



Seeing the Possibilities

The Need for a Mental Health Focus
Amongst Street-Involved Youth:
Recognizing and Supporting Resilience

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Advanced Grants

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Executive Summary

Achieving things is going to make me a better person. It is going to make me realize that no matter what obstacle this world is going to throw at me I am going to get around it, or crawl under it, I don't care, I am going to find a way around it, you know. (Youth Participant)

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. In response to this profound level of mental health need amongst street youth, our collaborative community-based research team undertook a comprehensive assessment of mental health challenges in order to ultimately provide direction for intervention.

This study employed a mixed methods approach, using quantitative and qualitative methods, as well as participatory action research. A convenience sample of 70 participants was recruited from four agencies serving homeless youth in Toronto. The participants completed a series of standardized questionnaires, interviews, and self-report measures to evaluate mental health symptoms, such as depression, self harm, suicidality, alcohol and substance use, physical and sexual abuse, as well as resilience and self-esteem. A subset of our quantitative sample (N=9) participated in individual qualitative interviews to discuss perceptions of mental health challenges and strengths. Youth were also recruited from two of our community partners to participate in two focus groups to discuss mental health need and resilience in homeless youth. A participatory action research (PAR) component also further extended the qualitative approach, enabling several youth to be actively involved in the dissemination phase of the study.

Our results indicate that these youth (ages 16–24) have profoundly high levels of mental health symptoms compared with healthy young adults. Specifically, these youth exhibit profoundly high levels of depression, anxiety (obsessive/compulsive and phobic), hostility, paranoia, psychoticism, and interpersonal sensitivity compared with healthy young adults. Nearly two-thirds of participants in our study had experienced physical abuse, while one-quarter had been sexually abused, and 31% expressed some form of suicidal ideation. About one-half of the participants engaged in some form of self-harm and virtually all identified issues with the use of substances. Even with these exceedingly severe levels of mental health symptoms and emotional distress, our participants exhibited moderately high levels of resilience and self-esteem.

The themes that emerged from the qualitative data included: “Surviving Life on the Street”; “Living with Mental Health Challenges”, “Finding Strength in the Midst of Challenge” and “Seeking Supportive Relationships”. The qualitative themes illustrate the juxta-positioning of tension, challenge and sadness with a determination to strive for a better life that was frequently described by the youth. Overall the qualitative mirrored the quantitative findings, specifically pertaining to the high levels of mental health symptoms. Participants readily described a myriad of mental health issues which they identified as either a consequence of being street-involved or related to pre-existing illness or challenges.

There is clearly an urgent need for increased access to mental health services to address the severe and complex mental health problems of street-involved youth. As therapeutic programmes and interventions are developed, it is critical to understand the propensity of youth to experience both overwhelming despair, as well as continued hope for a better future. Multi-component mental health programmes and interventions that are directed toward addressing mental health challenge, as well as enhancing youth's resilience and capacity to cope with adverse circumstances will provide opportunities for youth to work toward social re-integration and ultimately an improved quality of life.

Recommendations

The following recommendations are based on the study findings and pertain primarily to the experiences of youth directly related to mental health and mental health services:

- 1) ***There is an urgent need for increased access to mental health services for street-involved youth***, based on the finding that only 24% of youth in our sample reported using mental health services. From the perspective of youth in this survey, accessible mental health services should be offered on site, such as at shelters where they reside or at drop-in programmes. Youth in the study indicated that they are unlikely to access traditional mental health services, which are clearly identified as mental health services. This perspective seems to be linked to a general mistrust of the system and to the perceived stigma of dealing with mental health challenges.
- 2) ***Mental Health Services for street-involved youth need to be offered so that they are acceptable to the youth for whom they are intended***. According to youth in this study effective mental health services would be ***non-stigmatizing*** and would be offered in a ***non-threatening manner*** such that careful attention is given to engaging youth and developing a therapeutic relationship as a foundation for intervention. The emphasis placed by youth on helping others suggests that ***peer based programmes*** are also needed. Although beyond the scope of this study, numerous youth identified the lack of services for youth ages 25 to 35 suggesting the need for future study.
- 3) ***Multi-component mental health programmes and interventions are required to enhance youth's resilience and capacity to cope with challenging circumstances*** (such as past & current traumas) to withstand emotional distress and to build on existing strengths to pursue adaptive self-identified goals to lead an improved quality of life. It is clear from the study findings that the mental health challenges of youth are severe and complex. These challenges include: pervasive issues of depression; anxiety; addictive behaviours; self harm and suicidality. A number of youth are living with specific mental health diagnoses, which are frequently long standing in nature. Mental health programmes are also needed to respond to immediate crisis issues and to address ongoing treatment issues.
- 4) ***Skillful intervention requires the recognition of both positive and negative perspectives, and as such needs to emphasize positive self acceptance, as well as focusing on the need to move away from negative coping strategies, such as self harm or addiction toward more adaptive strategies, such as***



- building positive relationships.** It is important to recognize that many youth may hold both feelings of despair and hope simultaneously, although which perspective is at the foreground may vary depending on the immediate set of circumstances. Youth's propensity to hold onto a positive outlook or to be resilient is beneficial and provides a good base for engagement.
- 5) Youth in our study emphasized ***the need for programmes that target prevention of youth homelessness in the schools.*** Given that issues such as substance abuse appears to have taxed family systems during the adolescent period, programmes are required for both youth and their parents. These programmes could be based on a resilience perspective and include mental health promotion skills for youth and their families, such as effective communication, conflict resolution and understanding risk taking.
 - 6) ***Strategies are required to address the reduction of negative or stigmatized attitudes toward street-involved youth in order to create a climate of greater understanding and acceptance for youth in the community.*** Youth are vulnerable to the internalization of external stigma, given the fluidity of self definition at this transitional developmental phase. Strategies that target attitudes toward street-youth and mental health issues would be most helpful for this group which is frequently "doubly stigmatized."

"... the person I am with is changing me physically and also emotionally inside you know, making me feel that I can do whatever I put my mind to"
(Youth Participant)

Background

Toronto, Montreal and Vancouver have the largest populations of homeless or street youth in Canada (Hwang, 2001). The terms homeless youth and street youth are used interchangeably in the literature (Hwang, 2001), and as such, both terms are used throughout this report. It is readily apparent that homeless youth experience a range of mental health problems (Adlaf & Zdanowicz, 1999) with elevated rates of psychiatric disorders compared to non-homeless youth (Rhode, Noell, Ochs & Seeley, 2001). In fact, for youth living on the street, mental illness may be either a major risk factor for homelessness or may frequently emerge in response to coping with the multitudinous stressors associated with homelessness, including exposure to violence, pressure to participate in survival sex and/or drug use (Kipke, Simon, Montgomery, Ungar & Iversen, 1997; Smart & Adlaf, 1991; & Morrell-Bellai, Goering, 2000). Researchers (Whitbeck, Johnson, Hoyt & Cauce, 2004) have made the observation that living on the streets may, in fact, exacerbate existing mental illness in these young people. The most frequent psychiatric diagnoses amongst the homeless generally include depression, anxiety and psychosis (Stuart & Arboleda-Florez, 2000). What is particularly disturbing is the extremely high rates of suicide attempts and completed suicide within this vulnerable population (Kidd & Kral, 2002), with suicide attempts at least 10.3 times that of the national average for Canadian youth (Hwang, 1999, as cited in Kidd & Kral, 2002). Despite the literature that is emerging related to the mental health of homeless youth, there is a continued and urgent need to carefully assess the current level of unmet mental health need amongst street youth (Rhode, et al., 2001), as well as a desperate need to provide access to mental health treatment and services. What seems to be overlooked is the potential of persistent symptoms of mental illness and high levels of psychological distress in street youth to dramatically impede the young person's capacity to engage in opportunities for social re-integration through participation in housing and/or employment programs. In response to this profound level of mental health need amongst street youth (ages 16-24), our collaborative community-based research team has undertaken a comprehensive assessment of mental health challenges to gain an increased understanding of the need for mental health services and programmes. It was acknowledged by our team that an increased understanding of the mental health issues was necessary to provide direction for the development of specific interventions and programmes to strengthen mental health and resilience in this young vulnerable population.

Research Background

It has been estimated that 20% of children and youth are experiencing significant symptoms of a mental illness (Leavy, Goering, Macfarlane, Bradley & Cochrane, 2000). This figure almost certainly underestimates the rate of mental illness in homeless youth. As early as 1991, Kurtz, Jarvis & Kurtz made the observation that the underlying causes of homelessness in youth are frequently linked to mental health. These authors itemized 5 specific causes of homelessness that have profound consequences for mental health. These causes for homelessness include: 1) growing up in a homeless family; 2) the need to escape abuse; 3) being thrown out of home; 4) being from the child welfare system; referred to as “doubly homeless” & 5) immigrant youth without families and without legal status.

A number of studies have indeed documented highly elevated rates of mental health problems amongst street youth (Reilly, Herman, Clarke, Neil & McNamara, 1994; Slegers, Spijker, VanLimbeck, & van Engeland, 1998). A supporting research finding is the observation that major depression in homeless youth has been shown to be substantially elevated compared to non-homeless youth (Smart, Adalf & Walsh, 1994, as cited in Adalf & Zdanowicz, 1999; Rhode et al., 2001). The studies referenced use DSM-III-R diagnoses to assess the rate of mental illness in homeless youth. For example, a study of 140 youth living in shelters in New York City demonstrated that 90% of these young people met DSM-III-R for a mental disorder (Fietal, Margetson, Chamas & Lipman, as cited in Molnar, Shade, Kral, Booth & Watters, 1998). 75 % of the 140 were depressed and 41% had experienced suicidal ideation. A review (Slegers, et al., 1998) of 18 surveys of mental health of homeless youth concludes that few comprehensive studies exist, and that methodological shortcomings, such as differing sampling strategies and conceptualizations of homelessness, as well as methods used to assess mental disorder, preclude generalization of study findings. Further, a recent study by Whitbeck, et al. (2004) documents significant levels of mental illness in homeless and runaway youth (N=428) (including major depressive disorder, post-traumatic stress disorder & substance abuse), in moderate-sized US cities. Although studies documenting rates of abuse for street youth in Canada exist (Janus, Archambault, Brown & Welsh, 1995; Stewart, Steiman, Cauce, Cochran, Whitbeck & Hoyt, 2004), there do not seem to be studies that document the rate of mental illness in Canadian homeless youth. Despite the fact that Toronto, Montreal and Vancouver have the largest populations of street youth in Canada, investigators assert (Hwang, 2001) that it is difficult to estimate the prevalence of mental illness and substance abuse in homeless populations.

Toronto-based researchers (Adalf & Zdanowicz, 1999) devised a typology of mental health and substance abuse outcomes in a study of 211 street youth ages 13 to 24. Youth who were highly engaged in substance abuse to cope or who had a history of physical and sexual abuse, as well as substance abuse experienced higher levels of mental health symptoms. The authors suggest that this subgroup of homeless youth require an array of programs to deal with mental health issues, as well as employment-based rehabilitation. Similarly, a major study of suicide and abuse amongst 775 street youth by Molnar, et al. (1998) documented that suicidal behaviour is

closely linked to physical and sexual abuse prior to leaving home. Not surprisingly, these authors assert that suicidal assessment is an important component of treatment necessary for street youth to deal with the emotional consequences of abuse. In-depth qualitative interviews with street youth have revealed that experiences of isolation, rejection, lack of control and a pervasive sense of low self worth were associated with suicidal feelings (Kidd & Kral, 2002). Youth must also cope with victimization on the street, which has been found to be as high as 83% (N=374) in a study of urban youth (Stewart, et al., 2004). It is readily apparent that the vast numbers of street youth are already highly vulnerable and are predisposed to significant mental health problems.

Clearly, interventions are required to address the mental health needs of homeless youth. A number of studies suggest that homeless youth generally mistrust health care and service providers (Janus, et al., 1995; Rew, 2002), adding further complexity to the task of engaging homeless youth who are struggling with an array of mental health problems, while subsisting on the street and/or in a range of shelters. Any intervention developed for these youth must not lose sight of the overriding context of their lives. This group of young individuals is thrust prematurely into a hostile world where they are forced to assume responsibility frequently, beyond their years. Despite the pervasive hardship experienced by homeless youth, there is some indication that a strong sense of psychological resilience may exist in the midst of the chaos experienced by these adolescents and young adults (Adalf & Zdanowicz, 1999; Kidd & Shahar, 2008). Rew (2003) interviewed 15 homeless youth in a qualitative study of attitudes toward self-care. 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 involved forming relationships with peers and learning how to manage the many obstacles that emerged. 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 strengths included seeking resources and focusing on self improvement through gaining emotional maturity, learning skills and adopting healthier behaviours. In addition, a quantitative study of 208 homeless youth in New York City and Toronto (Kidd & Shahar, 2008) highlights the critical relationship between self-esteem and resilience further emphasizing the need to pay attention to these protective factors amongst this vulnerable group.

Ultimately, it was expected that the results of this study would support the development of an intervention that would strengthen resilience amongst homeless youth; enabling youth an opportunity for increased responsibility, along with feelings of hope and optimism for the future. The immediate purpose of the study was to complete a comprehensive mental health assessment to increase our understanding of the challenges and strengths pertaining to mental health amongst street-involved youth, thus providing direction for intervention.

Research Design and Methodology

This study employed a mixed methods approach, using quantitative and qualitative methods, as well as participatory action research. This mixed methods approach (Creswell, 2003) was chosen with the understanding that procurement of a diverse range of data would provide a comprehensive and informative understanding of the mental health needs of homeless youth. The inclusion of quantitative methods allows for generalization of the study findings, while qualitative methods allows for the subjective voice of the participant to be elicited (Creswell, 2003). Participatory action research (PAR) further extends the qualitative approach. PAR involves a collaborative partnership between participants and researchers that allows the voice of participants to be heard along with a focus on improving life circumstances (Speziale & Carpenter, 2003).

Ethics approval to conduct the study was obtained from both Ryerson University and St. Michael's Hospital.

Quantitative Methods

Design

The quantitative component of the study employed a descriptive cross-sectional correlational design.

Recruitment of the Sample

A convenience sample of 70 participants was recruited from four agencies serving homeless youth in Toronto, Canada: Covenant House; Evergreen Centre for Street-Involved Youth; Street Outreach Services; and Turning Point Youth Services. Participants met inclusion criteria if they were: 1) between the ages of 16 and 24; 2) had been without a home or without a place of their own for at least one month; 3) were able to read, comprehend and speak English; and 4) had the capacity to give informed consent (please note that these inclusion criteria were utilized across all components of the street youth study). Staff in each of the community agencies approached youth who met the inclusion criteria and invited them to participate in the study. Informed consent was obtained from all participants prior to their involvement. The participants completed a series of questionnaires, interviews, and self-report measures during a 90-120 minute interview session conducted by two trained research assistants. The interview sessions took place between August 2005 and June 2007.

Measures

The measures used to assess the youths' mental health needs are described below. All measures have been found to have satisfactory levels of reliability and validity in youth populations, although not all instruments have previously been used in street youth populations.

Sociodemographic Data: General information was obtained from participants regarding their age, gender, and current living situation, length of time on the streets, relationship status and mental health service use.

Symptom Checklist 90 (SCL-90): The SCL-90 (Derogatis, 1994) is a self-report scale that measures symptoms of major mental illness. The SCL-90 allows for the severity of symptoms to be assessed; not just the presence or absence of a particular diagnosis.

The Positive and Negative Syndrome Scale (PANSS): The PANSS was developed as a tool to separately measure positive and negative symptoms; their severity and relationship to global psychopathology. It is made up of 4 scales to assess mental illness and is conducted by interview (Kay, Fiszbein & Opler, 1987).

Centre for Epidemiologic Studies Depression Scale (CES-D): The CES-D (Radloff, 1977) is a well-known 20-item measure of psychological distress and depression that has been used in studies of homeless youth and adults.

The Beck Hopelessness Scale (BHS): The BHS (Beck, Weissman, Lester & Trexler, 1974) is a well known 20-item scale designed for the detection and assessment of hopelessness in a variety of populations.

Self-Harm Inventory (SHI): The SHI was developed for use in this study by adopting items from the Deliberate Self-Harm Inventory developed by Gratz (2001 as cited in Bjarehed & Lundh, 2008) to assess deliberate self-harm behaviours without suicidal intent. The modified version used in this report asked participants to report on deliberate self-harm behaviours in general over a range of time periods (i.e.- ever, past year & past month).

Depressive Symptom Index: Suicidality Subscale (DSI-SS): The DSI-SS is a brief measure containing four items from the Hopelessness Depression Symptom Questionnaire. Scores on each item range from 0 to 3 with a total possible score of 12, with higher scores reflecting greater severity of suicidal ideation (Joiner, Pfaff & Acres, 2002).

Juvenile Victimization Questionnaire (JVQ): The JVQ was first developed to provide a more comprehensive inventory of childhood victimization (Finkelhor, Ormrod, Turner & Hamby, 2005). It was developed and tested so that the language used is suitable for children as young as 8. In this study the JVQ was used to capture the experience of physical and sexual abuse.

Michigan Alcoholism Screening Test (MAST): The MAST is a widely used tool used to screen for alcoholism in adults. The original MAST was modified by Snow Thurber & Hodgson (2002) by slightly changing the content to be more appropriate for younger adults and to include the use of substances, as well as alcohol.

The Resilience Scale (RS): The RS (Wagnild & Young, 1993) is a 25-item self-report scale that measures resilience, a positive personality characteristic that enhances individual adaptation.

Rosenberg Self-Esteem Scale (RSE): The RSE (Rosenberg, 1979) is a 10-item self-report inventory developed to measure global self-worth. This instrument is the most widely used self-esteem measure and has been used in a number of adolescent and young adult populations.

Qualitative Methods

Ten individual interviews and two focus groups (each with 8-10 participants) were conducted between fall 2006 and fall 2007. An interview guide was prepared for both the individual interviews and the focus groups. Questions focused on understanding mental health issues and challenges, as well as the identification of services and strategies that could potentially be helpful in meeting these needs. All interviews and focus groups were audio-taped and the audio-tapes were transcribed verbatim. A subset of the research team began by independently reading and re-reading several transcripts to identify initial impressions that emerged from the interviews. After extensive discussion and consultation, the coding scheme was derived which was comprised of higher order themes; each theme comprised of a number of subcategories. Once the coding scheme had been developed, the transcripts for both the individual interviews and focus groups were coded by experienced research assistants and the co-principal investigator (EM); applying appropriate codes to sections of text. The co-principal investigator validated all coding completed by the research assistants.

Individual Interviews

A subset of our quantitative sample (N=70) was invited to participate in individual qualitative interviews to discuss perceptions of mental health and to identify what might be helpful to support the mental health of street-involved youth. As stated, we conducted 10 in-depth qualitative interviews; three with female participants and seven with male participants. One interview had to be discarded due to a malfunction of the tape recorder, resulting in 9 audio-taped interviews. Each interview was conducted by two experienced research staff; each interview lasting approximately 60 to 90 minutes. If a participant became distressed during the interview process, appropriate referrals to agency staff were made as indicated in the consent. Since all youth participated in the original quantitative phase of the study, informed consent had been obtained previously.

Focus Groups

Youth were also recruited from two of our community partners to participate in focus groups. The staff at the agencies approached youth, informing them of the study and referring all interested youth who met the inclusion criteria (see p. 6). Informed consent was obtained from all youth who participated in the focus groups. Two focus groups (approximately 1 hour in length) were conducted in order to: 1) elicit themes related to the mental health needs of street-involved youth and 2) identify factors that promote emotional well-being and resilience in homeless youth.

Participatory Action Research Methods

A convenience sample of four participants was recruited from one of our community agencies in Toronto for the Participatory Action Research (PAR) component of the project. The goal of the PAR project was to engage street-involved youth in a self-identified strategy to represent their ideas regarding what it means to be mentally and emotionally healthy. The youth who volunteered for the PAR project were invited to participate in a discussion group where the purpose of the PAR project was explained and themes related to the focus groups were shared. Consent for the PAR was obtained at the time of the discussion group and was reviewed with the participants before beginning the PAR process. The collaborative process began in July 2007 and was completed in the winter of 2008. The process provided a safe space to listen to the participants' stories and allowed the youth to take the lead. The PAR group met with two experienced research assistants every week to identify the focus of the project. After several meetings, a photovoice project was identified. The youth chose to take photographs and create a voice media project that would capture the meaning of mental and emotional health from the perspective of street youth. Each participant was provided with a digital camera and was asked to take photographs that reflected their perceived meaning of mental and emotional health. The participants were then asked to digitally record a narration that reflected their personal story or the meaning behind their photographs. Two of the original four participants met with personnel from media services along with the research assistants at Ryerson University to produce the final product. Two participants could not complete the project, since we were unable to contact them.

Study Findings

Quantitative Findings

Characteristics of the Sample

The sociodemographic data for the study participants is represented in Table 1. In total, 70 youth participated in the study. 48 youth identified themselves as male, 21 female and 1 transgendered (MTF). Their age ranged from 16-24 years old with a mean age of 20.21 years. The majority of youth (n=54) were living either in shelters or on the street at the time of data collection. The mean length of time for youth living in shelters or on the street was 456 days (~15 months) with 34.3% of the participants reporting that the time frame for their current living situation was longer than 6 months. The mean years of education reported by our study participants was 10.5 years. The majority of the youth were unemployed (n=55) at the time of the study employment.

Relationships: The youth were also asked about relationships that were important to them in their lives. 36% (n=25) of the youth reported they were in a relationship at the time of the study. Also, the vast majority of youth identified relationships, including extended family (n=32) or peers (n=31) as being very important to them presently or in the past.

Physical and Sexual Abuse: When responding to questions regarding physical and sexual abuse (JVQ) (Finkelhor, et al., 2005), most youth reported some type of victimization, specifically physical and sexual abuse. 61% (N=43) of youth reported being physically assaulted by an adult at some point in their life; with the majority of youth identifying the perpetrator as an adult family member. Just over 25% (n=19) of the youth reported a history of sexual abuse. Again the majority of youth identified the perpetrator as someone they knew, however, only 5 youth identified the perpetrator as a family member. With the exception of 2 participants, all of those participants who reported sexual abuse also reported physical abuse.

Table 1. Descriptive Statistics for Demographic Information of Sample n = 70

	Mean (SD)	Range
Age	20.21 (2.01)	16 - 24
Years of Education Completed	10.45 (1.90)	8-17
	Frequency	Percent (%)
Gender		
Male	48	68.6
Female	21	30.0
Transgender (male to female)	1	1.4
Living Situation		
Shelter	40	57.1
Street	14	20.0
Friend's/Partner's home	9	12.9
Transitional housing	4	5.7
Own place	2	2.9
Hostel	1	1.4
Length of Time in Current Living Situation		
Less than 2 months	28	40.0
Between 2 and 6 months	17	35.7
Over 6 months	25	34.3
Have you used Mental Health Services in the Past Month? ^a		
Yes	17	24.3
No	53	75.7

^a Mental Health Services includes visits with a psychiatrist or psychotherapist

Mental Health Symptoms and Emotional Distress

Table 2 presents the means and standard deviation for the study sample pertaining to measures of mental health symptoms and emotional distress, as well as normative comparison data. Overall, the participants in our study demonstrated high rates of mental health symptoms (SCL-90), as well as increased rates of psychotic symptoms (PANSS), depression (CES-D), and hopelessness (BHS). The SCL-90 measures the severity of mental health symptoms without specifying the presence of a particular diagnosis (Derogatis, 1994). Compared with normative means obtained from non-patient adolescents (Derogatis), the participants in this study had considerably higher levels of mental health symptoms. In addition, the youth in our study demonstrated increased levels of depression and hopelessness as measured by the CESD and BHS, respectively when compared to a normative sample of adolescents.

The PANSS interview provides a more comprehensive measure of psychotic symptoms and also includes a semi-structured interview to identify insight related to a particular psychiatric diagnosis. It is noteworthy that the scores obtained in this study approximate the scores obtained from a sample of young adults recovering from a first episode of schizophrenia (McCay, et al., 2006), suggesting that a number of the youth in this study are coping with some degree of psychotic symptomatology. Approximately one third of the youth (N=24) reported having 1 or more psychiatric diagnoses, with depression and additional other mood disorders being the most frequently reported. Other diagnoses identified included schizophrenia, post traumatic stress disorder (PTSD), anxiety disorders, personality disorders, substance abuse and anorexia. In addition, 7 individuals reported being diagnosed with attention deficit disorder or attention-deficit hyperactivity disorder (ADHD).

Table 2. Means and Standard Deviations for Mental Health Variables among Study Sample and Normative Sample n = 70

	Study Sample	Normative Sample
	Mean (SD)	Mean (SD)
SCL-90 Dimensions		
Somatization	1.24 (0.87)	0.61 (0.53) ^a
Obsessive-Compulsive	1.55 (0.89)	0.91 (0.65)
Interpersonal Sensitivity	1.19 (0.96)	0.99 (0.74)
Depression	1.40 (0.90)	0.80 (0.69)
Anxiety	1.20 (0.91)	0.66 (0.62)
Hostility	1.28 (0.99)	0.88 (0.81)
Phobic Anxiety	0.82 (0.92)	0.39 (0.52)
Paranoid Ideation	1.37 (1.02)	0.91 (0.73)
Psychoticism	0.94 (0.85)	0.63 (0.61)
PANSS		
Positive Symptom Scale	10.81 (3.32)	11.2 (3.47) ^b
General Psychopathology	25.65 (6.41)	26.55 (5.35) ^b
Depression (CES-D)	20.57 (12.68)	15.75 (9.28) ^c
Hopelessness (BHS)	4.77 (4.43)	2.32 (2.25) ^d

^a Derogatis L.R. (1994). *SCL-90: Symptom checklist-90-R*. Minneapolis, MN, National Computer systems Inc.

^b McCay, E., Beanlands, H., Leszcz, M., Goering, P., Seeman, M.V. & Ryan, K. (2006). A group intervention to promote healthy self-concept in first episode schizophrenia: A pilot study. *Psychiatric Rehabilitation Journal*, 30(2), 105-111.

^c Meyer, T.D., & Hautzinger, M. (2000). The structure of affective symptoms in a sample of young adults. *Comprehensive Psychiatry*, 44, 110-116.

^d Durham, T. W. (1982). Norms, reliability, and item analysis of the hopelessness scale in general, psychiatric, forensic psychiatric, and college populations. *Journal of Clinical Psychology*; 38, 597-600.



Self-Harm

High levels of deliberate self-harm and suicidality, as well as ongoing substance abuse issues were reported by our sample of street-involved youth. Deliberate self-harm is defined as, “deliberate, direct destruction or alteration of body tissue without suicidal intent, but resulting in injury severe enough for tissue damage (e.g. scarring) to occur” (Gratz, 2001, p. 255). 41% (n=29) of our youth reported engaging in acts of deliberate self-harm to their body as measured by the SHI. Further, 31.4% of the youth expressed some level of suicidal ideation as indicated by a DSI-SS score greater than 1 (Joiner, Pfaff & Acres, 2002). The adolescent MAST screens for both alcohol and substance abuse. 58.6% of our sample had scores greater than 4 on the MAST (Snow, Thurber & Hodgson, 2002), which indicates that there is a serious level of alcohol and/or drug abuse. Another 17% of the sample had MAST scores of 4 which are suggestive of a problem with alcohol or drug abuse (Snow, Thurber & Hodgson).

Resilience and Self-Esteem

Table 3 presents the means and standard deviation for the study sample, as well as normative comparison data for the measures of resilience and self-esteem obtained in this study. Overall, the participants in our study demonstrated moderate levels of resilience and reasonably high levels of self esteem. Compared with another street youth sample (Rew, 2001), our sample demonstrated elevated resilience scores. It is important to note that the majority of Rew’s sample was sleeping outdoors, whereas the majority of the sample in our study reported staying at a shelter. In addition, our study sample compared favourably to a sample of high risk, low income, minority high school students whose RS score was 132.5 (Hunter & Chandler, 1999). Our study results were also in accordance with the levels of self-esteem observed amongst a group of 18 year-old high school students (Chubb, Fertman & Ross, 1997), indicating good levels of self-esteem.

Table 3. Means and Standard Deviations for Resilience and Self-Esteem among Study Sample and Normative Sample

	Study Sample	Normative Sample
	Mean (SD)	Mean (SD)
Resilience Scale (RS)	130.27 (24.54)	111.98 (17.6) ^a
Self-Esteem Scale (RSE)	29.40 (6.18)	30.26 (5.86) ^b

^a Rew, L., Taylor-Seehafer, M., Thomas, N. N., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship*, 33, 33-40.

^b Chubb, N. H., Fertman, C. I., & Ross, J. L. (1997). Adolescent self-esteem and locus of control: A longitudinal study of gender and age differences. *Adolescence*, 32, 113–129.

Qualitative Findings

The results for the individual interviews and focus groups are presented together, since the same interview questions and coding schemes were used in both sets of data. No real differences in the content emerged according to the format, with the exception of ideas related to improving/supporting the mental health needs of street involved youth. As might be expected, the discussion of the general notion of support was more extensive in the focus groups, with less time given to the specifics of individual scenarios. Pseudonyms have been used when reporting the qualitative findings to maintain anonymity.

Overview of Themes

The themes that emerged from the data include: “Surviving Life on the Street”; “Living with Mental Health Challenges”, “Finding Strength in the Midst of Challenge” and “Seeking Supportive Relationships”. These major themes encompass the complexity of circumstances, feelings and emotions that emerge in the context of these young people’s lives. For example, “Surviving Life on the Street” includes a wide range of experiences that youth spontaneously shared as relevant to their current situation and to mental health. These experiences include stories of how youth came to be without a home, the numerous challenges that exist on the street, survival strategies as well as the complicated issue of perceived stigma. Virtually each of the themes is comprised of paradoxes, for example, harrowing stories of deprivation and abuse in conjunction with a will to somehow make things better. Stories of relationships also reflect opposing tensions and include relationships that pose significant risk to further entrenchment in street life as well as relationships that offer hope; a glimpse of what might be possible in the future. The qualitative themes that follow illustrates the juxta-positioning of tension, challenge and sadness that is frequently experienced along with a determination not to be complacent and to strive for a better life.

Surviving Life on the Street

Although we did not specifically ask youth to explain *why they were without a home of their own* at this point in time, most youth readily talked about the issues that they believed contributed to their existing current circumstances. The most frequent explanations given by participants for their current homelessness included lack of a stable and secure home. The following quotes illustrate the role of deprivation and abuse within unstable home environments that contributed to the current circumstances of these youth.

I was in foster homes from the age of 2...I went through 7 different foster homes...My parents...they didn't used to take care of me, just used to sit there, like that...I used to be locked up at night all the time. (Brian)

I was going back and forth from my parents and grandparents home. When I went to Ontario I lived with my aunt and uncle until I was 12, they adopted me when I was 11. There was a lot of abuse and what not going on there, like

physical abuse, sexual abuse, and all that great stuff...and finally I was like you know what screw it. (Sue)

Substance abuse was a dominant issue that appears to have overwhelmed the resources of youth and their parents during the critical transition from adolescent to young adult and as such was a significant factor contributing to homelessness. As one participant explained:

Okay, when I was fourteen, I fell into drugs and I started stealing from my parents. And then my anger came out and they kicked me out...And then one day they kicked me out for no reason at all and I broke in the door and they called the cops. (Lisa)

In the following quote this young man demonstrates a level of maturity and insight into the problematic nature of his drug abuse; recognizing his Mom's efforts to help, even though he was ultimately forced to leave his family home.

It was hard...being awoken up at, you know, 6 in the morning, my mom handing me, you know, a wad of cash, and telling me to pack my stuff and leave, right. I was confused, and wondering why, what happened, and whatever. But I realized I have no one else to blame but myself, right, because she did try and help me, she you know, tried to do everything she thought she could to, like within her power, but you know, but ultimately it was my choice not to take the help and continue to do what I was doing [being involved in drugs]. So you know, I hold no grudges against her, it was my own fault, and that is the way I see it now. (Brian)

These young participants readily shared many challenges that they encountered as they *negotiated life on the street*. Overall, life on the street was portrayed as violent, frightening and intimidating. Youth described needing to be tough to deal with the violence and theft that was part of life on the street. As one youth so clearly described:

...if you are intimidated by the people out there you're gonna get the crap kicked out of you, you are going to get walked all over, you're not gonna have the clothes that I am wearing right now, people will steal right out from under you. You have to be tough...there's a lot of fights that go on. You know new people, or we call them twinkies, think they are king's shit. And the people that have been here 5-10 years get offended by it. Then there is fights and fights, people robbing each other, prostitution going on. (Lisa)

Participants also identified that there were a number of barriers to obtaining essential services necessary for survival. For example, on a most basic level these youth identified that services, such as drop-in centres, are frequently not open on the weekend. In the following quote this young woman described how hard it was to find food on the weekend.

No, haha, drop in are never usually open on weekends, usually the street kids have to struggle to find food or make money to find food. So it is hard. (Erica)

Although youth acknowledged that there were services to support employment, some youth described encountering obstacles to pursuing employment, such as not knowing where to start to access service. Even when youth were engaged in an employment programme, some described feeling pressured to search for jobs, or feared being left on their own if they were unsuccessful, as illustrated in the following quote.

... helped me like find a job or they are helping me find a job. Like I use the job search program. The job program here sucks, they just send you out and if you don't come back with a certain number of names then goodbye, you are out...(Lisa)

Participants also identified the real challenge of not having a place of residence when applying for a job. As one participant stated:

I found that most employees won't hire you less you have a place of residence and without a place of residence you have to have some kind of income. So basically I consider it as a catch-22 nowadays. (Don)

On the other hand, the perceived value of the existing services and programmes was clearly illustrated when, on numerous occasions, participants expressed concern that street-youth over the age of 25 were unable to access youth-oriented service, as this participant states:

I know there are numerous youth out there who are above the age of 26, 27. They can't go to (name of programme) for psychiatric help. They have to pay for everything out of their own pockets. They can't afford to so they choose to leave it like that. So you don't get the results that you want, right. (Fred)

The *perception of stigma* was pervasive to the youth's experience of being without a home. There was a sense that living a life associated with homelessness was a mark against the youth that resulted in a *sense of shame*. Participants felt that street youth were viewed indiscriminately as an unworthy group that were typically given negative labels, such as "squeegee kids". In addition, participants experienced a general lack of understanding and support from the public as described by this young man:

There is a certain stigma of street-kids. A lot of people don't like to hire street kids because they are street-kids, for that reason. Like my employer, of course he is a jerk, total jerk... he is like "Do you do drugs?" and obviously I don't do drugs and I don't act like I do drugs. And he doesn't say "Do," he says "Are you on drugs?" And just stuff like that ... People think that I steal...I have a big jacket and I go into a store and I may not look like a regular person, and I think people stare at me because they think I am shoplifting and stuff like that because I don't know. (Rob)

Perceptions of stigma and misunderstanding extended to broader societal level where some youth perceived that a general sense of neglect, as one of our focus group participants explained:

...one of the biggest problems with youth is like neglect. We've been neglected a million times, we've joined one programme that is good for us and then it's gone..." (Focus Group Participant)

For some youth a stigmatized identity associated with life on the street seemed almost impossible to disengage from. One young woman described the experience of speaking at her high school about the risks associated with homelessness, once she was free of drugs. Even though she was no longer using drugs, she still felt the effects of stigma due to her challenges with homelessness and drug use. As she states:

I went and talked at my old high school about homelessness. ...They picked me because I am on the street, it's as simple as that. And the kids listened to me. I was like I am still there, I've been there for a while all of you in this school know who I am 'cause I'm the druggie who kept coming to school retarded off her head, would take off in the middle of the day, be gone for like four weeks (unclear). Everybody at my school knows me, even people who were not at that school when I was there know who I am. I haven't been there for like three years, nobody I know goes to that school anymore, I'm still known at that school. It's disgusting. (Lisa)

In addition, youth emphasized the *stigma associated with mental illness*. There was a sense that the stigma connected with mental health challenges profoundly affects people's sense of self worth, perhaps even exceeding the burden of stigma experienced by street youth generally. The following quote illustrates not only the perception of stigma, but the observation that being stigmatized influences behavior, thus limiting the possibility of accessing opportunity and help.

There is a big stigma attached to being a youth and living on the streets or in the shelters and having a mental problem, like a mental health problem. Because not everyone understands it... You know it is one of the biggest things, suffering from depression, whatever, you know you have people looking down on you saying - you suffer from depression, you aren't able to do this, right you have to be able to do this, right you have to be at home collecting ODSP because you aren't fit to work. Pretty much stigma is what other people would think of them... just for the fact that there are going to be that thing that a lot of the people feel they are going to be judged or you know, you know people are going to think they are crazy for going to this place... (Fred)

An unexpected finding pertains to the perception that discussing mental health challenges with shelter staff could be risky. This uncertainty associated with the disclosure of mental illness, is consistent with perceptions of stigma and mental illness, generally. The perceived danger of disclosing to staff seemed to be especially high if a trusting relationship had not been established, as described by one of our focus group participants.



I wouldn't be comfortable with staff asking me if I have a mental illness. Even if it was on a piece of paper if I was checking into a shelter, or anything like that, I would not feel...Just like how I am 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. Like you know what I mean? You know after being supported by a worker after a couple 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. (Focus Group Participant)

As youth lived for longer periods on the street, they described acquiring a certain “*know how*” that was necessary to survive. This knowledge could only be gained through experience, not through books, but through learning the *unwritten rules of the street culture*, as illustrated by the following quote.

If you're homeless, book-smarts are not going to help you, man. It's not. Street smarts is, street smarts is going to help you further your life than book smarts... if you're on the streets, you still have rules on the streets. There are still are unwritten rules, they may not be written rules, there are still rules on the streets. Things you do not do, you know what I mean? (Rob)

There was also an awareness that many youth may turn to life on the street to avoid rules. However, youth who had acquired a certain level of experience living on the street conveyed that there were indeed rules associated with life on the street, as described by this young participant:

Because most kids at home today, um, if they have parents, that have a lot of rules, they think they can go out on the streets and have less rules to deal with. But what most kids don't realize is that there are more rules out here than at home. A lot more rules to deal with. You got government rules, you got police rules, you got, you know, so many more I don't want to name them all. But kids today got to wake up. No matter where you go in life there are always rules to follow. (Don)

An overriding rule of life on the street seemed to be captured by this young woman who described the necessity of conveying respect for youth who had been living on the street for some time. Although not explicitly stated the essence of her message seems to convey the need to be respectful of youth who are experienced in order to be safe. She stated:

You know, be nice, be polite, have respect for other people...I'm older than you and I have a higher authority than you. Respect me, that's all. Don't come in here talking like you have been here for like six years, you've been here for maybe six days, you don't know what it's like yet. You just came from, what, mommy and daddy's house because they had enough of you? Or you ran away because, oh no, because mommy and daddy are too hard on you? That'll get you in trouble, keep your head down, that's what I would

have to say to them. It's all about respect down here, if you don't have respect for like other people... (Lisa)

Living with Mental Health Challenges

Overall the qualitative findings related specifically to mental health issues mirror the quantitative findings that indicate the presence of high levels of mental health symptoms. In response to questions about ongoing personal challenges, fears and uncertainties in the qualitative interviews, participants readily described a myriad of mental health challenges that they were experiencing, usually over some time. Youth explained that mental health challenges, including substance abuse, were either a consequence of being street-involved or constituted a pre-existing illness or set of challenges that contributed to their current homelessness. These perspectives are elaborated upon below.

As stated, many youth made a direct *link between mental health issues and the stress of being homeless*. In some instances the stress was experienced as a general sense of being overwhelmed; a pervasive sense of being lost, confused and unable to find direction. As this participant in one of our focus groups described:

[Living on the streets]...It's 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 'cause you're confused it's like you can't even use your own resources because you're still unsure of what to do... (Focus Group Participant)

A very specific connection was made by a number of participants between their circumstances of living on the street and the experience of being depressed:

when you are homeless...you do get depressed, you do get lonely sometime...most homeless have serious depression... (Focus Group Participant)

A number of the youth attributed the experience of depression to the numerous challenges that they were faced with, such as not having money, not having a job, dealing with the outside elements and not having enough to eat. This young man clearly attributes his depression to being homeless:

I have depression, well obviously or I think I have depression. It's clinical depression according to my doctor... It's more conditional than anything. I have depression because I am here; I am here because of this situation... If you have no job, if you have no money, and you are stuck here and on the street and its freezing, you are going to be really depressed. You know, that was kind of my situation earlier. (Rob)

In conjunction with feeling depressed youth also described a co-existing feeling of wanting things to be better. As described earlier, this juxtapositioning of feeling both despairing and at the same time feeling optimistic is characteristic of the youth that we interviewed in the study. As Don so aptly described:

I am not happy with...(and) in a way I am happy with myself and in a way I am not. I am sleeping on the sidewalks, you know. Honestly I don't like that, you know. It brings me down because I know I am a better person. So I guess you can say I am kind of depressed when I am outside, you know, and I want to get that depression out of me. I want to be able to look back and say, Hey I made it. I made it through hard times. Now I know I can achieve anything. (Don)

As described, many of our young participants identified the existence of a *pre-existing mental illness* or set of challenges that contributed to their current homelessness. Specific illnesses referred to included depression, bipolar illness and eating disorders. Other issues included anger control, interpersonal sensitivity, self harm and suicidality. Participants also referenced the fact that they frequently had to deal with a number of issues while they were growing up. For example this quote from a focus group participant illustrates the difficulties that ongoing mental health issues can present in coping with life challenges:

Because, like for example, I mean, 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 um, yah it affects not only you but everybody around you, and stuff like that. 'Cause I used the type of person that, if someone said something to me or looked at me wrong, instead of me just walking away I would like beat the person up... But now I'm just like...I still have that anger, but it's under control a little. I'm still working on it. (Focus Group Participant)

This young woman also describes the influence of a number of ongoing mental health challenges, such as an eating disorder, bipolar disorder, as well as issues with drugs and anger all of which seriously compromised her capacity to be happy:

Me, I pretend to be happy; I'm not really happy. I just pretend...I don't know. I have never really truly been happy... I don't even know what that would feel like. Like, even when I think I am happy, I actually think about it and I'll be like, hey, no, no. Smile anyway.... [I think about] everything. Parents, my eating disorder, stuff like that. This is going to sound crazy, but, like, I am totally whacked out because of all the drugs, and I've been diagnosed with a rage problem and I'm bipolar. So, I don't think a lot about things like, that are back in my head. That's why I am always smiling and happy. I'm really afraid of what would happen (unclear). I'd either kill somebody, kill myself, or just be a total nut-ball. Cause, I know if my anger came out, well, I don't want even go there. Like, I've had that issue since I was yag high. (Lisa)

For some youth there was a desperate sense of unhappiness that was almost impossible to escape. This description of self harm, depression and suicide attempts is consistent with the quantitative data and reflects the experience of a number of youth in our study and further illustrates the urgent need for mental health intervention. As this young man described he experienced he felt hopeless in the face of failed suicide attempts:

I've been at rock bottom numerous times. I've had two suicide attempts, I use to self-harm, I used to be a cutter. Even after the first time, I hear people saying, "I tried to commit suicide and it's changed my life." Trying to commit suicide and failing didn't

change my life. It just made me want to do it faster, I guess wanting to do it more, right. This is going to sound weird, but it is so sad that you get somebody who has hit rock bottom and they can't even commit suicide right and it's just that, and I know that sounds weird, but when you are suffering from depression and whatever, and you say, "You know what, finally doing something right." Suicide never fails, you feel even more as a failure because you can't even do the one thing that you thought would take it all away...(Fred)

Along with the description of mental illness and mental health challenges there was also a pervasive sense of skepticism related to psychiatric treatment; specifically receiving a diagnosis and the use of prescribed medication. Youth in one of our focus groups described receiving a number of different diagnoses; one youth thought that psychiatrists might even lie about psychiatric diagnoses. A general sense of mistrust regarding psychiatric medication was vocalized by this young woman:

... They need to stop giving people medication, like medicine...it is a cover up. I have been on Prozac. I don't know they are making me sleep, they are making me happy, right, I would feel fine and I would be on it for awhile and think alright I am better and I would get off of it. Then it would just be depressing you know. People should just screw all the pills...(Sue)

On the other hand, the use of street drugs was identified by a number of participants as a means of escaping the ongoing emotional turmoil associated with life on the street. It is noteworthy that even though a number of participants described using street drugs to obtain a sense of relief, for example "to get my mind off things"; they were also aware that the use of street drugs was a negative coping strategy to be avoided. In essence a tension existed between the wish to take drugs to escape the current situation with the notion that drugs will not solve difficult life circumstances. This young woman aptly describes this tension between wanting/needing to do drugs and moving toward a better life:

...Drugs keep you awake, drugs make you happy, right? And you don't have to worry about finding a place to sleep because you are on all the drugs, you don't have to worry about eating. All you have to worry about is drugs, and you really don't need money for that. Because there are enough people around to beat up and rob or enough people who will give you spots... So, that's why people are so into drugs around here... And it's just like screw it, I'm not going to wind up like toothless Joe over there. You know, I went through a blip in my life, I'm still going through that blip, I'm trying to stop that blip. Because I don't want to live my life like that. (Lisa)

Strength in the Midst of Challenge: The Emergence of Resilience

In spite of the wide range of mental health challenges that these youth experienced, areas of strength and resilience were also apparent for the majority of youth that we interviewed. To begin with it was evident that the majority of youth wanted to *strive for a better life*, even though many obstacles still lay ahead. There was also an emerging sense 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. Wanting to strive for a better life was described as a process whereby youth had, overtime, become *discontented with their current life circumstances*. As this young man clearly articulates:

There is more to life than drugs and alcohol. There is a whole different life out there and I want to explore it...life is hell and you've got to work around it. And there are going to be many obstacles in life and just got to deal with what obstacles come about you, that is the way I look at life...(Don)

When participants were asked about whether they had *plans for the future*, virtually all spoke of the desire to have *a home of their own*. Once they envisioned that they would have their own place, many of the youth expressed goals for the future that were consistent with their development as young adults. Specifically, their future aspirations focused on returning to school to launch a career, or on finding suitable occupation or employment. In addition, a noteworthy ambition was to give back to the community and to help others who may be coping with similar circumstances. In the following quote this young man describes his ambition to complete high school save for university and to ultimately help others. It is striking that he envisions such a full future given the many steps ahead:

One of my biggest long-term goals is to, currently, well graduate high school and save enough money to pay for tuition for university to start my career I guess, that is one of my long-term goals, and just to you know, be there for as many people as I can without having to actually sacrifice my needs and goals. (Fred)

Within the context of the qualitative interviews and focus groups, it was clear that youth had acquired a number of skills and attributes (typically associated with resilience), that would help them to “deal with the obstacles” that lay ahead. These skills and attributes included the capacity to: *learn from past experience*, engage in *positive coping strategies* (e.g. – choosing the right friends, thinking positively & helping others) and *pursue goals*. In the following quote this young man shares the realization that learning from his mistakes is a highly valuable exercise. As well, he seems to grasp that his past choices were *wrong for him* and that these choices were not helping him to achieve the life he envisions for himself:

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 tough 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. (Greg)

Another young man recognized that some of his past choices were frightening to him, but he now recognizes that *being scared* was perhaps a good thing; implying that he is now making better choices.

I've actually learned a lot from my past experience and stuff like that and like you say I got scared on my way...but being scared was actually a good thing for me, not a bad thing. (Brian)

This young woman adamantly describes the ongoing desperation that she feels about her current life, but recently she has become aware of the importance of *carefully choosing friends*. Although not explicitly stated it is implied that having *real friends* will help her to feel better. As she describes:

So like now I am like I have to do something or I am going to die. I have learned to choose my friends, I've learned to tell people like friends from real friends. Because there are friends you have that that just hang out and use each other. Real friends that don't want anything from you and don't use you. (Sue)

In the following quote, this young man is also aware that not all friends are true friends, as he puts it - real friends would try to help youth get off drugs and not perpetuate the problem. There is an underlying sadness apparent in this young man. He seems to be saying that he does not have many real friends that will help him make good choices.

There's a difference between friends and friends. Like I see them...into hardcore drugs now, a real friend would actually try to get you off it, and other friends like say no let's just do it, and won't do nothing. So like I see different kind of friends and I don't have much friends, just the people that I know and I hang around with sometimes. (Brian)

Youth who participated in the study described acquiring *positive coping strategies* to deal with difficult circumstances. For example the following participant discovered that he must focus on completing a task or goal, since in the past he would have readily given up on a goal.

If I start something I like to finish it. That's what I used to always do in the past is I start something and I'll just quit and get out of it. That is one of the things that I had to start working on all the time and I keep going right towards the end. (Brian)

One of the focus group participants talked about reading in a book store to obtain some privacy and inspiration while living in a shelter.

So I have to like find a day a week where no one knows where I am. Just get away, um. And also, for me it's reading, reading something inspirational philosophy, I usually go

to... Book Store. And just like sit down with a book, for like maybe half an hour...(focus group participant)

For a number of the youth, there was recognition that focusing on the positive, specifically “*doing positive things*” and “*having a positive attitude*” was beneficial. Youth described the need to pursue small goals, while at the same time keeping one’s head down and avoiding the drugs and gang culture on the street in order to strive for a better life. For example, this young man explains that it is necessary to *stick to one’s goals* and avoid the perils of the street:

try to improve your situation and work towards something and don’t get involved in ... the drugs and gang culture ... if you just try to stick to your goals ... just keep to your path and don’t worry about anybody. (Rob)

Some participants had developed an awareness that individuals are able to make positive choices to change. For example, this young man states that he would advise youth that it is necessary to make their own decisions to change. A perspective that is quite insightful and relevant:

Basically, what I would say, ‘It’s up to you to change what is going on. It is up to you. You can change it. I can give you advice. I can’t change your life for you. You got to change it yourself. (Don)

For many youth the notion of *helping others* was a primary factor that provided motivation to keep going; offering hope that in the future there would not be the same degree of suffering for youth. This young woman describes her wish to write a novel so that other youth can know that even when “life sucks” it is possible to “grow”; to do better. Her personal suffering is present in this quote. Despite her observation that she has grown, she feels that her parents continue to believe that she will not be successful in life. Writing a novel would be a means of proving them wrong. As she states:

I want to write it [a novel] I guess to help others in a way. Because like I went through a lot and I have seen a lot and I have heard a lot and you know have felt every emotion possible in this world. By helping other people, I get passed that. And do something with myself and grow sort of. You know what I mean, show people you know life sucks, if I can do it so can you kind of thing. That would be the whole point of the book. And laugh at my parents, be like ha, because they don’t think I can do anything with my life at all. I will be like here, look at that. (Sue)

Another young man sees value in participating in the research as a way of getting his story out in order to help others over the long term. He describes his wish to help others in this way:

That is one thing, I like talking with people, so if I can get my story out there, because you never know, me saying something could click inside of you guys, and you guys could go out and change something and help out a vast majority of people, right, so you

know, helping one person out, you know, you help out, you know, more in the long run, right. Short term pain for long gain, I guess, right. (Fred)

This young woman provides us with an understanding of how central the capacity to *help others* is to her conception of herself. She sees herself as a “good friend”, someone that others can turn to for help. As she states:

I normally am a good friend, if I meet someone on the street that I have gone to school with or something, I will keep an eye out for them, teach them what I know... just being a kind hearted person and just showing people that I love, or just normally showing them what to do and how to do it, and give them help if they need it. Everybody comes to me. (Erica)

Seeking Supportive Relationships

In the quantitative part of the study, participants indicated that relationships, specifically with extended family and peers, were important to them. In the qualitative component of the study participants were asked to identify what contributed to their mental or emotional health. In accordance with the quantitative findings, virtually all of the participants who participated in the qualitative interviews identified the centrality of supportive relationships in becoming mentally healthy and strong. Participants described supportive relationships across a number of dimensions including: *supportive connections with family; the understanding of friends who were also street-involved; and relationships with staff.*

Contrary to expectation, some of the participants in our study had *contact with family members*. In some instances, the youth simply described talking with family members. For others the relationship with parents was described as evolving from a challenging conflictual relationship in the past to a more supportive relationship in the present. The following quote illustrates a transition from a rocky relationship where this young man had been “kicked out” to a supportive interactive relationship between mother and son.

When I was 14...she kicked me out until I was about 17, it was really rocky you know, like may be twice, three times, I would see her, or something like that. But, you know, over the past year or two, its' gotten better. Like she has taken a lot more, I guess responsibility in the fact, like she says she could have been more for me when I was growing up...But you know the relationship has gotten better. Like you know I see her may-be 3-4 times a month, you know, I go over to her house when I can for the weekend with my daughter and my girlfriend...(Fred)

One participant commented on the merit of his girlfriend reconnecting with her family. From his point of view he had a role to play in helping his girlfriend to make this connection, which was highly valuable, not only for his girlfriend but for himself as well, as he states:

My girlfriend here is just starting to get along with her family again cause I've been pushing her to get along with her family. I've told her you just got one family in life, don't take it for granted. So she's working towards getting back into the good graces of her

parents and all that and I am glad I could have helped in that department there, you know...her family is also pushing me you know. Like that gives me more incentive...(Don)

The description of relationships with family, as supportive, differs considerably from the description of problematic unstable home environments that were frequently identified as the cause of the youth's current homelessness. These findings suggest that in some cases it may be possible to repair strained difficult relationships to the benefit of some youth.

Youth described many varied aspects of *friendship* that evolved as they attempted to deal with their life circumstances. As described previously, youth clearly spoke about the risks associated with *befriending the wrong crowd* and the need to *carefully choose one's friends*. As we talked with youth, it became clear that youth found it was possible to have supportive friends, frequently with youth who shared similar circumstances. As this young woman described friends were viewed as important source of support:

If you have friends out here that know you from the beginning of like, were on the street when they met you, they know what you've gone through, they understand because they want a home too. (Lisa)

Similarly, friends are an extremely important source of support for this young woman:

They (friends) help me a lot just by being there through a lot, bad times and good times.(Erica)

There was acknowledgment that friends have a significant influence on the lives of youth, which is in keeping with the developmental trajectory of adolescents and young adults, where friends become increasingly important. One participant acknowledged the positive influence of friends and added that friends can be any age:

...So these people influence me like I've met and I've talked to that have been open with and they've helped me when I've been down and out, or when I've just been down emotionally and it's good to have that kind of support as well. Anyone can be your friend, age doesn't matter. People can give you support at any age ...(Greg)

It was not unusual for youth to feel so comfortable with friends that they had met either in the shelter system or on the street, that relationships with friends were described as feeling like family. As this young woman described:

I normally am a good friend, if I meet someone on the street that I have gone to school with or something, I will keep an eye out for them, teach them what I know somewhat about, and then what I don't know they talk to someone else. We are all on big happy family. We watch each other backs while we are out here. (Erica)

The importance of *positive caring relationships with staff* was emphasized frequently by participants in this study. Although not all youth described positive encounters with staff, at least

half of the participants did describe meaningful interactions with staff. The perception that staff cared about the youth, seemed to be portrayed by: expressions of interest; active efforts to make contact; queries about what might be wrong, as well as being accessible. One youth offered a contrast between staff “who were just there for the job” and staff who care, as illustrated below.

Yeah, someone showing interest. Yeah that means a lot, means lot. I don't want to bash other shelters. There is a client-and-staff barrier. They are just here for a job and not here to help people. There are a couple of people who kind of care. I don't know, it means a lot when someone takes you to the side and asks you what's wrong. (Rob)

For youth in the study, the impact of a positive connection with staff is dramatic. In the following quote it is evident that the staff's expressions of confidence in this young woman inspired hope and engendered a positive competent sense of self. As Erica states:

I didn't think I could get a job or anything until a staff said hey you would be good for this and they bring my hopes up that I am able to do it and have faith in me that I can do it, if I put my mind to things I can do it. (Erica)

The qualitative data suggests that positive relationships with the staff may well have long lasting effects that go well beyond pursuit of a particular goal; transferring to a fundamental belief in the self as a valued and capable young person. As the young woman above conveys; she knows she can do things if she “puts her mind to it”. The fundamental role of having a concerned caring adult who believes in the youth and can offer hope and encouragement where there seemingly is none offers a push towards life's goals that may not otherwise be available to these youth. In the following quote, this young man clearly described the essential role of staff in helping him to achieve of new goals; ones that he would not have aspired to without the encouragement of staff. Although not explicitly stated, one has the impression that this young man was able to mature through his experience of being nurtured by staff, so much so that he now counts the *staff as friends*. The capacity to see “staff” as friends is also consistent with the developmental process that occurs in young adulthood where parents and teachers gradually shift from being perceived as authority figures to friends as young people take increasing responsibility for their own decisions and lives.

Like I get along with the staff very well, we are all good friends now. Whenever I keep coming here, it's like they give me an extra push ahead. You know I can succeed in something later on, They are also pushing me forward to achieve what I want and without all the support and pushing and all that who knows , I's probably be still be sitting on the sidewalk or whatever, you know.(Don)



Participatory Action

The PAR project began with brainstorming ideas with the youth who came up with the idea of using photographs, videography, and narrative to conceptualize their message about the mental and emotional health needs of street youth. Themes regarding the meaning of emotional and mental health, identified from the two focus groups in this study, were used to provide some direction to the youth who volunteered for the PAR project. These themes regarding emotional and mental health 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 everyday, knowing that you will be okay. In order to further understand the mental and emotional health needs of street-involved youth, the participants were asked to keep in mind the following questions while taking their photographs: 1) How do you define what it means to be mentally and emotionally healthy?; and 2) How do you try to achieve emotional health? As described in the methods section, four youth were given cameras as part of the photovoice project. Our participants were highly engaged in the process of developing the photovoice idea as a way to communicate and express their feelings, for example stating, *"Taking pictures is an easy way to communicate a feeling"*. The youth described that they felt that participation in the PAR project gave them an opportunity to have a voice, stating that *"It just gives you some, like, stability...It's just nice to know you're a part of something...you're impacting something"*. Also that *"We could give a different point of view instead of...all these older people who are trying to speak for us..."* The PAR project forms an important component of the dissemination strategy for the project. The photos taken by the 2 youth who were able to complete the project can be viewed at www.streetinvolvedyouth.ca.

Discussion

The purpose of the present study was to gain a greater understanding of the challenges and strengths pertaining to mental health for street-involved youth in order to provide direction for intervention. Although there has been a number of studies which describe the mental health challenges of street-involved youth, this study was unique in that it employed a mixed methods approach to describe the mental health challenges of youth using standardized instruments that allowed for comparisons with normative samples, thus enabling generalization of the findings to the broader population (Creswell, 2003) of street-involved youth. As well, the mixed methods approach adopted in this study included in-depth qualitative interviews with youth allowing the voice of participants to be heard (Creswell, 2003) with regard to both the experience of mental health issues, as well as ideas for intervention. The willingness of youth to engage in a participatory approach to disseminate the study findings further extends the opportunity to integrate the voice of youth in the project, particularly related to dissemination.

As might be expected, our quantitative findings demonstrated a higher rate of mental health symptoms, including depression and hopelessness, among our sample of street youth compared to normative populations. In addition, nearly two-thirds of participants in our study had experienced physical abuse, while one-quarter had been sexually abused, and 34% expressed suicidal ideation. About one-half of the participants had engaged in self-harm and virtually all engaged in alcohol and substance abuse. These findings are consistent with those documented in previous studies that examine mental health among street youth (Boivin et al., 2005; Fisher et al., 2005; Whitbeck et al., 2004). The high rates of substance abuse among homeless youth has been described as a particular area of concern, given that youth tend to engage in dual drug and alcohol abuse (Kelly & Caputo, 2007), which appears to be the case in this study. Substance use was also described as a means of coping with emotional pain and the difficult aspects of life on the street, which has also been reported in the literature (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008).

The qualitative findings further illuminated the quantitative findings; highlighting the clear relationship between the stress of homelessness (e.g. – being without a home, financial resources, feeling unsafe etc.) and emotional distress, such as depression and suicide. The quantitative data indicated that one third of youth stated they were living with pre-existing illnesses, (e.g.-bipolar disorder) and/or problematic issues, such as drug abuse and anger. On the other hand, the qualitative findings provided an understanding of the link between these pre-existing mental health challenges and their current homelessness.

Even with these exceedingly severe levels of mental health symptoms and emotional distress, our quantitative findings revealed moderately high levels of resilience (the capacity to overcome adversity) and self-esteem for the participants in our study. Although previous studies have documented the existence of psychological resilience among street youth (Adalf & Zdanowicz, 1999; Rew, Taylor-Seehafer, Thomas, Yockey, 2001; Rew, 2003), to our knowledge few studies have identified the interface between psychological resilience and acute distress in this young vulnerable group of young adults. The qualitative data is replete with examples where youth

demonstrated the juxta-positioning of suffering and upset alongside a determination to strive for a better life, allowing for a more in-depth understanding and particular meaning of the quantitative data.

The juxta-positioning of distress and strength was most evident in discussions of mental health challenges, where descriptions of strengths emerged simultaneously with descriptions of distress. Specifically, youth described feeling overwhelmed by their current circumstances and feelings of despair, then moved on to talk about a better future. Accordingly, youth also described the need to use drugs as an escape from emotional distress and their current discomfort, yet at the same time not wanting to “live life like that.” Virtually all youth in our study identified the centrality of supportive relationships in becoming mentally healthy and strong, yet many also described a need to be wary of relationships. Youth also conveyed that supportive relationships were pivotal to their capacity to master their current circumstances and to achieve some sense of independence and well being.

In conjunction with understanding the seemingly opposing states of suffering and resilience, the current study has also provided an extended understanding of the nature of resilience for youth who participated in the study. Specifically, youth described specific strategies that they employed to cope with life on the street, such as being tough, keeping one’s head down and choosing the right friends. In addition, youth described a number of coping strategies to deal more specifically with emotional distress, such as thinking positively, learning from past mistakes, helping others and pursuing goals in order to move ahead. It was striking that the goals of youth for the future, included going to college or university or finding a job, all consistent with their developmental phase of young adulthood. The literature suggests that insufficient attention has been given to protective factors and strengths for street-involved youth (Bender, Thompson, McManus, Lantry & Flynn, 2007). Interventions that focus on developing protective factors can enhance youths’ abilities to face challenges and solve problems (Bender et al., 2007).

Despite the focus on positive coping strategies to improve mental health and profoundly elevated levels of mental health symptoms, only 24% of youth in our sample reported that they were currently using mental health services. From the qualitative data, it was evident that some youth had developed a great deal of skepticism regarding psychiatric treatment and prescription medication. As such, there appear to be many obstacles for youth to access and engage in effective mental health services that would afford the opportunity for effective treatment that could be understood and accepted by youth. From the perspective of youth in this study effective mental health services would not be stigmatizing; but would be offered in a non-threatening manner that provide a sense of comfort and an opportunity to talk when youth are ready. The importance of a trusting relationship with staff as a basis for effective intervention is well described in the literature (Kidd, Miner, Walker & Davidson, 2007). The labeling of services as mental health services seemed to be problematic to youth, primarily due to stigma; a phenomenon also identified in the literature (Kidd et al., 2007). The detrimental role of stigma associated with mental illness and homelessness is of the utmost importance since it seemed to engender low self-esteem, shame and expectations for rejection and a sense of a limited opportunity.



There is clearly an urgent need for evidence-based interventions to address the severe and complex mental health problems of homeless youth. Evidence indicates that the longer youth spend on the street the greater the chance that they will engage in high risk behaviours, such as prostitution and suicide attempts (McCarthy & Hagan, 1992) and the greater the risk of chronic homelessness (Goering et al., 2002). The current study offers some perspectives to consider in the implementation of interventions to meet the mental health needs of this young vulnerable population. Understanding the propensity of youth to experience both overwhelming despair and, at the same time, to hope for a better future appears to be a critical vantage point upon which to build therapeutic programmes and interventions. Slesnick et al., (2007) emphasizes the importance of this multi-prong approach by indicating that effective interventions need to offer the possibility of disrupting a negative spiral, while at the same time providing support and skills to further positive linkages. Indeed numerous authors have encouraged researchers to develop and evaluate interventions that strengthen positive relationships and build resilience (Karabanow, 2004; Karabanow & Clement, 2004; Kidd, 2003; Kidd & Davidson, 2007; Johnson et al., 2005) The study's current findings also highlight the need for youth to acquire skills to specifically withstand and address emotional distress in conjunction with further developing strengths. Addressing the mental health problems of street youth, with an emphasis on psychological distress, as well as strengths, such as positive relationship skills should enhance the capacity for youth to engage in opportunities for social re-integration through transitioning to stable housing and/or employment programmes and ultimately an improved quality of life.

Conclusions

This study supports earlier research that mental health problems, such as loneliness, self-harm behaviours, depression, anxiety and suicidality are a significant part of life for street youth. In keeping with other findings in the field, our preliminary results indicate that these youth have profoundly high levels of mental health symptoms compared to healthy young adults. However, only 24% of youth in our sample reported that they were using mental health services, suggesting problems with access to and availability of appropriate services. Along with increased mental health symptoms, the youth in our study also reported increased resilience and self-esteem, in the context of distressing emotions and challenging life circumstances, suggesting that mental health programmes should address both challenge and strength in the provision of services for this young vulnerable population.

Dissemination

Publications

- McCay, E., Langley, J., Beanlands, H., Cooper, L., Mudachi, N., Harris, A., Bach, K., Dart, C., & Miner, S. (to be submitted) Mental Health Challenges of Street-Involved Youth.

Conferences

- McCay, E., Beanlands, H., Cooper, L., Langley, J., & Robinson, P. (2009). Supporting Resilience amongst Street-Involved Youth, Conference Presentation at the Canadian Federation of Mental Health Nurses 2009 National Conference, Hope, Health & Healing: Mental Health Nursing Around the corner, Around the World, Halifax, Nova Scotia, October 21, 2009
- Langley, J. & McCay, E., Mental health needs of transitional age street youth: A collaborative project. Conference presentation at the 28th Annual Meeting of the Canadian Academy of Child and Adolescent Psychiatry, Vancouver, British Columbia, September 8, 2008
- McCay, E., & Langley, J., Mental Health Needs of Transitional Youth on the Street, A Collaborative Project, Paper presented to the Canadian Psychiatric Association, Montreal, November 18, 2007
- McCay, E., Beanlands, H., Cooper, L., et al. Promoting Mental Health and Resilience in Street-Involved Youth, Paper presented at the 18th International Nursing Research Congress Focusing on Evidence-Based Practice, July, 2007, Vienna Austria.
- McCay, E., Langley, J., Beanlands, H., Cooper C., Howes, C., Bach, K., Approaches to Mental Health Needs of Transitional Street Youth, Poster presented to 17th International Nursing Research Congress Focusing on Evidence-Based Practice, Montreal, July 2006.

- McCay, E., Langley, J., Cooper, L., Beanlands, H., Robinson, P., Howes, C., Bach, K., Dart, C., Miner, S., Mudachi, N., & Rigatti, M. Mental Health Needs of Transitional Street Youth. Poster presented to the 4th International Conference on Urban Health, October 26-28, 2005. Toronto.

Web site

A summary of the findings of our study has been posted on the web site of the Strategic Alliance for the Advancement of Mental Health & Emotional Well-Being among Street-Involved Youth. We are gratefully acknowledge funding received from the Canadian Institutes of Health Research: Institute of Gender & Health, [The Wellesley Institute](http://www.wellesleyinstitute.com), and Ryerson University for the development of the web site.

The photos and narrations for the participatory action research project can be found on this site, as well as summaries of the quantitative and qualitative findings.

<http://www.streetinvolvedyouth.ca/>

Dissemination Events

Further information concerning these events can be obtained on the web site:
www.streetinvolvedyouth.ca

Registered Nurses' Association of Ontario: Take Your MPP to Work Event

On May 10, 2007, Minister of Health and Long-Term Care, the Honourable George Smitherman attended Ryerson University as part of the RNAO's 7th annual *Take Your MPP to Work* event as part of Nursing Week 2007. Mr. Smitherman was presented with the preliminary results of our *Community Collaborative Research Project: Understanding the Mental Health Needs of Street-Involved Youth*.

Workshop 2007: Mental Health Needs of Street-involved Youth in Canada: Establishing Evidence for a Policy Driven Agenda (Funded by CIHR)

The findings of the current study provided a catalyst for a workshop held on November 30, 2007. The findings of our study were presented at the workshop, with our community partners in attendance. Keynote speakers included: Dr. Lynn Rew, School of Nursing, University of Austin at Texas, Dr. Jeff Karabanow School of Social Work, Dalhousie University in Halifax, and Dr. Paula Goering, an expert in policy development, from the Centre for Addiction and Mental Health. Both Dr. Lynn Rew and Dr. Jeff Karabanow shared their research perspectives and ideas for interventions targeted at the mental health needs of street youth.



Key recommendations were developed targeting interventions toward street-involved youth:

1. Improve existing mental health services for this population by creating seamless coordination of available services; Introduce new services for mental health treatment and support; Improve access and availability of substance misuse services; Develop best practices for creating interventions for street youth
2. Educate the public regarding the strength and resilience of this population and their mental health needs to help lower stigma; Target use of the media as an intermediary
3. Advocate for more consistent funding by developing partnerships in the community with stakeholders, other researchers, and funding agencies; Develop and strengthen alliances and target specific agencies to meet their criteria for funding

References

- Adlaf, E. M., & Zdanowicz Y. M. (1999). A cluster-analytic study of substance problems and mental health among street youth. *American Journal of Drug and Alcohol Abuse, 25*, 639-660.
- Beck, A., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. *Journal of Consulting and Clinical Psychology, 47*, 861–865.
- Bender, K., Thompson, S.J., McManus, H., Lantry, J. & Flynn, P.M. (2007). Capacity for survival: Exploring strengths of homeless street youth. *Child Youth Care Forum, 36*, 25-42.
- Bjarehed, J. & Lundh, L.G. (2008). Deliberate self-harm in 14 year old adolescents: How frequent is it and how is it associated with psychopathology, relationship variables, and styles of emotional regulation? *Cognitive Behaviour Therapy, 37*(1), 26-37.
- Boivin, J.-F., Roy, E., Haley, N., & Galbaud du Fort, G. (2005). The health of street youth. *Canadian Journal of Public Health, 96*, 432–437.
- Christiani, A., Hudson, A.L., Nyamathi, A., Mutere, M. & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally-sensitive care. *Journal of Child and Adolescent Psychiatric Nursing, 21*(3), 154-164.
- Chubb, N. H., Fertman, C. I., & Ross, J. L. (1997). Adolescent self-esteem and locus of control: A longitudinal study of gender and age differences. *Adolescence, 32*, 113–129.
- Creswell, J. W. (2003). *Research design: Quantitative, qualitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Derogatis L.R. (1994). *SCL-90: Symptom checklist-90-R*. Minneapolis, MN, National Computer systems Inc.
- Durham, T. W. (1982). Norms, reliability, and item analysis of the hopelessness scale in general, psychiatric, forensic psychiatric, and college populations. *Journal of Clinical Psychology, 38*, 597-600.
- Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S., L. (2005). The victimization of children & youth: A comprehensive national survey. *Child Maltreatment, 10*(1) 5-25.
- Fisher, M., Florsheim, P., & Sheetz, J. (2005). That’s not my problem: Convergence and divergence between self- and other- identified problems among homeless adolescents. *Child & Youth Care Forum, 34*, 393-403.
- Goering, P., Tolomiczenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services, 53*(11), 1472-1474.

- Gratz, K.L. (2001). Measurement of deliberate self-harm: Preliminary data on the deliberate self-harm inventory. *Journal of Psychopathology and Behavioural Assessment*, 23(4), 253-263.
- Hunter, A., J., & Chandler, G., E. (1999). Adolescent resilience, *The Journal of Nursing Scholarship*, 31(3), 243-247
- Hwang, S.W. (2001). Homelessness and Health. *Canadian Medical Association Journal*, 164(2), 229-233.
- Janus, M.D., Archambault, F.X., Brown, S.W., & Welsh, L.A. (1995). Physical abuse in Canadian runaway adolescents. *Child Abuse & Neglect*, 19(4), 433-447.
- Johnson, K.D., Whitbeck, L.B. & Hoyt, D.R. (2005). Predictors of social network composition among homeless and runaway adolescents. *Journal of Adolescence*, 28(2), 231-248.
- Joiner, T., E., Pfaff, J., J., & Acres, J.,G., (2002). A brief screening tool for suicidal symptoms in adolescents and young adults in general health settings: reliability and validity data from the Australian National General Practice Youth Suicide Prevention Project, *Behaviour Research and Therapy*, 40 (4), 471-481.
- Karabanow, J. (2004). *Being Young and Homeless: Understanding how youth enter and exit street life*. New York, New York. Peter Lang Publishing INC.
- Karabanow, J. & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention*, 4(1), 93-108.
- Kay, S. R., Fiszbein, A. & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13, 261–276.
- Kelly, K. & Caputo, T. (2007). Health and street/homeless youth. *Journal of Health Psychology*, 12(5), 726-736.
- Kidd, S. (2003). Street Youth: Coping and Interventions, *Child and Adolescent Social Work Journal*, 20 (4), 235-261.
- Kidd, S.A. & Davidson, L.(2007). “You have to adapt because you have no other choice”: The stories of strength and resilience of 208 homeless youth in New York City and Toronto. *Journal of Community Psychology*, 35 (2), 219-238.
- Kidd, S.A. & Kral, M.J. (2002). Suicide and prostitution among street youth: A qualitative analysis. *Adolescence*, 37(146), 411-430.
- Kidd, S., Miner, S., Walker, D., & Davidson, L. (2007). Stories of working with homeless youth: On being "mind-boggling", *Children and Youth Services Review*, 29 (1), 16-34.
- Kidd, S. & Shahar, G. (2008). Resilience in homeless youth: the key role of self-esteem. *American Journal of Orthopsychiatry*, 78(2), 163-172



- Kipke, M.D., Simon, T.R., Montgomery, S.B., Unger, J.B., & Iversen, E.F. (1997). Homeless youth and their exposure to and involvement in violence while living on the streets. *Journal of Adolescent Health, 20*(5), 360-367.
- Kurtz, P. D., Jarvis, S. V., & Kurtz, G. (1991). The problems of homeless youth: Empirical findings and human service issues. *Social Work, 36*, 309-314.
- Leavy, J., Goering, P., Macfarlane, D., Bradley, S. & Cochrane, J. (2000). *The Gap: Moving toward youth-centered mental health care for transitional aged youth (16-24)*. Unpublished Report, Health Systems Research Unit, Centre for Addiction & Mental Health, Toronto, Ontario.
- McCarthy, B. & Hagan, J. (1992). Surviving on the Street: The experiences of homeless youth. *Journal of Adolescent Research, 7*(4), 412-430.
- McCay, E., Beanlands, H., Leszcz, M., Goering, P., Seeman, M.V. & Ryan, K. (2006). A group intervention to promote healthy self-concept in first episode schizophrenia: A pilot study. *Psychiatric Rehabilitation Journal, 30*(2), 105-111.
- Meyer, T.D., & Hautzinger, M. (2000). The structure of affective symptoms in a sample of young adults. *Comprehensive Psychiatry, 44*, 110-116.
- Molnar, B.E., Shade, S.B. Kral, A.H., Booth, R.E., & Watters, J.K. (1998). Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse & Neglect, 22*(3), 213-222.
- Morrell-Bellai, T., Goering, P. N., & Boydell, K. M. (2000). Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing, 21*, 581-604.
- Radloff, M. (1977). The CES-D: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 28*, 385-401.
- Reilly, J. J., Herrman, H. E., Clarke, D. M., Neil, C. C. & McNamara, C. L. (1994). Psychiatric disorders in and service use by young homeless people. *The Medical Journal of Australia, 161*, 429-432.
- Rew, L., Taylor-Seehafer, M., Thomas, N.Y., & Yockey, R.D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship, 33*(1), 33-40.
- Rew L. (2002). Characteristics and health care needs of homeless adolescents. *Nursing Clinics of North America, 37*(3), 423-431.
- Rew, L. (2003). A theory of taking care of oneself grounded in experiences of Homeless Youth. *Nursing Research, 52*(4), 234-241.
- Rew, L. & Horner, S. D. (2003). Personal strengths of homeless adolescents living in a high-risk environment. *Advances in Nursing Science, 26*, 90-101.
- Rew, L., Taylor-Seehafer, M., Thomas, N. N., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship, 33*, 33-40.



- Rhode, P., Noell, J., Ochs, L., & Seeley, J.R. (2001). Depression, suicidal ideation and STD-related risk in homeless older adolescents. *Journal of Adolescence*, 24, 447-460.
- Rosenberg, M. (1979), *Conceiving the self*. New York: Basic Books, Inc., Publishers.
- Slegers, J., Spijker, J., Van Limbeek, J., & Van Engeland, H. (1998). Mental health problems among homeless adolescents. *Acta Psychiatrica Scandinavica*, 97, 253-259.
- Slenick, N., Prestopnik, J., L., Meyers, R., J., & Glassman, M. (2007). Treatment outcome for street-living, homeless youth, *Addictive Behaviors*, 32 (6),1237-1251.
- Snow, M., Thurber, S., Hodgson, J.M. (2002). An adolescent version of the Michigan Alcoholism Screening Test. *Adolescence*, 37(148), 835-840.
- Stewart, A.J., Steiman, M., Cauce, A.M., Cochran, B.N., Whitbeck, L.B., & Hoyt, D.R. (2004). Victimization and posttraumatic stress disorder among homeless adolescents. *Journal of the American Academy of Child Adolescent Psychiatry*, 43(3), 325-331.
- Speziale, H. J., & Carpenter, D. R. (2003). Designing data generation and management strategies. In H. J. Speziale & D. R. Carpenter (Eds.), *Qualitative research in nursing: Advancing the humanistic imperative* (pp. 27-42). Philadelphia: Lippincott, Williams, & Wilkins.
- Stuart, H. L. & Arboleda-Florez, J. (2000) Homeless shelter users in the post-institutionalization era. *Canadian Journal of Psychiatry*, 45, 55-62.
- Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the resilience scale. *Journal of Nursing Measurement*, 1, 165-178.
- Whitbeck, L. B., Johnson, K. D., Hoyt, D. R., & Cauce, A. (2004). Mental disorder and comorbidity among runaway and homeless adolescents. *Journal of Adolescent Health*, 35, 132-140.



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