specifically with extended family members ($n = 32$) or peers ($n = 31$), as very important either currently or in the past. Of the participants, 36% ($n = 25$) reported being in an intimate relationship at the time of the study. Only 24% of the sample reported using mental health services during the preceding month.

*Abuse.* A substantial proportion of the participants were victims of physical and/or sexual abuse. Specifically, 61% ($n = 43$) of participants reported being physically assaulted by an adult at some point in their lives, with the majority of those identifying the perpetrator as an adult family member. Just over 25% ($n = 19$) of participants reported a history of sexual abuse, with the majority of those identifying the perpetrator as someone they knew but only five identifying the perpetrator as a family member. All but two of the participants who reported sexual abuse also reported physical abuse.

***Self-harm and suicidality.*** Of the participants, 41% (*n* = 29) reported engaging in acts of deliberate self-harm, as measured by the SHQ. Further, 31.4% of participants reported suicide ideation, as indicated by a DSI–SS score greater than 1 (Joiner, Pfaff, & Acres, 2002). Further, 58.6% of the sample reported a high level of alcohol and/or drug abuse.

### Mental Health Challenges

Table 1 presents the means and standard deviations for the sample and comparative data pertaining to mental health challenges. Overall, the participants had high scores for mental health symptoms (SCL–90), depression (CES–D), and hopelessness (BHS). Mean scores on the same measures obtained from the literature are provided for comparison purposes. Specifically, the participants in this study had similar or elevated levels of mental health symptoms compared to 118 American urban homeless adolescents (McCaskill et al., 1998). The participants also demonstrated higher mean scores on measures of depression (CES–D) and hopelessness (BHS) than those in the literature. The comparative data for the CES–D were obtained from a sample of 1,639 postsecondary students in Germany with a mean age of 19.10 (Meyer & Hautzinger, 2003). The comparative data for the BHS were taken from a sample of 231 American high-school students with a mean age of 15.7 (Brausch & Muehlenkamp, 2007). In addition, approximately one third of the participants in the present study (*n* = 24) reported one or more psychiatric diagnoses, with depression and other mood disorders being the most frequently reported. Additional diagnoses identified were schizophrenia, post-traumatic stress disorder, anxiety disorders, personality disorders, substance abuse, and anorexia.

### Mental Health Strengths

Table 1 presents the means and standard deviations for the sample and comparative data pertaining to mental health strengths. Overall, the participants demonstrated moderate levels of resilience (*M* = 130.27; *SD* = 24.54) and reasonably high levels of self-esteem (*M* = 29.40; *SD* = 6.18). Specifically, resilience scores were elevated compared to another sample of street youth (*M* = 111.98; *SD* = 17.6) (Rew et al., 2001), the majority of whom reported sleeping outdoors, whereas the majority of participants in the present study reported sleeping in shelters. Comparison with other vulnerable groups, such as adolescent mothers (*M* = 146.6; *SD* = 14.08) (Black & Ford-Gilbe, 2004) and battered women (*M* = 143.1; *SD* = 24.00) (Humphreys, 2000), further suggests a moderate level of resilience amongst the participants in the present study. The participants demonstrated self-esteem levels similar to those of 18-year-old high-school students (*M* = 30.26; *SD* = 5.86) (Chubb, Fertman, & Ross, 1997), indicating reasonably high levels of self-esteem.

| Table 2 | *Correlations Between Challenges and Strengths* | | | |
|---|---|---|---|---|
| | **SCL–90** | **CES–D** | **BHS** | **DSI–SS** |
| **RS** | –.504★ | –.541★ | –.469★ | –.375★★ |
| **RSE** | –.731★ | –.719★ | –.688★ | –.581★ |

★ *p* < .000   ★★ *p* < .001

RS = Resilience Scale
RSE = Rosenberg Self-Esteem Scale
SCL–90 = Symptom Checklist 90
CES–D = Centre for Epidemiologic Studies Depression Scale
BHS = Beck Hopelessness Scale
DSI–SS = Depressive Symptom Index–Suicidality Subscale

### Mental Health Challenges and Strengths

As indicated above, correlations were calculated between measures of mental health challenges and strengths, as well as with continuous variables descriptive of the sample, in order to gain an understanding of the relationships amongst the study variables. The scores on measures of mental health challenges (SCL-90, CES-D, BHS, and DSI-SS) were all statistically negatively correlated with scores on measures of mental health strengths (RS & RSE) (Table 2). Specifically, increased levels of mental health challenges, such as depression, hopelessness, and suicide ideation, were significantly associated with decreased levels of resilience and self-esteem. In addition, characteristics of the sample, such as age, length of time without a home, education, and employment, were not significantly correlated with measures of mental health challenges and strengths.

## Qualitative Results

### Focus Group Data

Two focus groups, each with eight to ten participants, were conducted in order to elicit the youths' perception of their mental health needs. Four themes emerged from the data: *surviving life on the street, living with mental health challenges, finding strength in the midst of challenges,* and *seeking supportive relationships.* These broad themes encompass the complexity of circumstances, feelings, and emotions that emerged in the context of these young people's lives. In this report, those qualitative themes that best facilitate the understanding of both challenges and strengths (*living with mental health challenges* and *finding strength in the midst of challenge)* are described. Thus the qualitative data are being used to explicate the quantitative findings, a mixed-methods approach that is described by Creswell (2003). It is important to note that even though the quantitative and qualitative samples were composed of different participants, they were

recruited from the same settings, during the same time period, based on the same inclusion and exclusion criteria. It is thus reasonable to expect that the different perspectives would inform one another. A full report of the study's qualitative findings will be published separately.

### Living With Mental Health Challenges

Overall, the findings from the focus group data are consistent with the quantitative data, with participants describing a wide range of mental health challenges, including specific mental health symptoms such as depression, suicide ideation, and substance abuse. Focus group participants observed that mental health issues associated with homelessness arise from a complex interplay of factors. Overall mental health challenges were thought to result from being street-involved or as a consequence of mental health issues that participants may have been living with for some time. The perceived link between mental health issues and the stress of being homeless described by a number of youths is illustrated in the comment of a focus group participant:

> *[Living on the street] is like the universe hit you over the head with a two-by-four, and it's confusion. Where do I go from here? . . . I'm just so scattered right now . . . It's just confusion. And that's sometimes the most frustrating thing, because you're confused, it's like you can't even use your own resources because you're still unsure of what to do.*

Several participants observed that, for people who are homeless, depression may be related to a number of circumstances associated with homelessness, such as drug use or lack of friends, as illustrated by the words one participant:

> *. . . when you're homeless . . . you do get depressed, you do get lonely sometimes . . . Most homeless have serious depression . . . and it may come from drug use . . . or not having friends.*

Many participants also indicated that a *pre-existing mental illness* or set of challenges contributed to their state of homelessness. Specific illnesses included depression, bipolar illness, and eating disorders. Other issues included anger, interpersonal insensitivity, self-harm, and suicidality. It was clear that a number of youths had ongoing mental health challenges, as evidenced by the following comment:

> *I've been through a lot growing up, but I never started dealing with it until I was about 17/18. I'm now 21. . . . And it affects not only you but everybody around you and stuff like that. . . . I used [to be] the type of person that, if someone said something to me or looked at me wrong, instead of . . . just walking away I'd, like, beat the person up. . . . But now*

*. . . I still have that anger but it's under control a little. I'm still working on it.*

Participants indicated that the perception of stigma was pervasive to the experience of being homeless, resulting in an overall sense of shame and low self-esteem. Perceptions of stigma, misunderstanding, and neglect by society were evident:

*One of the biggest problems with youth is, like, neglect. We've been neglected a million times. [We join a] program that's good for us and then it's gone.*

The participants also emphasized the stigma of mental illness. There was a sense that the stigma associated with mental health challenges profoundly affects people's sense of self-worth, perhaps even exceeding the burden of stigma experienced by street youth generally. A number of participants perceived that it was risky to disclose their mental health challenges to shelter staff. The perceived risk of disclosing to staff seemed to be especially high if a trusting relationship had not been established:

*I wouldn't be comfortable with staff asking me if I have a mental illness . . . just like how I'm not comfortable with them asking me if I'm Black, Asian, White, or whatever on a piece of paper of any sort. I just feel like it could lead to a very uncomfortable feeling of discrimination or just something you don't feel like you need to reveal on intake. You know what I mean? You know, after being supported by a worker after a couple of months of getting to know someone, maybe the comfort might be there and I might want to reveal something like that, knowing that there won't be any repercussions. But for now, like, no way.*

Along with the perceived stigma of homelessness and mental illness, there was a pervasive sense of scepticism about psychiatric treatment — specifically, having a diagnosis and using prescribed medications. Some participants had received a number of different diagnoses. One youth expressed the view that psychiatrists might even lie about diagnoses. On the other hand, a number of participants described positive, exceedingly helpful relationships with agency staff:

*And they, the staff, one of the staff would come in here, talk to us, and say what we would call input into what things happened in here. This place has helped a lot of people out, especially me.*

### Finding Strength in the Midst of Challenge

In spite of the wide range of mental health challenges faced by these young people, areas of strength and resilience were apparent for the

majority of participants. It was evident that the majority wanted to *strive for a better life,* even though many obstacles still lay ahead. There was also a sense of purpose, that obstacles to a better life could be overcome, a perspective consistent with the theoretical standpoint of resilience — specifically, the capacity to adapt to life's challenges (Hunter & Chandler, 1999). For example, one participant showed a remarkable degree of determination to move beyond his current situation. Also apparent was the level of danger inherent in the struggle: Risks must be surmounted, or one could wind up dead:

> *Like, okay, I'm homeless . . . I'm not going to beat myself up about it. Because if I do that, I'm just going to stay homeless. That's how people die in the woods, you know what I mean? They just sit there and they're like, "How did I get myself in this position?" . . . because they're not going out and trying to survive, like, get food, you know what I mean? And, I don't know . . . I plan everything. So I became homeless. Okay, what do I have to do? Whatever it takes to get me money to get a house of some kind, maybe, you know, some kind of shelter, other than a shelter.*

It was clear that these young people had acquired a number of skills and attributes (typically associated with resilience) that would help them to "deal with the obstacles" that were anticipated in the future. For example, one of the focus group participants, who lived in a shelter, spoke about the need to not dwell on the negative:

> *You just keep moving. Sometimes you're not focusing on the negative . . . So I have to, like, find a day a week where no one knows where I am. Just get away . . . For me, it's reading, reading something inspirational — philosophy. I usually go to [bookshop] and just sit down with a book, for, like, maybe half an hour.*

For a number of participants, there was recognition that focusing on the positive — specifically, having a positive attitude — was beneficial. One youth explained that it was not helpful to be down on oneself:

> *If you beat yourself up about things, you're just going to feel bad . . . and it's going to keep getting worse. Trust me, I've been there. But I've learned to not beat myself up like that.*

Participants also emphasized the benefits of positive role models and a comfortable environment. In particular, a few youths thought that it would be beneficial to hold focus groups such as those described in this study in a university setting, as the environment would be motivating and comfortable:

> *It's all in the setting, in making the people feel comfortable in opening up. I'm sure that we'd feel more comfortable out somewhere [the university],*

> *you know, idealistic, that we are able to pick as a setting as opposed to the side room at [the shelter].*

They also described the value of talking with peer role models. Generally, the participants felt that they would be more open to consulting with other youth who were close to them in age and who knew what it was like to deal with similar issues:

> *. . . a peer-to-peer kind of thing, you know. You may feel comfortable talking to someone who's close to your own age as opposed to someone who's older . . . you may look at them as an authority as opposed to a friend.*

## Discussion

The purpose of this study was to gain a deeper understanding of the challenges and strengths pertaining to mental health for street-involved youth, in order to ultimately provide direction for intervention. Overall the quantitative findings demonstrate high levels of mental health symptoms amongst the sample of street youth. The quantitative data also indicate that one third of the participants reported living with pre-existing illnesses (e.g., depression, bipolar disorder, anxiety disorders). In addition, the majority of participants had experienced physical abuse, one quarter had been sexually abused, and a substantial number expressed suicide ideation. About one half of the participants had engaged in self-harm and virtually all engaged in harmful use of alcohol and substances. These findings are consistent with those documented by previous studies (Boivin et al., 2005; Fisher, Florsheim, & Sheetz, 2005; McCaskill et al., 1998; Whitbeck et al., 2004). The qualitative findings further illuminate the quantitative findings, highlighting the clear relationship between the stress of homelessness and emotional distress as well as the role of pre-existing mental health challenges and homelessness.

In spite of the exceedingly severe mental health symptoms and emotional distress, the participants demonstrated moderately high levels of resilience and self-esteem. As expected, self-esteem and resilience were significantly negatively correlated with indicators of emotional distress. Interestingly, self-esteem emerged as the variable most highly negatively correlated with mental health challenges, including depression, hopelessness, and suicide ideation. This observation is consistent with the findings of Kidd and Shahar (2008), who found that self-esteem was the strongest protective factor related to suicide ideation and loneliness amongst a similar group of street-involved youth in New York City. These authors recommend programming that explicitly focuses on raising self-esteem by concentrating on personal success and achievements, as well as evidence-based interventions such as dialectical behaviour therapy and motivational interviewing.

Although previous studies have documented the existence of mental health strengths, such as self-esteem and resilience, amongst street youth (Rew, 2003; Rew et al., 2001), few studies have identified the complexity of the relationship between psychological strengths and acute emotional distress in this vulnerable population. Although it is evident that mental health strengths and challenges are highly correlated, the majority of participants appeared to be experiencing acute distress. The focus group data offer further evidence that even when faced with mental health challenges, young people may be determined to strive for a better life.

Regardless of the extremely high levels of mental health symptoms reported by the participants, only 24% reported using mental health services. This finding is somewhat surprising given the availability of promising mental health programs in large cities. The qualitative data indicate that some youths had developed a great deal of scepticism about psychiatric treatment and prescription medications, which helps to explain why mental health services were used by only 24% of participants. From the perspective of the young people in this study, effective mental health services should not be stigmatizing and should be offered in a non-threatening manner at a pace suitable for this population. The importance of a trusting relationship with staff as a basis for effective intervention is articulated in the literature (Kidd, Miner, Walker & Davidson, 2007). The labelling of services as "mental health services" seemed to be problematic for the participants due primarily to stigma, a phenomenon also identified in the literature (Kidd et al.). The role of stigma in mental illness and homelessness is of the utmost importance, since it appears to engender low self-esteem, shame, expectations of rejection, and a sense of limited opportunity.

There is an urgent need for evidence-based interventions that address the mental health problems of homeless youth (Klein et al., 2000; Slesnick et al., 2007). There is evidence indicating that the longer young people spend on the street the more likely they are to engage in high-risk behaviours such as prostitution and attempted suicide (McCarthy & Hagan, 1992) and to become chronically homeless (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002). Further, McManus and Thompson (2008) point out that symptoms related to the traumatic experiences of street-involved youth frequently preclude the ability to transition out of homelessness. The present findings offer some perspectives to consider in the implementation of interventions to meet the mental health needs of this vulnerable population. Understanding the propensity of young people to experience overwhelming despair and at the same time hope for a better future is a critical vantage point from which to build programs and interventions that are in keeping with the

philosophical underpinnings of dialectical behaviour therapy, a therapy that addresses these seemingly contradictory motivations in life.

Slesnick et al. (2007) emphasize the importance of this multi-prong approach. They point out that effective interventions offer the possibility of disrupting a negative spiral while at the same time providing the support and skills needed to strengthen positive linkages. Indeed, numerous authors have encouraged researchers to develop and evaluate interventions that strengthen positive relationships and build resilience (Johnson, Whitbeck, & Hoyt, 2005; Karabanow, 2004; Kidd, 2003). The present findings also highlight the need for young people to acquire the skills to withstand emotional distress and at the same time work at developing strengths. This approach is consistent with the recommendations of McWhirter, Besett-Alesch, Horibata, and Gat (2002), who cite the importance of developing skills pertaining to emotional self-awareness and social coping while also being mindful of self-esteem issues.

### Limitations

This study used a cross-sectional design and a relatively small convenience sample that was not necessarily representative of all street-involved youth in the city in which it was conducted. As reported by other studies, the recruitment of street-involved youth is challenging given the difficulty of reaching those who are most at risk. In addition, the quantitative and focus group data were taken from two independent samples. Although these samples were recruited from the same settings within a similar time frame, there is no guarantee that the data obtained were equivalent. These limitations could affect the generalizability of the findings.

In spite of its limitations, this unique mixed-methods study extends the literature by highlighting the propensity of young people to experience both exceedingly high levels of mental health challenges and a reasonably solid sense of self, along with hope for a better future. Addressing the mental health problems of street youth through multi-faceted mental health programs may well help these young people to transition to stable housing, achieve social re-integration, and, ultimately, achieve improved quality of life.

The findings of this study have laid the groundwork for a Canadian Institutes of Health Research partnership study (with the Canadian Commission on Mental Health). That project will assess the effectiveness of a specific intervention (dialectical behaviour therapy) in reducing distress and maladaptive coping mechanisms and in promoting positive relationships and overall functioning amongst street-involved youth participating in transitional housing programs in three Canadian cities (Halifax, Toronto, and Calgary).

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