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HEALING HANDS

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Protecting the Mental Health of Homeless Children & Youth

Among the most vulnerable of persons without a safe and dependable place to call home are those who have not yet reached physical or emotional maturity. The following articles focus on mental and behavioral health issues for homeless children and youth living with one parent or none — doubled up with relatives or friends, in emergency shelters, in foster care or group homes, or on the street. A brief review of the recent literature summarizes mental health risks and service needs of homeless minors and young adults, and highlights recommended strategies to prevent the developmental delays and major behavioral problems that are associated with prolonged homelessness. Eight homeless service providers discuss the challenges they face in working to protect the mental health of growing numbers of rootless young people in Daly City, California; Seattle, Washington; San Antonio, Texas; Chicago, Illinois; Cleveland, Ohio; and Baltimore, Maryland.

Residential instability and the conditions that precipitate it clearly have negative effects on the emotional well being of children and youth, who comprise over one-fourth of the homeless population in the United States.[1]

MENTAL HEALTH RISKS A growing body of literature published during the past decade documents learning disabilities, behavior disorders and emotional problems frequently observed in homeless minors and young adults. Research findings suggest that homelessness increases the likelihood of these problems, and that persistent homelessness amplifies mental health risks, regardless of age.

Children in families Loss of stability and safety; fractured families; hunger; overcrowded living conditions; disrupted education secondary to multiple moves; increased exposure to disease, violence, substance abuse and mental illness — these are the conditions that elicit and exacerbate emotional problems in homeless children.[2,3,4,5]

Unruly behavior or emotional withdrawal is often the earliest response of young children to the crisis of homelessness. Under-stimulation by mothers preoccupied with survival concerns or their own emotional problems frequently results in developmental delays for homeless children under five.[4]

Transience and anxiety contribute to learning disabilities in school-age children whose education is interrupted by multiple moves, and whose attention is distracted by loss of sleep, frequent illness and hunger. The negative impact of shelter life on self-esteem, combined with lack of consistency in schools and daycare arrangements, often results in more pronounced behavior disorders and depression, further undermining academic competence and later achievement.[2]

Youth on their own Research on homeless youth (variously defined as ages 12 to 17, 21 or 24) is sparse and under-representative, since many unaccompanied young persons tend to avoid public health and social service sites where surveys are typically conducted. Most studies are local and lack comparison groups. Collectively, these studies indicate that mental health risks are higher for youth who are homeless and living on their own.[4]

The majority of homeless youth in America are single males over age 13, from less impoverished backgrounds than homeless adults. A long history of family disruption, residential instability and interrupted schooling characterize these young people. Unaccompanied homelessness in minors is most often precipitated by family conflict, neglect and/or physical or sexual abuse.[4b]

Many homeless youth have mental health, alcohol and drug problems, often in combination. The highest rates of substance use and abuse are seen in street youth, followed by sheltered youth and runaways, then housed youth. These rates increase with age. Homeless youth demonstrate significantly more disruptive behavior and conduct disorders than domiciled youth, increasing the likelihood of juvenile detention. Major mental illness is rare in both groups. Nevertheless, enhanced exposure to violence places youth living on their own at higher risk for anxiety disorders, depression, posttraumatic stress disorder (PTSD), suicide attempts and other health problems that exacerbate and are complicated by emotional problems.[4b]

SERVICE NEEDS & BARRIERS The literature clearly indicates what is needed to protect mental health and prevent prolonged homelessness in minors and young adults. Comprehensive, integrated services that promote the well being of the whole family are crucial for children

who are homeless and at risk of homelessness. Runaway and "throwaway" youth need a broad range of targeted support services — street outreach, job training and employment, education, transitional housing, youth staffing and mentors, as well as comprehensive health care including mental health services and substance abuse treatment.[4]

Unfortunately, even where such services exist, they are not always available to or used by the persons who need them most.[6] Lack of health insurance is a serious barrier to specialty care for older children and youth ineligible for Medicaid. Even small children who are eligible may lose their Medicaid and their homes when moms lose welfare benefits. Many predict a dramatic increase in the number of homeless families as more single mothers reach TANF time limits.[1a,2,3a]

Limited shelter placements, fear of shelters and health care providers, and distrust of highly structured, rule-bound programs are other service barriers for homeless youth. Few agencies respond to their psychosocial and developmental needs. Those that do must work creatively to promote utilization of mental health and social services for this elusive population. Drop-in centers and shelters are often used as gateways to other services.[4,6]

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Why Homeless Children Misbehave

Single-parent families struggle to adjust to the terror and instability of homelessness. After opportunities for doubling up with friends and family members have been exhausted, they find themselves in shelters or on the street, living in crisis. Shelter life means congregate living in one room with no separate space for children, no playmates and often threatening adult companions with overt mental illness or addictive disorders.

ACTING OUT "Some homeless children develop behavior problems they may not have had before coming to the shelter," observes **Jay Sanchez, LMSW**. "That's how children communicate their fear and anxiety — through lots of acting out." Sanchez is program director at El Centro Del Barrio in San Antonio, Texas — one of ten federally funded HCH programs specifically tailored to the needs of homeless children. Her agency serves mostly children under age 12.

"We do a lot of crisis intervention and problem solving to help these families deal with the stress of being homeless," says Sanchez. "Staff identify developmental delays and teach parents about the social, emotional and developmental milestones they should expect to see in their children. They also model good parenting techniques." To address behavior problems, members of a clinical team — a social worker, a child development specialist and a mid-level nurse provider — conduct informal sessions in a transitional shelter, teaching moms with infants and toddlers how to interact with their children in constructive ways.

"The severity of behavior disorders depends on how long a child has been homeless," observes **Ruth Gray, LSW**, service coordinator at Care Alliance, Cleveland, Ohio, who spent five years doing street outreach to homeless families. "The longer a child is exposed to a homeless life style, the more stress is exhibited."

To illustrate her point, Gray tells of a three-year-old boy who had lived on the streets with his mother for most of his life. She wasn't abusive or neglectful, but to maintain order and protect him from harm, she placed highly restrictive limits on what the boy could do and not do. One day, he became so angry that he tried to stab his mother and kicked Gray when she attempted to restrain him. A danger to himself and others, he could no longer function on the street. The HCH project advocated strongly for the county to take financial responsibility for his behavioral health services and placement in foster care. Gray helped the mother learn how to save money and get an apartment. Her son began therapy and did well in foster care. Within two years, mother and child were reunited in stable housing with ongoing therapy.

"Mental health services are often unavailable to homeless persons

- Almost half of school-age children and over one-fourth of children under five suffer from depression, anxiety or aggression after becoming homeless.[2]
- More than one-fifth of homeless children 3-6 years old have emotional problems serious enough to require professional care.[3a]
- Homeless children are twice as likely as poor housed children to have learning disabilities, and three times as likely to have emotional and behavioral problems.[3a]
- The strongest predictor of emotional and behavioral problems in both homeless and housed poor children is their mother's level of emotional distress. Over 60% of homeless mothers have been violently abused, and 45% have a major depressive disorder.[3a]
- Nearly half of school-age homeless children have witnessed family violence, and one in five become homeless because of it.[2]
- Homeless children are physically abused at twice the rate of other children, and are three times as likely to be sexually abused.[3a]

until they are housed," notes Gray, consistent with the belief that nothing can be done until basic needs are met. It may take a minimum of six months to a year for housing to become a reality for many homeless families. "We need to address all of these clients' needs simultaneously," she insists.

ADHD OR NOT? A concern expressed by several HCH practitioners is the serious potential for mistaking an adjustment disorder for Attention-Deficit/Hyperactivity Disorder (ADHD) — an organic brain disorder. Ritalin has reportedly been used as a Band-Aid to subdue unruly behavior without trying to understand its cause. "A number of homeless children have been mislabeled as having ADHD when they were actually suffering from PTSD or situational anxiety," reports Ruth Gray. "Children suspected of ADHD need to be referred to a pediatrician and a psychiatrist for thorough assessment, care and follow-up."

"We don't jump to conclusions about a mental health diagnosis, especially while a child is homeless," adds Ray Sanchez. "Children sometimes model the behavior of parents who are acting out because of PTSD or some other emotional problem, but don't have the disorder themselves. We see a lot of mental illness in homeless parents, but not so much in their young children."

"The most important initial step is to obtain a thorough history and determine whether the child has received treatment for behavioral disorders," explains **Patti Ormiston, CFNP**, one of two nurse practitioners at Mercy Children's Health Outreach Project, Baltimore, Maryland. She and her colleagues frequently encounter developmental delays, attention seeking behaviors, aggression, regression, depression, hyperactivity and PTSD in young clients.

"Once we establish a relationship with a homeless family, it becomes easier to address concerns about a child's behavioral and emotional problems," she says. "We discuss behavior management techniques, such as establishing regular routines for the child, and appropriate interventions for misbehavior. The most difficult part may be helping a parent recognize the need for further evaluation by a mental health professional."

RECOMMENDATIONS "In a few years, we're going to see huge numbers of children and families on the streets who are casualties of welfare reform," predicts Gray. To prepare for this eventuality, she advises more in-service training for paraprofessionals in HCH projects about how to deal with children's mental and behavioral health problems, and more child advocates in homeless shelters. She also recommends forming strategic alliances across disciplines and agencies to promote greater cultural sensitivity and responsiveness to the needs of homeless children.

Ormiston recommends that lead testing be made available to children in shelters, as lead toxicity is quite common and may be the cause of behavioral and learning problems. Sanchez is concerned about reduced access to primary and mental health care under Medicaid managed care. "Health plan providers may be far away, or a mother fleeing domestic violence may avoid regular providers. Homeless beneficiaries should be allowed to see any provider, get care anywhere and have Medicaid cover it," she contends. ■

Homeless Youth: Falling through the Cracks?

Clinicians in many areas report limited services of all kinds for runaway adolescents and older youth. We identified agencies where comprehensive youth services *are* available, and asked what they are doing to address mental health issues that may prolong homelessness.

DOUBLED UP Daly City Youth Health Center — a subsidiary of the San Mateo County HCH Project outside San Francisco, California — is a school-based clinic that serves homeless youth or those at risk of homelessness, ages 13–21, both in and out of school. Services include mental health outreach, primary care, vocational counseling, mentoring and peer education training. Over half of their clients are immigrants; most are Latinos or Filipinos. Students from 33 countries attend one of the five high schools served. "Because our community is so ethnically diverse, cultural competency is a main concern," remarks homeless education administrator Carol Forest.

"Most youth we see are in extremely over-crowded living situations — ten people in a one-bedroom apartment belonging to a relative, for example," remarks mental health coordinator **Marianne LaRuffa, MFT**. "Many of these kids are out doing drugs; some end up on the street. For most, there's usually some mental health issue." It's often hard for these youth to get a special education assessment or psychological testing, which must be requested by a parent. Only two psychologists serve the whole school system of 5,000 students. Outreach workers and a public health nurse make home visits. "Links with teachers and school administrators facilitate follow-up with these kids, who tend to disappear for awhile," says LaRuffa.

- Nearly one-third of homeless children and youth (6-17) have at least one major mental disorder that interferes with their daily activity, compared to 19% of low-income, housed children and youth.[3a]
- Homeless teens in Detroit have significantly higher rates of disruptive behavior disorders and alcohol abuse/dependence than matched housed adolescents, but similar rates of drug abuse and other mental disorders.[4b]
- Two-thirds of a sample of street youth in San Francisco met diagnostic criteria for posttraumatic stress disorder.[4b]

ON THE STREET YouthCare's Orion Center in Seattle, Washington offers one-stop services to homeless youth, ages 12–21 — an alternative public school, meals provision, case management, mental health services, an onsite job project and a therapeutic recreation program including camping, sailing, dog training and volunteer opportunities.

Mavis Bonnar provides case management at Orion, where she has worked since its inception in the early 1980's. She also works in a juvenile detention center and does street outreach. "Parenting by community is the concept by which we operate," she says. "Orion is committed to re-parenting troubled youth and modeling healthy relationships."

The 45th Street Clinic, also in Seattle, provides referrals and outreach to indigent, homeless youth, ages 12–23, at two drop-in centers and on the street. Most youth served are not in school. Depression, anxiety and identity issues are their primary mental health concerns, according to Youth Clinic coordinator **Seema Mhatre, MSW, MPH**. "Youth on the street don't have the support or guidance they need, and wait too long to seek care," she says. "As a result, mental health problems from abuse, neglect and abandonment get worse."

Mhatre tries to engage clients and build their trust wherever she sees them. "A lot more street-based mental health services are needed," she says, "but not many mental health professionals are willing to provide them. Especially needed is expertise in dealing simultaneously with co-occurring mental health and substance abuse issues."

IN STATE CUSTODY Neon Street Programs in Chicago, Illinois provide educational and vocational counseling, employment placement, health and mental health care to youth between 12 and 21 years old who do not live with a parent. Most clients are wards of the state, in foster care, group care or shelter care. Clients receive health care through Neon's sister program, Chicago Health Outreach.

Neon Street is located in the uptown area of Chicago, in a "social service-friendly" neighborhood that is a veritable "Hollywood for the homeless," says clinical coordinator **Martin Jordan, MA**. "Wards of the state in Illinois have access to a wealth of services, far more than other homeless youth. The challenge is to get clients motivated to use them." It takes good case management skills and strong relationships with clients and other agencies to accomplish this. "We use a very individualized approach," explains Jordan. "Within a week of the first encounter, the educational coordinator, employment coordinator and therapist do brief initial assessments independently, then share their impressions and work as a team to develop and implement an intervention strategy."

The ideal trajectory is placement in a group home until age 18, independent living in a free apartment until youth finish school, work experience, then emancipation at age 21. In reality, "it's hard to get the kids to leave sometimes," admits Jordan. Research indicates that foster care is an independent predictor of homelessness.[3a] To prevent prolonged homelessness and promote self-sufficiency, staff provide all the transitional support they can after emancipation. ■

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