Mental Health & Addiction Interventions for Youth Experiencing Homelessness:
Practical Strategies for Front-line Providers

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ACKNOWLEDGEMENTS

PREFACE

Challenged mental health, be it in the form of extreme stress, addiction, or mental illness, goes hand in hand with youth homelessness. In most situations, it can be understood as a normal response to abnormal circumstances. Those circumstances feature the severe forms of pre-street adversity— poverty, neglect, abuse, bullying, and discrimination—that are so common in this population. On the street, adversity for this highly marginalized population includes victimization, trauma, stigmatization, poverty, poor physical health, and the constant stress of day-to-day survival. Regardless of the causes or consequences, poor mental health is a daily reality for street-involved youth.

Youth homelessness is a large-scale and complex problem. There are human rights implications and complex care system and policy considerations. The population of youth who are homeless is diverse, and the numbers are high: 40,000 in Canada (Gaetz, Donaldson, Richter, & Gulliver, 2013); over one million in the United States (Lee, Tyler, & Wright, 2010); and 75,000 in the United Kingdom (Quilgars, Johnson, & Pleace, 2008).

We have a lot of information about the kinds of mental health problems youth who are homeless face. Most youth describe problems that began before they left home (Craig & Hodson, 1998; Karabanow et al., 2007). The limitations of the mental health service sector are particularly apparent for youth with more severe forms of mental illness. Embry, Stoep, Evans, Ryan, and Pollock (2000), for example, found in their study that 15 of 83 youth with severe mental illness who were released from residential psychiatric treatment became homeless following discharge from services.

Rates of psychiatric symptoms and general distress among youth who are homeless are at a level that is commonly seen among youth in outpatient and inpatient psychiatric care settings (Kidd et al., 2017). One study found three times the prevalence of mental illness among youth who are homeless compared with youth who have housing (Craig & Hodson, 1998). The prevalence of specific mental illnesses varies from study to study (Merscham, van Leeuwen, & McGuire, 2009; Xiaojin, Thrane, Whitbeck, & Johnson, 2006), but studies have generally found the following rates among youth who are homeless:

- Major depression: 31%;
- Bipolar disorder: 27%;
- Posttraumatic stress disorder: 36%; and
- Substance use disorders: 40%.

Of those youth with a mental illness, 60% present with multiple diagnoses (Slesnick & Prestopnick, 2005). Rates of psychosis vary quite a bit, but it is likely that psychotic illnesses are considerably more prevalent among youth who are homeless, particularly among those who use methamphetamines (Martin, Lampinen, & McGhee, 2006).

Pre-street conditions (e.g., abuse, neglect), street adversity (e.g., trauma, victimization, chronic stress), and specific forms of discrimination (e.g., based on sexual or gender identity, Indigenous heritage) have strong associations with psychological distress, mental illness, and addiction among youth who are homeless (Craig & Hodson, 1998; McCarthy & Thompson, 2010; Merscham et al., 2009; Mundy, Robertson, Robertson, & Greenblatt,, 1990). Homelessness itself is inherently traumatic (Goodman, Saxe, & Harvey, 1991). Studies show a dose–response type of relationship between exposure to homelessness and mental health decline (Hadland et al., 2011; Kidd, Gaetz, & O'Grady, 2017).

In terms of accessing services, most youth with severe mental illness are not receiving any form of treatment (Kamieniecki, 2001; Slesnick & Prestopnik, 2005). Access to publicly funded resources is difficult, and even when resources are available, many youth avoid them. Moreover, community service agencies have very little capacity to provide care for people with more severe mental illness and addictions. Barriers to mental health care for these youth include lack of a health card or benefits documentation, no formal diagnosis, substance use, unstable housing, and long waiting lists.

As is typical of many social challenges, we are much better at describing the problems than we are at generating solutions. The knowledge base problem that attends mental health intervention for youth experiencing homelessness is further compounded by very poor resourcing of services for this population. These two issues present a major challenge for service providers for various reasons:

- Most experienced service providers have a good experiential knowledge base about the risk and adversity considerations that affect the youth they serve. Thus, more information about risk is often not needed or very helpful.
- The limited information that is available about effective mental health and addiction interventions is scattered and very difficult to access. Most direct service providers do not have access to the academic publications that provide this information. Even if they are accessible, most publications are very technical and provide outcome data but very little information on implementation and intervention components. There is detailed information about interventions for high-risk youth in the broader literature,

but without specialist assistance, it is very difficult to find, extrapolate, and translate these approaches to daily practice in settings that serve youth who are homeless.

- There is an increasing desire and demand in the service sectors for evidence-based and evidence-informed interventions. This demand is driven by interest in providing effective services and by accountability requirements of funders and partners.
- Service providers in this sector are under-resourced (Kidd, 2012), which results in high staff turnover, large caseloads, budgets that do not cover specialist staff and intensive trainings, and similar factors that can hamper the ability of service staff to meet complex mental health needs. Basic safety and survival considerations come first, as they need to, with few resources left to address mental health.
- Broader mental healthcare systems are poorly designed to meet the needs of youth who are homeless (Schwan, Kidd, Gaetz, O'Grady, & Redman, 2017). Service access, flow, and intensity are poorly matched to youth who are experiencing the life chaos that attends homelessness and to youth without family supports. Another consideration is the adverse reactions of many youth to institutional services when such experiences in the past have been highly aversive (e.g., bullied in school, failed child protection efforts). Moreover, the needs of these youth are often acute, and addressing them requires intense, coordinated, and expensive supports that are seldom available in cash-strapped public health systems.

Given these many challenges, service providers often seek information and advice about the best mental health practices for street-involved youth. As researchers and practitioners, we ourselves face these questions on a regular basis across a range of forums. We are dissatisfied with what is available to guide these critical front-line efforts. Nothing better illustrates the importance of mental health interventions for this population than the fact that suicide and drug overdose are the primary causes of death and that the general mortality rate among these youth is many times that of youth who have housing (Roy et al., 2004). Assembling this book is our effort to curate in a single resource the best available information on mental health–oriented intervention in this field. We have sought to produce chapters that focus on practice, noting key approaches, considerations, and implementation and evaluation strategies that can be readily understood and used by service providers and administrators. We have brought together some of the most experienced people around the world to produce this peer-reviewed guide that we hope will become a key go-to resource for service providers.

The book contains four sections covering a range of topics that service providers inquire about most often. **Part 1: Approaches and Interventions** describes specific approaches to addressing the mental health and substance use challenges of youth experiencing homelessness. Topics include the community reinforcement approach and motivational enhancement therapy, dialectical behaviour therapy, mindfulness approaches, trauma-informed care, ecologically based family therapy, and crisis response. **Part 2: Specific Groups** reflects the diversity among youth experiencing homelessness. While many of the interventions and approaches described in this book may be relevant across groups, we need to pay attention to the unique needs of LGBTQ2S, Indigenous, newcomer, and black youth, as well as mothers with children in their care, and youth who are transitioning out of homelessness. We also discuss service providers as a specific group, one that needs support around preventing the burnout that is common in doing this challenging work. **Part 3: Contexts and Considerations** focuses on where and how interventions are delivered. The two most common intervention contexts—drop-in centres and outreach—are the focus of the first two chapters. Other topics include supported employment, arts-based approaches, peer support, digital technologies for engaging youth, interagency partnerships, and interventions in developing countries. **Part 4: Assessment and Evaluation** aims to support service providers who are increasingly required to provide outcome evidence in order to obtain funding and to inform service improvement and resource allocation. The first chapter describes system-level assessment tools for guiding decisions about how to allocate scarce resources such as housing. The second chapter guides service providers in thinking through how they can best capture the processes and outcomes of their work. We close with an afterword written by a young person with lived experience of homelessness.

Our hope is that the approaches described in this book will inform your work in the field. We encourage you to engage with colleagues around needs assessments within your organizations to determine a good starting point. Everyone involved could use this guide in the planning process, thinking through the recommendations, implementation considerations, and staff models and partnerships that are necessary to deliver and sustain interventions for youth experiencing homelessness.

HOW WE DEFINE "YOUTH" IN THE BOOK

The terms "youth" and "young people" are used throughout this book, and refer to people between adolescence and young adulthood. We generally define youth as being between age 16 and 24, which is the age range in most jurisdictions for youth-serving agencies.

We wish you the best with your efforts to do this extremely important, demanding, and rewarding work.

Sincerely,

Sean Kidd, Natasha Slesnick, Tyler Frederick, Jeff Karabanow, and Stephen Gaetz

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FOREWORD

At this year's Canadian Alliance to End Homelessness conference, I had the good fortune to hear Jesse Thistle's remarkable story about growing up in Brampton, Ontario, and his search to find meaning for himself and come to terms with the trauma of his family. Jesse is 40 years old and of Métis/Cree/Scots descent. His work as a historian and advocate around issues of Indigenous People's intergenerational trauma has earned him the highly prestigious Trudeau and Vanier awards. Receiving these awards and other recognition for his work, Jesse told the rapt audience of more than 800 attendees, would have been unimaginable a decade ago.

He went on to describe episodes from his youth—early memories of parental abandonment, the shattering of his nuclear family, and the love and care he received from his grandmother. In adolescence, Jesse was having problems in school, and he turned for relief to marijuana and alcohol, and later went on to many other drugs as his life as a young man unraveled. Desperate, living from one moment to the next, and committing crimes to support his addiction, Jesse spent years cycling in and out of homelessness, with temporary stays in and out of relatives' homes, jail, detox centres, and hospitals. While I listened to his story, it was difficult to reconcile the well-dressed, articulate, and thoughtful presenter at the conference with the images of the youth he described.

This comprehensive and timely volume seeks to answer questions related to Jesse's story: What was it that helped Jesse turn his life around? How did the youth who struggled with intergenerational trauma, neglect, addiction, poor health, and much more transform himself into the scholar recounting this narrative today? Who or what helped him along the way? And why or how was it effective? The chapters on assessment; cultural, social, and clinical sensitivity; and effective program models and interventions provide invaluable information and resources for anyone concerned about or working in the field of youth homelessness.

In my three decades of working with young people and adults experiencing homelessness and other complex problems, I've observed the positive impact on clients' lives of successful programs and interventions. I've also seen the negative impact when programs or interventions fail. Fortunately, today there are effective, evidence-based programs for ending homelessness, interventions that facilitate engagement with those who have lost

hope, as well as person-centred treatments to address trauma, addiction, and other complex needs. The insights presented in this volume can help to alleviate years of hardship and misspent resources by illustrating how to intervene early and effectively to address youth homelessness and prevent problems from becoming chronic and severe.

Jesse's story is inspiring because it teaches us that people can and do recover from tremendous problems and suffering. It also illustrates that a well-timed and healing intervention can have a life-changing impact. A major turning point in Jesse's life was when his grandmother summoned him to her deathbed. She asked him to promise that he would attend college one day. "Because I know you are smart," she confided. At that time, Jesse, in his early 30s and in the throes of addiction, could not act on his word. However, his grandmother's words and her faith in him registered in his psyche and provided hope through difficult times. As we listened to Jesse speak, we learned that he eventually kept that promise and was able to realize the potential within. This volume will prepare those working in this field to better help the young people they work with to also realize their potential within.

Sam Tsemberis
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Clinical Director, Housing First for Youth (A Way Home Canada)

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PART 1

APPROACHES & INTERVENTIONS

1.1 SUBSTANCE USE & MENTAL HEALTH INTERVENTIONS FOR YOUTH WHO ARE HOMELESS: THE COMMUNITY REINFORCEMENT APPROACH & MOTIVATIONAL ENHANCEMENT THERAPY

Brittany Brakenhoff & Natasha Slesnick

INTRODUCTION

The relationship between mental health, substance use, and homelessness is complex. An estimated 48%–98% of youth who are homeless meet criteria for at least one mental health diagnosis (Hodgson, Shelton, van den Bree, & Los, 2013). Common disorders include depressive disorders, anxiety disorders, posttraumatic stress disorder, psychosis, substance use disorders, and attention-deficit/hyperactivity disorder (Hodgson et al., 2013). Between 69% and 86% meet criteria for a substance use disorder (Medlow, Klineberg, & Steinbeck, 2014). Compared with their housed peers, youth who are homeless have elevated rates of co-occurring substance use and mental health disorders (Hodgson et al., 2013; Kamieniecki, 2001). While mental health disorders and substance misuse can increase the risk of experiencing homelessness, homelessness itself can exacerbate pre-existing mental health issues and trigger new psychological symptoms and maladaptive behaviours, such as substance use (Hodgson et al., 2013). Given the limited access that youth who are homeless have to healthy coping mechanisms, substance use may be one of the only ways they have learned to cope with mental health problems and the challenges of homelessness.

Left untreated, substance use and mental health problems create additional barriers to exiting homelessness (Hodgson et al., 2013; Medlow et al., 2014). They can increase vulnerability, putting youth at further risk of street victimization (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Whitbeck, Hoyt, & Yoder, 1999). Substance use and mental health problems are also associated with increased deviant behaviour, which can lead to arrests and legal trouble (Chen, Thrane, Whitbeck, & Johnson, 2006). They can also decrease motivation to improve the situation (Auerswald & Eyre, 2002). This complacency may decrease the likelihood that youth will seek assistance from social programs, obtain or maintain employment, or take steps toward stabilization (Auerswald & Eyre, 2002). Intervention efforts to improve the lives of these youth may have limited impact if underlying substance use and mental health problems are not treated.

Findings from clinical trials with youth experiencing homelessness have demonstrated promising substance use and mental health outcomes using the community reinforcement approach (CRA) and motivational enhancement therapy (MET). Slesnick, Prestopnik, Meyers, and Glassman (2007) first identified CRA as an effective intervention for this population in a randomized clinical trial comparing it with treatment as usual. Specifically, youth who participated in CRA reported increases in social stability and decreases in drug use and depression compared with youth who only received the usual drop-in centre services. In a follow-up study that compared CRA, MET, and case management, and that tracked outcomes for 12 months, participants in all three interventions showed reductions in substance use, depressive symptoms, and days spent homeless (Slesnick, Guo, Brakenhoff, & Bantchevska, 2015). CRA and MET have been associated with similar improvements among youth who leave home (Slesnick, Erdem, Bartle-Haring, & Brigham, 2013). Given the similarity in positive outcomes with CRA and MET that have been found in earlier clinical trials, service providers can choose between the two interventions based on the needs of their agency and clients (Slesnick et al., 2015).

THE COMMUNITY REINFORCEMENT APPROACH

THEORETICAL BASIS

CRA is an operant-based intervention that was developed by Hunt and Azin (1973) to treat alcohol use disorders. Meyers and Smith (1995) continued to adapt CRA to treat illicit drug use. Since CRA was originally developed to treat substance use, descriptions of this approach often use substance use as the targeted behaviour, but other problem behaviours, such as self-harm, can be targeted as well. Therapists can choose from a menu of modules to fit the needs of their clients.

Youth who are homeless often have an extensive history of negative experiences. Street culture and family of origin experiences tend to reinforce maladaptive behaviours and punish prosocial ones. Consistent with behavioural theory, CRA focuses on reinforcements and consequences of behaviours so that positive, non-substance–using behaviours are more reinforcing than substance–using (and other negative) behaviours. The intervention is guided by the assumption that people continue to use drugs or alcohol because their substance use is reinforced by their environment. Thus, CRA can be a powerful

intervention for youth who are homeless because it focuses on reshaping their relationship to their environment. Creating experiences of reinforcement for positive behaviours and reducing reinforcement for negative behaviours have the potential to set youth on a positive path. Meyers and Smith's (1995) CRA treatment manual provides a more detailed description of the theoretical assumptions guiding CRA interventions.

COMPONENTS OF CRA

CRA uses behaviourally based interventions and skills development to help clients reduce substance use. A full list and description of intervention modules and techniques, as well as worksheet templates and examples of techniques, can be found in the CRA treatment manual (Meyers & Smith, 1995). While CRA provides flexibility to implement modules that fit the needs of the client, several hallmark features should be implemented when using CRA, including the Happiness Scale and goals of counselling, functional analysis, and skills training with role-playing. The following section describes how these intervention components have been implemented in previous trials with youth experiencing homelessness.

The Happiness Scale and goals of counselling

The Happiness Scale (Meyers & Smith, 1995) identifies several areas of life that may be important to youth, such as employment, substance use, and relationships. The therapist asks clients to rate their level of happiness in each area. The scale is typically completed at the start of each therapy session. In the first session, it is used to identify the client's goals for counselling, and in subsequent sessions, it measures progress toward those goals.

After completing the Happiness Scale, the client and the therapist identify goals for areas in which the client reported dissatisfaction. They then develop an intervention to meet that goal and set a time frame. Identifying simple and achievable goals increases the chance of success. For example, if a client indicates being unhappy in terms of employment, the initial goal could be to identify one place where the client would like to work. Because youth who are homeless often have experienced failure and disappointment in many areas of their lives, setting up early success and positive interactions can boost their confidence and sense of self-efficacy. Over time, the achievement of small goals can lead to more substantial ones.

Functional analysis

Therapists should complete a functional analysis during the beginning phases of treatment. Sample forms for a functional analysis can be found in Meyers and Smith's (1995) CRA manual. The purpose of the functional analysis is to reveal the situations in which youth are most likely to use substances. First, the therapist identifies internal triggers (e.g., feelings, mood) and external triggers (e.g., fights with friends, getting money) for substance use. For example, a client might find that she always feels the urge to smoke after arguing with her romantic partner. Next, positive consequences of the client's substance use are identified. The therapist then helps the client find alternative behaviours that achieve the same positive outcomes. For example, if the client says smoking helps her calm down after a fight with her partner, the therapist helps her determine prosocial behaviours that are relaxing, such as listening to music or exercising. The therapist and the client also discuss the negative consequences of the client's substance use. Identifying negative consequences can motivate clients to decrease their substance use. In later sessions, the therapist can gently remind the client of those negative consequences. It is also recommended that the therapist complete a functional analysis of targeted prosocial behaviours with the client to highlight positive behaviours the client enjoys that can replace substance use. Additional functional analyses can be completed if the client wants to discuss other behaviours. The information gathered from the functional analysis informs the direction of treatment and helps the therapist determine which treatment modules to use.

Skills training and role-playing

CRA includes modules for skills training in several areas, including employment, communication, drug and alcohol refusal, relapse prevention, and problem solving. The specific skills targeted in the intervention depend on the counselling goals the client identifies. Regardless of the targeted skills, in-session role-playing is a critical component in building new skills. During role plays, the therapist identifies a situation the client may experience and coaches the client on how to handle it. Role-playing in session gives clients an opportunity to practise the skills they are learning and allows the therapist to observe and provide feedback on the targeted skill. Observation during the role play can help the therapist understand aspects of the skill that may be more challenging for the client. The therapist should reinforce positive behaviours observed during the role play. For example, if the target area is employment, the client can role play a job interview with the therapist. The therapist may observe that the client provides inappropriate responses to interview questions, but appears confident and makes good eye contact. The therapist can help the client develop more appropriate responses to the questions, but also commend the client

for appearing confident and using good body language. Whenever possible, therapists should engage clients in role plays because the more the client practises, the more likely the client will be to apply the skills learned in therapy to real-life situations.

MOTIVATIONAL ENHANCEMENT THERAPY

THEORETICAL BASIS

Motivational enhancement therapy (MET) was derived from principles of motivational interviewing, which was originally developed as a brief intervention for alcohol use problems after it was observed that brief therapies could be as effective as more intensive therapies at eliciting behavioural change (Miller & Rollnick, 1991). It was hypothesized that successful interventions have the same core components, and that the additional components of more intensive interventions may be unnecessary. As such, motivational interviewing was designed to incorporate the core components of successful interventions (Miller, Zweben, DiClemente, & Rychtarik, 1995). Miller and Sanchez (1994) used the acronym FRAMES to capture the core components of brief interventions:

- **Feedback** on personal risk or impairment;
- Emphasis on personal **responsibility** for change;
- Clear **advice** to change;
- A **menu** of alternative change options;
- Therapist **empathy**; and
- Facilitation of client **self-efficacy**.

MET was developed for a large substance use treatment trial called Project MATCH (Miller et al., 1995). Its development was guided by the treatment components identified by FRAMES (Miller et al., 1995). MET places the responsibility for change on the client. It posits that everyone has the ability to change, but that people have varying levels of motivation to do so. Prochaska and DiClemente's (1983) transtheoretical model outlines the different stages of change that a person may experience, including willingness and desire to change. MET is structured to encourage behavioural change by increasing motivation to change. The MET treatment manual developed by the National Institute on Alcohol Abuse and Alcoholism provides full details of the intervention (Miller et al., 1995). The following section explains how the intervention can be applied with youth who are homeless.

COMPONENTS OF MET

Session structure

MET is a four-session brief intervention that is separated into two phases of treatment: building motivation to change and strengthening commitment to change. Before the first session, the client completes an assessment of current substance-using behaviours. The first session focuses on giving the client structured feedback on the behaviours reported in the initial assessment. The feedback addresses the client's level of substance use in comparison with normative use and identifies possible problems caused by the substance use. The goal of the feedback is to increase the client's desire to change by identifying the risks and problems caused by substance use. The second session continues to focus on increasing the client's motivation to change and begins to move toward the second phase of treatment by developing commitment to change. The third and fourth sessions are offered as boosters to monitor progress and provide continued encouragement.

Phase 1: Building motivation to change

The first session focuses on eliciting the client's motivation to change. Behavioural change is unlikely to occur if the client feels the therapist is demanding change. MET provides guidelines and strategies for subtly guiding clients toward discussions about change and increasing their motivation. The following section describes these strategies.

Listening with empathy. While empathy is critical in any therapeutic relationship, MET specifies strategies therapists can use to convey empathy. A central tenet of MET is to meet clients where they are at, rather than trying to impose behavioural change on them. Clients decide the changes they believe would benefit their lives. The role of the therapist is to listen, and to help clients explore their desire for change. All interactions should convey a message of acceptance and support. A positive therapeutic relationship allows clients to examine their problem behaviours and desire to change in a safe and open environment.

Affirming the client. Instilling hope that change is possible is a necessary component of motivating clients to change. Clients must believe that they are capable of changing their behaviour. Therapists can encourage this by identifying clients' strengths and providing praise for their progress during therapy. Additionally, therapists can maintain a positive focus in sessions by reframing clients' negative statements. When therapists reframe a statement, they offer clients an alternative interpretation of the problem. For example, if a client says, "I've always been a screw-up; even my own family thinks I am a failure,"

the therapist could respond, "It sounds like you are hard on yourself. It seems to me that you are doing what you have to do to successfully survive on your own, even if you don't always like what you have to do to survive. Hopefully, we can work together to figure out some strategies so you can not only survive, but also enjoy life." Overall, helping clients develop a more hopeful and positive view of their situation is an important component of motivating them to change their behaviour.

Eliciting self-motivational statements. Therapists should not provide clients with reasons to change their behaviour, rather, the reasons for changing behaviour must come from the clients themselves, so they can develop self-motivation. Asking clients about their concerns about substance use is one way to elicit motivation to change. If a client struggles to identify any concerns, the therapist can present personal feedback and inquire about problems the client highlighted in the initial assessment. For example, a therapist could say, "I can see that you feel there are a lot of positives about your substance use, but in the assessment you completed, you reported that you spent more money than you would like on heroin. How do you feel about the financial impact that using heroin is having on you?" The therapist should always maintain a questioning approach with clients, and refrain from placing demands on them or telling them their behaviours are problematic. The therapist can also help clients determine discrepancies between their goals and their behaviour. For example, the therapist could say, "It sounds like you really want to get your own apartment. How do you think using heroin prevents you from getting an apartment?" Overall, the key is to use a non-confrontational approach, and to have clients formulate their own reasons for wanting to change their behaviour.

Handling resistance. MET handles resistance differently than do traditional therapies. Several therapeutic strategies may unintentionally evoke client resistance and thus must be avoided in MET. Typically, if a therapist confronts or argues with clients, they will respond with resistance and continue to defend their position. In MET, rather than arguing, the therapist provides a reflection of the client's statement, or provides a reflection that amplifies the client's defensive position. For example, if a client says, "I love smoking, I don't want to quit," the therapist could respond, "It sounds like there are things you really like about smoking and it doesn't sound like it is causing you any difficulties." This response gives the client a chance to identify opposing views to the original statement and develop a more balanced position. If clients still appear resistant, the therapist can shift the focus by directing the conversation away from the conflicted issue being discussed. Additionally, when clients are oppositional, the therapist is encouraged to

roll with resistance, which means accepting the resistance rather than trying to change it. Acknowledging and respecting resistance to change makes clients feel more open to discussing their ambivalence with the therapist.

Phase 2: Strengthening commitment to change

While the first phase of treatment emphasizes reasons for change, the second phase focuses on developing a plan for change. The therapist cannot move to this phase until the client is sufficiently motivated to change; thus, the therapist must be able to recognize readiness to change. The amount of time to reach the second phase varies for each client. Clients who are ready to move to this second phase often exhibit less resistance and provide self-motivating statements more often than they did in the earlier phase of treatment.

Making a plan. Once clients are motivated to change, it is important to help them develop a plan for change. The therapist must communicate free choice and ensure that the developing plan matches the client's desired changes. One strategy to help clients identify the changes they want is to help them recognize consequences of action and inaction by helping them visualize the consequences of not making any changes, as well as the consequences of making the desired changes. Once clients decide on the changes they wish to make, they may request information and advice on how to change. It is important that the therapist refrains from providing the client with specific instructions on how to change; instead, the therapist should help clients devise their own strategies that will work for them. The therapist can act as the expert and provide factual information when clients request it. For example, if a client wants to know if there is a drug to help reduce withdrawal symptoms from heroin, the therapist should discuss methadone or other medication options. Once a plan is developed, the therapist can ask the client to make a commitment to change. This can be a verbal commitment from the client, or the therapist and the client can complete and sign a change plan worksheet, which highlights the changes the client wants to make and how the client intends to make those changes. Some clients will not be ready to make a commitment to change, and it is important that the therapist respects their decision.

IMPLEMENTATION CONSIDERATIONS

HARM REDUCTION APPROACH

It is unlikely that youth who are homeless will present for substance use treatment. They may use illicit drugs and alcohol to cope with mental health challenges, trauma, and the stress of being homeless. Moreover, substance use is often an important aspect of street culture, giving youth a way to connect with others (Auerswald & Eyre, 2002). Initially, youth may be uninterested or hesitant to give up something that provides them with many immediate benefits. If they feel the therapist is pressuring them to quit using, they may not return to therapy. This means that rather than setting abstinence as the goal, treatment should involve identifying risk-reduction behaviours youth are willing to try. Those who do not want to abstain from substances may be willing to reduce their use or engage in safer practices (e.g., not sharing needles, not exchanging sex for drugs) if they understand the benefits of these new behaviours. As therapy progresses and youth experience the benefits of risk reduction, they may be motivated to further reduce their substance use.

Some youth may need treatment beyond what is provided by CRA and MET. The therapist can connect them with other resources. In cases of severe alcohol and/or drug addiction, youth may need medical care, such as detoxification services, in order to address physical withdrawal symptoms. Youth with opioid addiction may need help getting connected to an opioid replacement therapy program. Additionally, some youth may present with severe mental illness that requires a higher level of care than is provided by CRA or MET. Even when youth require more intensive treatment, CRA and MET can be useful approaches for beginning the engagement and linkage process.

HIERARCHY OF NEEDS

It may be difficult for youth who are homeless to feel motivated to address mental health and substance use problems if their basic needs are not being met. Applying Maslow's (1943) hierarchy of needs theory, this means that substance use and mental health interventions for youth experiencing homelessness need to also address youths' basic needs for food, shelter, clothing, and so on. Many strategies can be implemented to meet this goal; for example, in the trials discussed in this chapter, intervention took place at drop-in centres or shelters,

where the basic needs of youth could be met. Another strategy is to provide CRA or MET in conjunction with case management. One example of this is ecologically based therapy (discussed in chapter 2.5), which simultaneously provides housing assistance, CRA, and case management to mothers who are homeless. Overall, youth will likely be more willing to participate in therapy if their basic needs are also being met.

TREATMENT DURATION & CONTINUED CARE

To date, research has examined the effectiveness of a four-session MET intervention and a 12-session CRA intervention with youth who are homeless. While youth in the research trials tended to report improvements following participation in MET and CRA, most youth still reported continued substance use and problem behaviours; these youth may have benefited from more therapy. Agencies can offer additional sessions if they have the resources. It is sometimes necessary to set a predetermined number of sessions for research trials; however, real-world settings may allow more flexibility, with the number of sessions determined by the needs of the client and progress in therapy. As the termination of therapy approaches, client and therapist should discuss plans for care once treatment is completed, including whether the client will need or want additional therapy. The therapist should help connect the youth with follow-up care.

CONCLUSION

Substance use and mental health challenges are common among youth experiencing homelessness. CRA and MET have shown the most promise at addressing these challenges among this vulnerable population. Youth who are homeless exhibit unique challenges when presenting for treatment, and MET and CRA provide effective strategies for engagement and behaviour change. To date, clinical trials have demonstrated similar effectiveness of both approaches. Consequently, service providers may consider how each intervention fits with their agency's philosophy and available resources when deciding which intervention to implement. Regardless of the chosen intervention, service providers must ensure youth who are homeless are given the space to identify treatment goals that are meaningful to them. While progress may be slow given the extensive challenges these youth experience, research has demonstrated that with the right tools and support, change and behavioural improvement is possible, even for the most vulnerable youth.

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1.2 DIALECTICAL BEHAVIOUR THERAPY TO ENHANCE EMOTIONAL REGULATION & RESILIENCE AMONG STREET-INVOLVED YOUTH

Elizabeth McCay & Andria Aiello

INTRODUCTION

It is well known that youth who are homeless experience a high degree of emotional and psychological distress (McCay et al., 2010). Mental health challenges such as depression, anxiety, and self-harm are often linked with difficulties regulating emotion on a day-to-day basis. Taken as a whole, these challenges often interfere with the capacity of street-involved youth to engage in the full spectrum of health and social services intended to support them in exiting the street so they will then be able to engage in independent, healthy adult lives. There is an overwhelming need for evidence-based interventions to address the mental health challenges faced by youth who are street involved in order to support adaption and reintegration (Altena, Brilleslijper-Kater, & Wolf, 2010; Coren et al., 2013). Furthermore, it has been observed that the current intervention literature overlooks the core mental health problems, such as emotional and psychological distress, experienced by these youth (Chen, Thrane, Whitbeck, & Johnson, 2006; McCay et al., 2010).

One evidence-based approach that offers promise in addressing the dramatic emotional needs of youth who are homeless is dialectical behaviour therapy (DBT). DBT is an evidence-based intervention designed to treat a range of serious mental health challenges, including mood and anxiety disorders, self-harm behaviour, and suicidality (Linehan, 2000; McMain, Korman, & Dimeff, 2001; Miller, Rathus, DuBose, Dexter-Mazza, & Goldklang, 2007a). DBT was originally developed for the treatment of borderline personality disorder, a serious mental disorder characterized by the inability to manage emotions effectively (Linehan, 1993). More recently, DBT has been adapted for a wide range of mental health challenges, and has proved to be effective across a range of adult and adolescent populations. While literature evaluating the effectiveness of DBT for youth who are homeless is limited, the treatment has demonstrated the capacity to decrease self-harm and suicidality, and to improve mental health indicators such as depression and anxiety (Bohus et al., 2004), all of which include problems with regulating emotion. These findings suggest that DBT may be effective in meeting the needs of street-involved youth.

Based on this strong evidence base, our research team implemented and evaluated DBT with street-involved youth across two Canadian agencies that provide services to this population (McCay et al., 2015a). The results from this collaborative study that involved 60 youth indicated that participants in the DBT intervention experienced a reduction in mental health distress. Specifically, they showed significant improvement in overall mental health problems, depression, hopelessness, self-esteem, social connectedness, resilience, and overall functioning. These improvements were maintained at four and 10 weeks post-intervention. In the qualitative component of the study, youth told us that DBT helped them manage their emotions and tolerate distress, improved their relationships, and strengthened their sense of self. Overall, the findings suggest that DBT is a promising approach to helping vulnerable youth become more resilient and lead independent lives.

This chapter provides an overview of DBT, including individual therapy and group skills training, as well as crisis support and consultation team meetings. We then discuss the adaptations we made to the intervention to better meet the needs of street-involved youth (McCay et al., 2015a). Given that engagement with this group can be challenging, we also describe strategies we used to build commitment and trust with youth. We then explain how we implemented the intervention, highlight what we learned during the process, and identify which aspects of the intervention youth found particularly helpful in making changes in their lives. Finally, drawing on our experiences of working with street-involved youth, we discuss important considerations in implementing DBT in community settings.

DIALECTICAL BEHAVIOUR THERAPY

From a theoretical perspective, DBT is based on the understanding that inadequate emotion regulation underpins a diverse range of difficulties in coping with life challenges. Emotion dysregulation or extreme emotional sensitivity may develop due to biological vulnerability and/or may arise within the context of invalidating interpersonal circumstances (Koerner & Dimeff, 2007). DBT is comprised of cognitive behavioural approaches in combination with acceptance-based practices originating from the Zen school of Buddhism (McMain, Korman, & Dimeff, 2001). DBT emphasizes the need for therapeutic acceptance, as well as the need to focus on changing maladaptive coping mechanisms, such as self-harm or substance abuse, which are used to avoid painful emotions and perceptions of the self.

Overall, DBT is a therapeutic intervention that balances acceptance of the individual's current difficulties with the need for change. Our study applied the adolescent version of DBT by Miller, Rathus, and Linehan (2007b), which shares many conceptual and practical similarities with the adult version. As in standard DBT, the adolescent version includes individual therapy, skills training, crisis support, and consultation team meetings. Each component is described in the following section.

COMPONENTS OF DBT

Individual therapy

The individual therapist assumes the role of coordinator for each individual's participation in DBT, and is responsible for conducting the individual therapy sessions and developing the crisis plan. DBT provides clear guidelines regarding the goals of the intervention. Foremost, the therapist must identify with the client the need to decrease:

- Life-threatening behaviours;
- Therapy-interfering behaviours, including coming late to sessions and missing sessions; and
- Behaviours that negatively affect quality of life, such as substance abuse, depression, school truancy, relationship problems, and disordered eating.

These hierarchical DBT goals give the therapist clear guidelines about what issues are priorities to be dealt with in the individual sessions. Clients complete diary cards to track problematic behaviours, which are then reviewed with the therapist. The therapist also employs a strategy called chain analysis, which is a detailed behavioural analysis that determines how a client arrived at a dysfunctional response. This understanding can then be used to help the client make a different choice in the future. The therapist also encourages clients to strengthen their behavioural skills by attending a DBT skills training group.

Skills training

The skills training component of the DBT intervention is provided in a group setting. In their book *Dialectical Behavior Therapy with Suicidal Adolescents*, Miller et al. (2007b) present a 16-week format for DBT skills training. The training involves four four-week modules, each focused on one of the following skills:

- Distress tolerance;
- Interpersonal effectiveness;

- Emotion regulation; and
- Walking the middle path.

All skills group modules include didactic content, role plays, and homework practice. Each module is structured as an independent entity, with the orientation to the principles of DBT and core mindfulness skills repeated at the start of each module. Mindfulness is integral to all of the modules and emphasizes being observant in the moment, as well as being non-judgemental.

Crisis support

The skills taught in the DBT skills training group are designed to address a number of problems, including impulsivity, emotional instability, and interpersonal problems (Miller et al., 2007b). As clients continue to learn and practise skills to manage difficult emotions, the DBT therapist is available via pager to provide crisis support as needed.

Consultation team meetings

The DBT consultation team is an essential part of the DBT intervention. The purpose of the team is to hold each therapist within a therapeutic frame and address problems that arise in the course of delivering the intervention. The goal of consultation is to allow therapists to discuss their difficulties providing DBT in a non-judgemental and supportive environment that also helps improve their motivation and capabilities.

ADAPTING DBT FOR STREET-INVOLVED YOUTH

Table 1.2-1 outlines the key adaptations we made to the 16-week DBT intervention described by Miller et al. (2007b) for the purposes of our study. While Miller et al. presented a 16-week DBT intervention for adolescents who were suicidal, our study implemented and evaluated DBT with street-involved youth who were either accessing or living in a shelter and who were experiencing elevated levels of distress, but were not necessarily suicidal (see Lynk, McCay, Carter, Aiello, & Donald, 2015).

TABLE 1.2-1: KEY ADAPTATIONS TO A DBT INTERVENTION FOR STREET-INVOLVED YOUTH

16-WEEK DBT INTERVENTION[a]	ADAPTED 12-WEEK DBT INTERVENTION
Target population	
Adolescents who are suicidal	Street-involved adolescents who are experiencing elevated levels of distress
Length of intervention	
16 weeks (individual therapy, skills training, crisis support, consultation team meetings)	12 weeks (individual therapy, skills training, crisis support, consultation team meetings)
Skills training modules	
Four modules: distress tolerance, interpersonal effectiveness, emotion regulation, walking the middle path Core mindfulness skills are repeated at the start of each module.	Three modules: distress tolerance, interpersonal effectiveness, emotion regulation (walking the middle path, which deals with teenager–family dilemmas, is omitted) Core mindfulness skills are repeated at the start of each module. Youth-oriented examples are provided to reinforce concepts.
Crisis support	
DBT therapist is available via pager to provide crisis support as needed.	24-hour crisis support is available within the community agency. Youth complete a safety plan, which is available to crisis support staff.

[a] *Miller, Rathus, & Linehan (2007).*

The research team and our community partners decided to shorten the intervention from 16 to 12 weeks because street-involved youth are often in and out of shelter. This was accomplished by omitting the "Walking the Middle Path" skills training module, which involves a family component focused on teenager–family dilemmas (Miller et al., 2007b). This seemed appropriate because the youth in our study did not live at home, and many of them had either very strained or non-existent relationships with family members.

The final key adaptation to the intervention involves crisis support. In standard DBT, therapists carry pagers so clients can reach out to them in times of crisis. In our study, it was not feasible for front-line community agency staff to carry pagers because they would not be available to respond to a crisis call after hours. However, the two community agencies in our study offered 24-hour crisis support to all youth residing there, and youth participants were encouraged to access this support if they needed it. Youth also developed a safety plan, which was kept as part of their file so it could be accessed easily by crisis support staff.

STRATEGIES TO PROMOTE ENGAGEMENT & COMMITMENT

Specific strategies were implemented to promote engagement in and commitment to the intervention. First, the DBT skills training group was offered in the late afternoon and early evening so participants who were going to school or working could attend. Pizza was provided at each group session, which helped create a welcoming environment. For each individual therapy and skills group session attended, participants received a $5 honorarium to cover costs associated with attending, such as transportation.

As in standard DBT and in the adolescent version developed by Miller et al. (2007b), our study implemented the four-miss rule: group members who missed four consecutive skills training sessions (and/or four individual sessions) would have to leave the intervention. Not only was commitment to the intervention deemed to be of paramount importance, but the community agency's commitment to promoting engagement in the intervention was crucial as well. Both agencies in the study demonstrated flexibility in allowing youth who had transitioned to independent housing to also participate in the intervention, underscoring the recognized value of DBT in strengthening resilience for these youth. Furthermore, front-line agency staff delivering the intervention made efforts to maintain regular contact with study participants, sent email reminders about upcoming sessions, and were flexible in scheduling and sometimes rescheduling individual therapy sessions as needed, trying their best to accommodate participants' schedules.

In order to promote engagement in and commitment to the intervention, it was crucial for agency staff conducting individual therapy and running the skills training group to establish respectful, supportive, and trusting relationships with participants. Validation is an essential part of DBT. In keeping with the core dialect in the intervention—acceptance

and change—staff consistently recognized that youth were doing their best, and reinforced their strengths while encouraging them to do better, try harder, and be more motivated to change. In the individual and group sessions, staff gave relevant youth-oriented examples to reinforce concepts and elicit examples from youth themselves.

WHAT WE DID & WHAT WE LEARNED

We learned a great deal from delivering the adolescent version of DBT to a group of street-involved youth. We gained insights not only through observations that front-line agency staff who delivered the intervention made, but also through qualitative interviews with some youth participants about their experiences of DBT. Below we describe insights specific to individual therapy and the skills training group, as well as what we learned about the implementation process.

INDIVIDUAL THERAPY

The 12-week DBT intervention included one orientation session followed by 12 individual therapy sessions incorporating those DBT strategies and tools described earlier. For example, the DBT target pyramid was used to help define the youth's specific problems as primary target behaviours. Together, youth and staff explored the need to:

- Reduce life-threatening behaviours;
- Reduce therapy-interfering behaviours;
- Reduce quality-of-life interfering behaviours; and
- Increase behavioural skills, prioritizing each according to this hierarchy.

Furthermore, youth participants were expected to fill out a DBT diary card every day to self-monitor target behaviours, emotions, and skills. Consistent with a strengths-based approach, youth were encouraged to track not only problematic behaviours, but also positive behaviours. By reviewing the diary card together at the beginning of every individual session, youth and agency staff collaboratively set the agenda for the session. To build awareness and acceptance of specific problems, youth and staff would complete a DBT behavioural chain analysis and then conduct a solution analysis to generate, evaluate, and implement alternative solutions.

There was some uncertainty about whether participants would use the diary card. Some did fill out their diary cards independently between sessions, but others required more prompting and completed their entries with agency staff during sessions. Overall, youth found they gained self-awareness through participating in the DBT intervention, and the diary card was important in facilitating this self-awareness. Filling out the diary card helped them understand their emotions and the relationships between their emotions and behaviours.

The diary card was also helpful to front-line agency staff who were delivering the intervention because it provided direction and focus in individual therapy sessions. Beyond the use of concrete tools such as the DBT diary card, it was the core principles of the intervention that had a profound impact on both youth and staff. Not only did youth feel validated and understood, but the balance between acceptance and change that is central to the intervention provided a new way for agency staff to have difficult conversations with youth. It was this balance between acceptance and change that enabled staff to establish and maintain trust with the youth while enforcing agency rules.

SKILLS TRAINING

The 12-week intervention included 12 skills training group sessions that were delivered concurrently with the individual therapy sessions. As described earlier, the DBT skills training group included three modules—distress tolerance, interpersonal effectiveness, and emotion regulation—each of which ran for four weeks. Each module began with an orientation and a review of core mindfulness skills. New participants had the opportunity to join the DBT skills training group at the beginning of each new module. As in standard DBT, participants received handouts, as well as homework or practice sheets as tools for summarizing and reinforcing DBT concepts.

Each skills training group session lasted 1.5 hours. Sessions began with a mindfulness exercise, followed by an overview of the session content and a homework practice review. The first half of each session was largely dedicated to exploring with the youth their application of DBT skills. During the second half, front-line agency staff presented the didactic material on the new skills being taught, assigned the homework practice exercise for the upcoming week, and led a wind-down exercise.

There was some uncertainty about whether participants would engage in and benefit from the mindfulness exercise at the beginning of each skills group session. Like the diary card, the mindfulness exercises enhanced self-awareness, creating space for reflection and making different choices. One participant who was struggling with drug abuse commented that engaging in mindfulness gave him a sense of separation from his thoughts and emotions that he had previously sought through drugs, but without any of the harmful side effects. This separation created the space in which he could observe his thoughts and emotions, rather than be overwhelmed by them.

Participants benefited greatly from sharing their experiences, challenges, and successes with one another in the skills training group. They explained that it was validating and empowering to be in a group with other youth who had endured similar circumstances and struggles. The support of front-line agency staff was equally important in creating a safe and validating group environment. As we explained earlier, the flexibility of staff was key to promoting engagement in the intervention; for example, youth participants were not permitted to use their cell phones during the group sessions, but drawing was allowed if it helped them focus or manage anxiety.

CRISIS SUPPORT

The front-line agency staff who delivered the individual therapy sessions introduced the crisis support plan during the orientation session. Youth were reminded that they could access the agency's 24-hour crisis support if they experienced a crisis after hours. It was the responsibility of the individual therapist to follow up with other agency staff about any crisis calls. Together, youth and staff developed a safety plan. As part of the plan, the youth identified coping mechanisms they found helpful and signed an agreement to adhere to the plan. This plan was then made available to crisis support staff.

Crisis supports were consistent and readily available through our agency partners, and as such, crisis support was incorporated within the DBT intervention offered to youth. It became evident that even though our adapted DBT intervention did not adopt the 24-hour pager model, the availability of the 24-hour crisis support through the agency and the adoption of a youth-oriented safety plan were effective at providing crisis support for youth in the study.

CONSULTATION TEAM MEETINGS

Weekly consultation team meetings were held over the course of the intervention to support ongoing skill development and adherence to DBT for front-line agency staff delivering the intervention. To accommodate geographic distance between the sites, these peer-led meetings were conducted via teleconference, and included both agency staff delivering the intervention and members of the research team. The meetings were held at the same time every week and lasted one hour. Together, agency staff discussed their experiences and challenges around delivering DBT. In keeping with the core dialect in the intervention—acceptance and change—these experiences and challenges were validated, while the team worked together to increase adherence to DBT principles, thus enhancing each member's ability to respond to challenges and deliver the intervention more effectively.

Informal feedback suggests that agency staff found the regular staff teleconferences to be most helpful in supporting the implementation of DBT within their respective agencies. Specifically, staff reported that ongoing consultation and clinical support were a key factor in supporting the therapist's confidence and learning (McCay et al., 2017).

IMPLEMENTATION CONSIDERATIONS

GETTING STARTED

Successful implementation of DBT takes into account the life circumstances of street-involved youth, as well as the potential impact on organizational programs, staff roles, and client interactions. At the same time, the implementation process can highlight existing strengths in service delivery. Many of the principles of DBT build on and are reflected in the therapeutic relationships between staff and youth, making for a more focused structure to existing practices rather than major organizational change.

If possible, having a staff person act as lead in implementing DBT will make for a smoother transition. As well, our collaboration between a university and a community agency serving youth was central to the success of the project. Partners may bring different perspectives to care delivery; ideally they should share similar values in working with youth. The advantage of partnerships is that they bring together the expertise and

resources (human and material) of each organization in planning and implementation, specifically, sharing decision making and collaborating in navigating challenges that may arise (McCay, Cleverley, Danaher, & Mudachi, 2015b).

The DBT intervention may need to be modified so it aligns with organizational capacity and the needs of youth. Clear outcomes and realistic time frames for implementation are essential for integrating the intervention within current practice so it is feasible and sustainable. Staff will be adopting an approach to working with youth that involves acquiring new knowledge and shifting perspective. Even with comprehensive training, it takes time to be comfortable with the material and develop skill in addressing the range of issues presented by youth. Putting in place the necessary supports (e.g., ongoing consultation) is critical to sustaining the change that is being implemented.

ENGAGING STAFF & PROVIDING TRAINING

Successful implementation of DBT requires the commitment and support of agency administration and staff. Strong administrative support sets the expectations for the agency and ensures access to the needed resources, such as for training and consultation. Furthermore, engaging staff who work directly with youth is a critical step in the implementation of DBT. Our approach was to meet with staff to describe the study, specifically the components of the intervention and the nature of staff involvement in concrete terms.

Staff training is an opportunity to build staff capacity in acquiring a new therapeutic skill, but it requires planning and dedicated time. The individual or group delivering staff training should have the necessary expertise in DBT and plan to be available for consultation going forward in order to assist staff. We employed a multifaceted approach that took into account the demands on staff time and different learning styles, and that provided follow-up support to reinforce content. A range of methods was used that enabled staff members to learn the material at their own pace. (For more information on the training, see McCay, et al. [2015].)

KEY MESSAGES FOR PRACTITIONERS

- DBT is a highly promising approach to meet the mental health needs of street-involved youth and strengthen resilience.
- The core dialectic of validation, while supporting the need to change, is central to the DBT youth-centred approach.
- Front-line staff members are essential to the successful implementation of DBT and require training and organizational support.

CONCLUSION

Our experience suggests that DBT is a promising approach to support street-involved youth in coping with mental health challenges. This in turn strengthens overall functioning, emotional regulation, and resilience. Further, the success achieved in this study was due in large part to the commitment and dedication of staff, who conveyed unconditional acceptance while supporting the need to change. Finally, although the positive results attained in our study are promising, there is a need for further research to demonstrate DBT's effectiveness in helping youth make positive changes in their lives.

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1.3 MINDFULNESS APPROACHES FOR YOUTH EXPERIENCING HOMELESSNESS

Samantha M. Brown & Kimberly Bender

INTRODUCTION

Mindfulness involves bringing attention to what is happening within us and around us in moment-to-moment experiences, without labelling experiences as good versus bad, and refraining from reviewing the past or planning for the future (Kabat-Zinn, 1994). Mindfulness practice is found to be an effective approach for improving well-being among adults, with increasing support for its use in enhancing regulatory capacities among vulnerable youth populations. The approach originated from Eastern culture and Buddhist traditions. More recently, practitioners and researchers have integrated Buddhist meditative practices into Western society to foster mindfulness and address individuals' physical and mental health needs (Kabat-Zinn, 1982; Linehan, 1993). Common mindfulness practices include meditation, yoga, and relaxation and visualization exercises. Although less studied, these practices have proven beneficial in reducing stress and improving self-awareness, anxiety, and emotional and behavioural reactivity among youth experiencing homelessness.

Pilot studies that examine whether mindfulness intervention is possible in shelter settings and is acceptable to young people experiencing homelessness generally find that youth will attend mindfulness training and that those who do may experience important benefits (Bender et al., 2015; Grabbe, Nguy, & Higgins, 2012). This chapter begins by describing the general objectives and components of mindfulness-based practice. It then discusses how mindfulness-based programs have been implemented with youth experiencing homelessness and what the outcomes have been. The chapter concludes with key strategies for practitioners to consider in their work with youth accessing homeless services.

CONTEXT & EVIDENCE

In Western society, mindfulness practice has grown largely from cognitive-behavioural work. Cognitive-behavioural approaches train people to identify their automatic thinking patterns and then challenge them. As individuals change their negative automatic thoughts, their emotions and behaviours are improved, thereby promoting more adaptive functioning and improved well-being. As seen in Table 1.3-1, mindfulness-based practices similarly emphasize the recognition of thoughts and our reactions to them, but the approach diverges from traditional cognitive-behavioural approaches in several ways. Rather than evaluating one's thoughts, mindfulness encourages the person to observe these thoughts non-judgementally, with a focus on acceptance or acknowledgement rather than on changing those thoughts. Because this approach can be new and challenging, it is recommended that practitioners who facilitate mindfulness work engage in the practice themselves to truly understand it.

TABLE 1.3-1: DIFFERENCES BETWEEN COGNITIVE-BEHAVIOURAL
             WORK & MINDFULNESS PRACTICE

CONSTRUCT	COGNITIVE-BEHAVIOURAL WORK	MINDFULNESS PRACTICE
Judgement vs. observation	Evaluate and judge thinking patterns as negative vs. positive or unrealistic vs. realistic.	Observe what is going on internally and externally without criticism.
Change vs. acceptance	Change thinking patterns or behaviours.	Become aware of what is happening in a given moment without clinging to thoughts or feelings.
Observer vs. participant	Does not require provider to engage in own cognitive-behavioural work.	Requires provider to practise mindfulness to fully understand its meaning.

Mindfulness-based practice has been implemented in various settings with many different populations. It has been introduced in hospitals, schools, and community mental health centres, among other settings. Within these settings, mindfulness has been successful in addressing many behavioural and physical health problems. Practising mindfulness has been shown to reduce chronic pain (Kabat-Zinn, 1982; Randolph, Caldera, Tacone, & Greak, 1999), mood disorders (Teasdale et al., 2000), substance relapse (Bowen et al., 2009), stress (Tang et al., 2007; Williams, Kolar, Reger, & Pearson, 2001), and

interpersonal concerns (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Wachs & Cordova, 2007). Mindfulness has also been associated with improvements in medical problems (Speca, Carlson, Goodey, & Angen, 2000).

MINDFULNESS OBJECTIVES, COMPONENTS, & APPROACHES

Often, the objective of mindfulness practice includes engaging in a form of mental training that helps people increase their ability to intentionally direct their attention to current experiences without critically evaluating them or becoming attached to them. For example, when people experience stress or negative feelings, they often get stuck in these thoughts and feelings, ruminating about the problem or not being able to let go of the negative feelings. The objective of mindfulness is to develop skills to be aware of these thoughts, feelings, and sensations without getting stuck in them.

Several components associated with mindful practice may explain how this approach can promote positive health and well-being. Reviews of mindfulness (e.g., Baer, 2003) have identified common elements of the practice that may be particularly responsible for reducing stress and improving coping, and that thus contribute to adaptive change in a person's life. As seen in Table 1.3-2, these components include mindful practice, acceptance, cognitive control, self-regulation, and relaxation, among others. For example, learning to accept both pleasant and unpleasant experiences has the potential to promote less reactive behavioural responses over time (Baer, 2003). Engaging in various mindfulness strategies may also induce relaxation. Although relaxation effects are not the primary focus of mindfulness practice, relaxation undoubtedly has beneficial effects in helping the mind and body reset.

TABLE 1.3-2: COMPONENTS OF MINDFULNESS

COMPONENT	DESCRIPTION
Mindful practice	Paying attention to present-moment experiences
Acceptance	Bringing awareness to experiences without judgement
Cognitive control	Directing thoughts and actions with intent
Self-regulation	Modulating thoughts and behaviours
Relaxation	Reducing physical and mental arousal

Several strategies and activities have been developed to increase mindfulness. They can be implemented as stand-alone exercises, integrated into existing programming, or sequenced together in a more intensive mindfulness program. Each strategy and a brief description is provided in Table 3-3.

TABLE 3-3: STRATEGIES FOR CULTIVATING MINDFULNESS

MINDFULNESS STRATEGIES	DESCRIPTION
Meditation	An inner state of concentrated focus on an object to increase awareness of present-moment experience
Yoga	A discipline that involves controlled breathing, specified body positions, and meditation
Deep breathing	A breath exercise in which a person focuses on deep, slow breathing
Body scan	A full-body exercise that brings awareness to sensations that occur throughout the body
Visualization	A mental exercise in which a person recreates a sensory experience by imagining an object, action, or outcome
Loving kindness	A strategy to cultivate compassion by bringing attention to positive attitudes toward self and others
Daily informal practice	A strategy that brings awareness to immediate experience and daily tasks (without having to carve out special time for it)

To understand how formal mindfulness practice may look, consider this description of meditation. In sitting meditation, participants may be instructed to sit in a relaxed but upright position with their eyes closed or to direct their attention to an object of focus. The foundation of mindfulness practice is generally directed to the person's breath. Therefore, the person may be asked to focus on breathing—not to change how the person is breathing, but to simply pay attention to the breath as it enters and leaves the body. When the mind wanders to either internal stimuli (e.g., thoughts, feelings, sensations) or external stimuli (e.g., sights, sounds, smells), the person is instructed to note and accept these experiences, but to bring attention back to the focus of observation (e.g., breath). The person is encouraged to do this without thinking and striving to conceptualize this process or take action (Gunaratana, 2011).

Mindfulness practice can also be integrated into one's life informally. In this case, individuals may be instructed to attend mindfully to day-to-day tasks and experiences. For example, one may be asked to bring awareness to the act of eating breakfast. The person may be instructed to attend to the texture, taste, and smell of the food and to do so non-judgementally (e.g., not labelling the food as tasting good or bad). Again, when the mind wanders to thoughts or feelings away from the food or act of eating, the person is instructed to bring attention back to the present moment. Such informal practice can be translated to various domains of a person's life.

IMPLEMENTATION CONSIDERATIONS

Mindfulness is relatively new as an intervention approach with youth who are experiencing homelessness. A small body of research has examined mindfulness with youth and adults experiencing homelessness (Bender et al., in press; Grabbe et al., 2012; Maddock, Hevey, & Eidenmueller, 2017; Schussel & Miller, 2013; Viafora, Mathiesen, & Unsworth, 2015). These pilot studies typically involve adapting established manualized mindfulness interventions to individuals experiencing homelessness and testing that adaptation with small samples of people seeking homeless services (often shelter services). As such, most of what we know about mindfulness with youth who are experiencing homelessness describes the types of programs provided, whether these programs can attract and retain people experiencing homelessness, whether those who participate change over time in key ways, and how people respond to participating.

Generally, we find mindfulness-based approaches are being provided in a variety of homeless service settings and has been fairly well received by young people. While most often provided in shelter settings, mindfulness approaches have also been used in drop-in centres, transitional housing, and through school-based services. Most often these interventions require sustained engagement with young people, as they are typically offered through eight weekly group sessions, but some programs provided mindfulness training for longer periods (16 weeks) and some condensed training to only a few days. The models provided vary from having a very therapeutic focus to incorporating a training or didactic approach to building mindfulness skills. This suggests some flexibility in both the space and time frame needed to engage young people in mindfulness training and practice. Across these settings and formats, youth appeared interested and engaged in learning about mindfulness and how to apply it to their lives (Bender et al., in press; Grabbe et al., 2012; Schussel & Miller, 2013; Viafora, Mathiesen, & Unsworth, 2015).

Despite the early stage of research, the existing evidence is promising. Mindfulness has been associated with important benefits for youth experiencing homelessness. Mindfulness practice demonstrates promise in reducing symptoms of depression, anxiety, and impulsivity (Grabbe et al., 2012; Maddock et al., 2017; Schussel & Miller, 2013). In addition, it has been shown to increase spirituality and resilience (Grabbe et al., 2012), and to improve personal and emotional well-being, relationships with others, and positive expectations about the future (Schussel & Miller, 2013; Viafora et al., 2015). Youth experiencing homelessness who have received interventions that incorporate mindfulness training also show improvements in the ability to detect risky interactions and situations (Bender et al., in press). Strategies associated with attaining these outcomes in this hard-to-reach population focus on increased awareness and acceptance, and on improved coping and self-regulation.

Specific examples from the field demonstrate how mindfulness is being implemented and tested across homeless service settings. Among adults experiencing homelessness, mindfulness has been piloted as a clinical intervention (Maddock et al., 2017) in a short-term emergency shelter where adults experiencing homelessness were engaged in an eight-week mindfulness-based program with each session lasting two hours. The sessions followed a standard mindfulness-based stress reduction protocol, which included mindfulness meditation with attention focused on the breath, body scans, awareness training using yoga poses, and practising mindfulness in the context of stressful interactions and situations with others. These mindfulness skills helped adults who were homeless cope with and handle their mental health and addiction challenges, which in turn contributed to increases in more action-oriented coping strategies such as acknowledgement and acceptance of their thoughts and feelings rather than using avoidant coping strategies. Furthermore, participants described being more centred, which reduced ruminating about their past or worrying about their future. Over the eight-week period, participants reported significant reductions in mental health symptoms, including anxiety, depression, and impulsivity (Maddock et al., 2017).

Similarly, among youth aged 18–21, mindfulness meditation has been piloted to address mental health and substance abuse in a youth service organization that offered drop-in, emergency, and long-stay transitional housing (Grabbe et al., 2012). In this pilot, youth participated in a manualized eight-session Youth Education in Spiritual Self-Schema program that used mindfulness meditation to teach participants to pay attention neutrally to what was happening in the moment, using their breath as the primary object

of focus. Participants learned strategies based in Buddhist philosophy and in cognitive and dialectical behaviour therapy (DBT) approaches. The ultimate goal was to help youth shift from automatic self-schemas (i.e., reactions to stress that trigger low self-esteem and drug cravings) to "spiritual" schemas that promoted positive behaviour and abstinence from drug use, delinquency, and self-harm behaviours. Central to the cognitive component of this program was asking youth to identify negative automatic responses to situations, stop them, and then replace them with alternative ways of thinking. Mindfulness practice involved formal meditation to draw attention back to spirituality during high-stress situations. As such, mindfulness was used to help youth direct their attention under stressful conditions and self-regulate their emotions. Youth who participated in the program demonstrated longer-term improvements in spirituality, resilience, and mental well-being, as well as reductions in psychological symptoms (Grabbe et al., 2012).

Others have integrated mindfulness practice with traditional therapeutic approaches in shelters serving young people aged 18–24 (Schussel & Miller, 2013). Schussel and Miller integrated a mindfulness practice component derived from Tibetan Buddhism with traditional interpersonal therapy in 16 group sessions. In some traditions, sound is used to assist with meditation and relaxation. In this study, mindfulness was introduced for the first 20 to 30 minutes of a 1.5- to 2-hour group, in which a Tibetan singing bowl was used to help youth practise using the tones for focus and relaxation, followed by rhythmic breathing with counting. The facilitators then led youth through a visualization exercise that involved imagining their best selves and all of their positive qualities before joining with the rest of the group, where they were asked to project loving kindness to others in the group. After completing these exercises, youth reported greater clarity and feeling calm and relaxed, which in turn allowed them to better engage in the therapeutic group discussions that focused on self-efficacy. At the completion of the program, youth reported reductions in depression and anxiety, as well as positive changes in their sense of well-being and understanding of themselves. For practitioners interested in integrating mindfulness into their practice, this study provides preliminary support that incorporating mindfulness-based strategies into an existing group structure may be one way to orient youth to the treatment setting and help maximize engagement and the effects of the therapeutic time together.

In educational settings, mindfulness has also been used to improve emotional well-being among youth facing homelessness (Viafora et al., 2015). In developing an eight-week mindfulness-based course in a middle school serving students experiencing homelessness,

researchers combined materials from two existing mindfulness interventions for children: Planting Seeds (Nhat Hanh, 2011) and Still Quiet Place (Saltzman, 2008). Students met weekly for 45 minutes in the classroom and engaged in mindful listening and eating exercises, guided breathing, and brief discussions about continued practice of these skills between sessions. Students were taught to apply these new skills to many different experiences. For example, students could use mindfulness while taking a test, when managing emotions, or during interactions with others. Through participation in this program, students learned awareness skills to help them manage anger, sadness, and impulsivity, and they described feeling a greater sense of emotional well-being as they continued in their mindfulness practice (Viafora et al., 2015).

With a skills training approach as opposed to a clinical focus, mindfulness has been used in a youth shelter setting to train youth experiencing homelessness to better attend to risks in their environment and interactions with others (Bender et al., in press). Youth experiencing homelessness are a particularly vulnerable population because they are at an increased risk for victimization by strangers as well as acquaintances. While this vulnerability is likely due to dangerous living situations and few resources to avoid such circumstances, it may also be due, in part, to previous trauma that makes it more difficult for youth to pick up on risk cues and avoid dangerous situations. Offered in an intensive three-day skills training course, Safety Awareness for Empowerment (SAFE) trains youth to direct their attention to internal feelings and thoughts, interpersonal interactions, and environmental cues that may indicate they are in a dangerous or risky situation, and then helps them problem solve ways to get out of those situations, act assertively, and seek help. SAFE uses interactive activities, group discussions, and role plays of case scenarios to help youth apply basic mindful attention training to situations they are likely to face while homeless. Youth randomly assigned to the SAFE intervention were significantly more likely than those who received shelter services as usual to identify risk cues in scenarios depicting youth at risk (Bender et al., in press).

Clearly, mindfulness-based approaches are beginning to be used in a variety of settings serving youth experiencing homelessness, with diverse formats and aims, including clinical treatment approaches and preventative skills training. Despite promising preliminary findings, rigorous research is still needed to determine more confidently that mindfulness interventions are responsible for these positive outcomes among those experiencing homelessness, to explain how or why these benefits occur, and to increase our understanding of who is most likely to benefit from the approach.

KEY STRATEGIES FOR PRACTITIONERS

Mindfulness may be a strong fit for young people experiencing homelessness. These youth have elevated rates of trauma, anxiety, depression, and substance use. As they often have few resources, they may live in shelters, which are often temporary and hectic, and which may create added stress. Mindfulness may cultivate a sense of privacy and control (Grabbe et al., 2012) while offering a tool for self-regulation and coping in these stressful environments. Furthermore, for a group that typically has difficulty accessing intensive and ongoing mental health services, mindfulness may offer simple self-care skills that allow youth to manage their reactions to their chaotic living situations.

CHALLENGES

Despite these potential benefits, certain challenges are likely to be encountered when implementing mindfulness with young people experiencing homelessness. Practitioners are likely to find youth irregularly attend mindfulness groups and/or drop out of mindfulness training early. For example, in Grabbe et al.'s (2012) study of youth in shelter services, only 55% of participants attended four or more sessions of an eight-session program. This low attendance may have been due to the challenge of engaging young people in structured programming. Youth, whether due to past experiences or to disconnection from traditional institutions, may not be accustomed to staying focused in structured groups, and may thus appear distractible or interrupt facilitators (Grabbe et al., 2012).

RECOMMENDATIONS

Because qualitative research suggests the mindfulness-based interventions are well received by youth experiencing homelessness, who find it to be calming, relaxing, and accessible, intermittent attendance may be likely due to instability, unpredictable stressors, and transience experienced by this population. Youth who are in more stable situations, such as transitional housing, demonstrate interest in attending mindfulness training over several weeks and even volunteer to co-lead such interventions (Grabbe et al., 2012), suggesting that this approach could be particularly well targeted to youth in transitional housing who can overcome some of the obstacles to regular attendance. On the other hand, mindfulness may be a practice that can be cultivated even after having missed sessions. Thus, less structured programs that allow

for rolling enrollment may be a strategy for engaging more transient or less stable youth with some benefit. Moreover, some of the distractibility youth experience may highlight the exact skills that mindfulness aims to cultivate by helping youth recognize their distraction and direct their attention in the moment. Doing so requires that facilitators have patience and build rapport to help youth work through distractions, use them as examples, and maintain engagement. It also requires practice on the part of youth participants (Bender et al., 2015).

SUGGESTED ADAPTATIONS

Although mindfulness seems to be a good fit for reaching and serving youth who are homeless, mainstream mindfulness programs are often adapted to help them better engage. Such adaptations attempt to overcome some of the challenges mentioned above and suggest key strategies to integrating mindfulness in homeless service settings. Table 1.3-4 lists key adaptation strategies and the rationale for incorporating these adaptations to address the specific needs of youth experiencing homelessness.

TABLE 1.3-4: SUGGESTED ADAPTATIONS TO MINDFULNESS INTERVENTIONS WITH
        YOUTH EXPERIENCING HOMELESSNESS

SUGGESTED ADAPTATION	RATIONALE
Make attendance convenient.	Accelerating the timing of the program to offer sessions more intensively over a briefer period of time or permitting rolling enrollment will allow more transient or mobile young people to engage in mindfulness programming.
Provide opportunities to practise.	Including role plays in the group and allowing time to practise new skills between sessions will help young people realize the relevance of these skills and apply them in challenging and chaotic environments.
Involve peer co-facilitators.	Peers who have graduated from the mindfulness program may serve as ideal co-facilitators with adult service providers because they can help youth apply material learned to realistic situations and demonstrate the utility of such skills.
Do not pathologize.	Youth rarely identify with traditional diagnostic or pathological frameworks; changing language to instead normalize common symptoms and struggles can introduce mindfulness as a way to navigate experiences.

TRAINING & RESOURCES

Practitioners or service providers who are interested in incorporating mindfulness into their work with young people experiencing homelessness have several options for increasing their knowledge and skills in this approach. Some providers may have the resources and interest to become formally trained in specific mindfulness interventions. Several structured evidence-based interventions exist. One of the most well-known mindfulness-based interventions is mindfulness-based stress reduction (MBSR), developed by Jon Kabat-Zinn (1982). Originally created for use in medical settings for populations with chronic pain and stress-related conditions, MBSR involves eight to 10 weeks of group sessions focused on building meditation skills; mindful breathing; and observation of thoughts, feelings, and emotions without judgement. MBSR is available, at a cost, through the Mindfulness-Based Stress Reduction Professional Training Institute in San Diego, California. A second structured intervention is mindfulness-based cognitive therapy (MBCT; Teasdale, Segal, & Williams, 1995), which adds cognitive components to mindful practice and focuses on preventing relapse of depressive symptoms. The intervention teaches individuals to step back or detach from their thoughts, emotions, and sensations and become aware that these elements are not permanent or factual. This approach can help with cognitive processes such as rumination or catastrophizing where individuals may get stuck in obsessive and dysfunctional thinking patterns. The step-by-step process of teaching mindfulness has been described in the book *Mindfulness-Based Cognitive Therapy for Depression* (Segal, Williams, & Teasdale, 2012) that many practitioners may find useful. Mindfulness training has also been incorporated into established therapies such as dialectical behaviour therapy (Linehan, 1993) and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), which also provide formal training to practitioners.

For many service providers, limited resources for extensive training combined with shorter service interactions with young people who are homeless make structured mindfulness interventions less feasible. In these cases, service providers may access additional reading material and downloadable exercises to help them integrate mindfulness approaches into their current agency roles. Service providers can learn more about the philosophy and theory guiding mindfulness practice in the books *Wherever You Go There You Are: Mindfulness Meditation in Everyday Life* by Jon Kabat-Zinn (1994) and *Mindfulness in Plain English* by Bhante Gunaratana (2011). They can also access specific mindfulness tools, such as meditation practices and breathing exercises, at www.freemindfulness.org/ or marc.ucla.edu/mindful-meditations. Such tools can be incorporated into existing skills groups or individual case management meetings with youth within the context of usual services.

CONCLUSION

Despite emerging evidence supporting the positive effects of mindfulness-based practices with youth who are experiencing homelessness, this intervention can benefit from further exploration. As practitioners continue to implement mindfulness practices in homeless service settings, continued evaluation is necessary. Assessing who engages in such practices, how they experience the approach, what suggestions they have for improvements, and what benefits are associated with participation is critical to developing evidence-based interventions for this important group of young people.

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1.4 TRAUMA-INFORMED CARE FOR STREET-INVOLVED YOUTH

Elizabeth K. Hopper, Jeffrey Olivet, & Ellen L. Bassuk

We are so much more than homeless. "Homeless" is not a character trait. It is just where we happen to be at the moment and the situation in which we find ourselves. We are often pretty phenomenal and interesting people—get to know us beyond what you see on the surface—without being too nosy about our histories.

—Excerpt from Y2Y Harvard Square Young Adult Advisory Council,
  Words of Wisdom and Advice for Staff and Volunteers

INTRODUCTION

Youth homelessness is a major public health problem that garnered increased interest and focus in recent years in Canada and the United States. The connections between youth homelessness and child welfare, foster care, and juvenile justice have been well established (Bender, Yang, Ferguson, & Thompson, 2015; Dworsky & Courtney, 2009; Zlotnick, 2009). Similarly, service providers and policy makers have become aware of the high rates of homelessness among sexual and gender minority youth and among young people of colour (Corliss, Goodenow, Nichols, & Austin, 2011; Keuroghlian, Shtasel, & Bassuk, 2014). Youth who experience homelessness also have high rates of traumatic stress and the mental health consequences that result from physical and sexual abuse, neglect, and other traumatic experiences (Whitbeck, Hoyt, Johnson, & Chen, 2007; Wong, Clark, & Marlotte, 2016). Despite these high rates of traumatic exposure among young people experiencing homelessness, service providers often feel ill-equipped to understand and respond to the trauma-related needs of the young people they serve. This chapter reviews trauma and youth homelessness, discusses specific strategies to implement trauma-informed care in service settings, and provides excerpts of interviews with youth and service providers that illustrate the challenges these youth face and how trauma-informed services address their unique needs.

CONTEXT & EVIDENCE

Trauma is pervasive in the lives of youth who are street involved or homeless, and is both a cause and a consequence of homelessness (Davies & Allen, 2017; Coates & McKenzie-Mohr, 2010). Childhood neglect and emotional, physical, and sexual abuse are common experiences for these young people; in one large multisite study, 79% of youth who were homeless reported multiple childhood abuses (Bender et al., 2015). Many of these youth have run from abusive or neglectful home environments, while others have been kicked out of their homes, including young people who are abused or rejected as a result of their sexual orientation or gender identity (Corliss et al., 2011; Keuroghlian et al., 2014).

Homelessness and street involvement leave these young people vulnerable to repeated victimization. They are at high risk for sexual and physical assaults (Stewart et al., 2004). Youth who have left home and are street involved often create street families, seeking the love or connection they did not receive at home (National Child Traumatic Stress Network [NCTSN], 2014). Opportunistic exploitative adults and peers may take advantage of their unmet emotional needs, placing these youth at high risk of sexual exploitation and sex trafficking (Dank et al., 2015; Gwadz et al., 2009; Heerde, Scholes-Balog, & Hemphill, 2015; Tyler & Johnson, 2006).

In addition to repeated victimization, young people experiencing homelessness are typically plagued by chronic stress, including unmet basic needs, food insecurity, loss of possessions and pets, lack of privacy, lack of routines and a sense of security, and loss of friends, family members, community and social supports. Many have been involved with various systems, such as the foster care, mental health, and criminal justice systems, that have failed to meet their needs or provide an adequate safety net.

This type of chronic and repeated exposure to adversity and trauma leads to serious mental health consequences (Davies & Allen, 2017). Repeated victimization tends to have cumulative impacts: in one multisite study of youth experiencing homelessness, the likelihood of a posttraumatic stress disorder (PTSD) diagnosis more than doubled with each additional experience of childhood abuse; each additional type of street victimization (robbery, physical assault, and sexual assault) was associated with almost twice the risk of a substance use disorder; and multiple childhood abuses and street victimization approximately doubled the likelihood of developing depression (Bender et al., 2015). This cumulative impact on mental health may be particularly true when early traumas include sexual victimization (Wong et al., 2016).

As is the case with most youth who are street involved or homeless, when children are exposed to chronic or repeated deprivation, losses, adversity, or abuse during pivotal developmental periods, without the context of a supportive caregiving environment, they often show wide-ranging impacts called complex trauma. Complex trauma can have devastating effects on a child's emotions and impulses, self-perception, interpersonal relationships, physiological responses, and ability to concentrate, think, and learn (Cook et al., 2005; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Herman, 1997). Young people with complex trauma may have difficulty engaging with service providers and benefiting from traditional youth services.

DEVELOPING TRAUMA-INFORMED SERVICES FOR STREET-INVOLVED YOUTH

Despite serving people affected by trauma, many agencies that work with street-involved youth have not adapted their services to meet the unique needs of young people with trauma generally, or with complex trauma specifically. Without a clear understanding of complex trauma, service providers may misinterpret trauma-related symptoms, interpreting challenging behaviours as markers of youth who are "manipulative," "lying," or "hostile." If they personalize difficult interactions with these young people, service providers can experience increased stress and emotional reactivity, which may lead to a cyclical escalation of conflict. Because of the extensive trauma exposure common to youth who are homeless and street involved, trauma-informed care is needed for these young people.

Providing trauma-informed care that is expansive enough to address complex trauma requires a philosophical and cultural shift within an agency in which all staff members—from the decision makers to clinicians to support staff—are knowledgeable about trauma-informed approaches and are able to shift their fundamental approach to services. The entire organization and staff must understand how trauma affects young people and how they interact and engage with service providers, and must be committed to implementing trauma-informed strategies. In addition, staff must understand how the relationship of severe trauma at critical developmental stages impedes the formation of trusting interpersonal relationships (Hopper, Bassuk, & Olivet, 2010).

Using a theoretical framework guides change toward becoming trauma informed. Ideally, this framework would target the unique needs of young people experiencing complex trauma. The ARC (Attachment, Regulation, and Competency) model provides a theoretical framework, core principles of intervention, and a guiding structure for service providers working with youth and families who have experienced multiple or prolonged traumatic stress (see Blaustein & Kinniburgh, 2010). It has been applied with street-involved youth (Hollywood Homeless Youth Partnership, n.d.). Another complex trauma framework is TARGET-A (Trauma Affect Regulation: Guide for Education and Therapy, for Adolescents and Pre-adolescents), which is geared toward managing current post-trauma responses and developing concrete skills to cope with triggered responses (Ford & Russo, 2006). The TARGET model has been applied heavily with juvenile justice–involved youth, as well as within homelessness service settings (Advanced Trauma Solutions, n.d.).

BASIC PRINCIPLES & STRATEGIES

Several key principles guide our recommendations for designing trauma-informed interventions for youth who are homeless and street involved.

Understanding traumatic stress in street-involved youth

Young people end up on the streets because every system that was supposed to support them has failed. Often there is trauma—the bad things that happen to you or the good things that don't happen—that drives young people into homelessness. Then once young people are on the streets, that experience is also traumatic. Being homeless is traumatic for youth on many levels. First, there is the basic anticipatory stress of the unknown. Where am I going to sleep, how will I get enough food? There is fearing for safety: Will I be assaulted, will my stuff get stolen? Then there is the actual violence of being young and vulnerable: sexual exploitation, violence, assault.

—Ayala Livny, advocate and former director of a drop-in centre for youth experiencing homelessness

Before adapting services to meet the unique trauma-related needs of youth who are homeless and street involved, we first need to clearly understand what those needs might be. Education and training are essential in shifting the perspective from "What's wrong with you?" to "What has happened to you?" Training is needed for all staff, from administrators to direct care staff to support staff, to better understand trauma. Training should explore:

- The prevalence of trauma exposure among young people experiencing homelessness;
- The meaning of complex trauma and its association with forming trusting interpersonal relationships;
- The implications of adaptation to trauma at different ages and developmental levels; and
- The link between traumatic experiences and adverse health and mental health outcomes.

This understanding is enhanced by learning about the neuroscience that underlies post-trauma responses. The Trauma Center at Justice Resource Institute (www.traumacenter.org) offers training on traumatic stress and complex trauma, along with training and consultation on the ARC framework (arcframework.org). The Hollywood Homeless Youth Partnership, a consortium of agencies affiliated with the NCTSN, has implemented the ARC model with youth who are homeless or who have left home. The consortium has developed an 11-module online training course for direct care staff working with youth who are experiencing homelessness, including modules on trauma and resilience (NCTSN, n.d.1).

Treating youth with respect

> *Dignity and self-worth are not things you are going to "give" us. Confidence and self-esteem are byproducts of our own skills and resilience. You can treat us with respect and dignity, and help create opportunities for us to build our skills and showcase our resilience. But please don't think you are going to give us self-esteem or dignity. We give these things to ourselves.*
> —Excerpt from Y2Y Harvard Square Young Adult Advisory Council,
>   *Words of Wisdom and Advice for Staff and Volunteers*

Systems can be dehumanizing. Frustration and helplessness can lead some service providers to become cynical or to distance themselves from the young people they are serving. Unfortunately, living in settings that are depersonalizing can reinforce messages that some young people experiencing homelessness learned very early in life: "You are not worthwhile," "You are not good enough," or "Something is wrong with you." Trauma-

informed systems for these young people take a non-judgemental approach instead. They should be person-centred, which includes using person-first language; for example, "a young person experiencing homelessness," not "a homeless kid"; "a child struggling with substance use problems," not "an addict"; "a child who has been sexually exploited," not "a teen prostitute." Staff should model and encourage pro-social behaviour by treating one another and the young people they are serving with respect and dignity. Within trauma-informed systems, diversity is valued and embraced. The setting and staff should reflect the diversity of the young people served, including differences in race and ethnicity, sexual orientation and gender identity, language, and culture (see also chapters 2.1–2.4 on working with minority youth). Services should be made accessible to diverse populations, including considering differences in abilities and language.

Establishing emotionally safe caregiving systems

> *Some people ask me why I never stay in shelters. [The adult] shelters are meat markets where the strong prey on the weak, the scared, and the lonely. I have seen way too many injustices, and frankly, I feel safer on my own. In street life you are alone anyway and can trust only yourself.*
> —TC, age 21

Many street-involved young people have had complicated relationships with the adults in their lives. Many are isolated from their families or other sources of support, and some have never had stable, consistent, or safe caregivers. For many of these young people, systems become their caregiving environment. This raises many questions, including, Do these settings feel safe to these youth, or are they on guard? Do they feel understood by the staff members? How is the program working to build trust with them? What happens when their favourite staff person leaves or when they are transitioned to a different service setting? These types of transitions and relational losses can further reinforce mistrust and alienation already experienced by many of these young people.

Trust and boundaries

Programs that serve youth who are homeless and street involved and who have complex trauma must attend to the relationships between a young person and their service provider network. Trauma-informed service providers aim to be trustworthy by responding in similar ways over time and following through on what they say they are going to do. Although service providers should be authentic and flexible enough to allow real connection with the young people they serve, they must remember that clear boundaries

contribute to emotional safety. For example, while outreach workers might use familiar lingo and thoughtfully share elements of their own experience (e.g., "I think I get what you're saying; I was on the streets myself when I was young"), they should also be mindful of their professional role (e.g., as a mentor versus a friend) and limitations (e.g., avoiding promises like "I'll always be there for you").

Self-awareness and emotional regulation

When a person becomes agitated, aggressive, or dismissive, it is natural for people to respond with their own emotional responses, such as anger or defensiveness. When a young person makes unhealthy choices, service providers who care about them might feel anxious and helpless. However, these types of emotional responses and associated efforts to control the person's behaviour can be triggering for traumatized youth and can unintentionally escalate their responses. In these situations, service providers should focus on being aware of their own emotional responses, use emotional regulation tools (such as deep breathing, grounding, or counting backwards from 10) to modulate their own responses, and depersonalize the situation by considering the behaviour as a potential reaction to trauma, rather than as a personal attack.

Attunement

Attunement, which means sensitivity to another person's emotions and needs, is another important component of healthy attachment relationships and plays a crucial role in de-escalating triggered reactions in youth with complex trauma. Instead of focusing on behaviour management, trauma-informed service providers attempt to understand the meaning behind these behaviours—the unmet need or coping effort that is driving the behaviour. For example, some young people may break rules to prove to themselves and to authorities that they have some control over their lives. Similarly, when young people are "fronting," which means showing power emotions such as anger or excessive confidence, service providers should be aware that this type of reaction is a common complex trauma response that avoids more vulnerable feelings such as fear, shame, or even hopefulness.

Management of triggered responses

Service providers should be aware of potential triggers for youth, including common emotional triggers associated with complex trauma, such as feeling rejected, controlled, or blamed. At the systemic level, homelessness service settings and street outreach programs should review policies, procedures, and physical space to identify and mitigate potential triggers. For example, punitive models (e.g., "three strikes and you're out") tend to be

triggering for young people with complex trauma and leave particularly impacted young people without options for services. When young people are triggered, staff members might provide support by helping the youth to notice that they are upset, and to calm down, become aware of the trigger, and plan for the next time they are triggered. Because people do not think clearly when they are very upset, it is helpful to focus on the emotion instead of the behaviour to help the young person calm down before trying to problem solve. To support this emphasis on managing overwhelming emotion, some programs for youth with complex trauma create calming spaces with sensory tools (e.g., music, stress balls, weighted blankets) to help young people regulate. (For a further description, see the SMART program manual by Warner, Cook, Westcott, & Koomar [2014].)

Self-care

Because this work requires an emotional investment and can involve secondary trauma exposure to service providers, many of whom have their own history of exposure to trauma or adversity, it is essential that service systems acknowledge the impact of this work and support staff by providing supervision, promoting self-care, and offering resources to manage burn-out and vicarious trauma responses (for more discussion of vicarious trauma and self-care, see chapter 3.1).

An empowerment approach for trauma-informed services

Because youth who have experienced trauma and homelessness often have had power taken from them, services should provide the opportunity for youth to reclaim power in their lives.

Structure and predictability

Young people can feel out of control when they do not know what to expect; this lack of predictability is a central part of the lives of many children who do not have a stable place to live or a stable caregiving environment. A clear structure, with a consistent schedule and regular routines and rituals, can help build a sense of predictability. Providing information can be an important part of increasing a young person's sense of control. This means sharing clear guidelines about expectations within the service setting, with transparency around decision-making processes, and defined incentives and consequences. As opposed to punishment, which is used to assert control, trauma-informed consequences are clearly connected to the behaviour, intentionally designed to teach and shape behaviour, and given with empathy. Although rules and consequences should be generally consistent, it is important to have enough flexibility to adapt consequences so they are consistent with the

needs and functioning of a particular young person. There should be a predictable process for discussing and addressing conflicts and concerns on either side. (For more discussion and examples of trauma-informed consequences for youth who are homeless, see Schneir et al. [2009].)

Individualized approaches emphasizing resilience and coping

To further increase young people's control, they should be involved in developing collaborative agreements about goals and behaviours. Assessment of socio-emotional needs can be overlooked in some settings, where the extent of unmet daily needs sometimes overwhelms attention to social and emotional concerns; these individualized needs should be included in service plans. Consistent with an empowerment approach, a strengths-based framework emphasizes identifying each person's own resilience, along with their internal and external resources. Coping plans should be individually tailored and developed in conjunction with each young person. This interactive process gives young people the opportunity to share their biggest challenges and unique coping strategies, and provides structure to the concept that staff is available for regulatory support.

Collaborative engagement

> *The young people we work with are the experts on their own needs. We learn the most from listening to their voices. They shape our understanding of how to do this work well.*
> —Sarah Rosenkrantz, co-executive director, Y2Y, Cambridge, Massachusetts

Choice and the opportunity to make decisions should be a central part of programming. Even small opportunities can be important, such as involving youth in decisions about what types of food to have available, the physical surroundings, and what types of communal activities to arrange. Service providers offering services to this population should avoid power assertion (the "because I said so" approach). Explanations should be made available about the reasoning behind certain policies, and young people should have an active voice in discussions about establishing and making adaptations to policies. A clear process should be developed for youth to provide feedback on programming and services, including methods for direct feedback (individual conversations or community forums), as well as opportunities for anonymous feedback (such as a suggestion box). A collaborative approach should be used, in which both service providers and youth are involved in developing and refining organizational mission and goals, establishing rules and regulations, developing materials, and contributing to all aspects of programming.

Offering trauma-specific services

Any program working with young people who have been exposed to trauma should develop or ensure access to trauma-specific services. Many programs choose to develop collaborations with community agencies that are motivated to serve this population and are knowledgeable about their unique needs.

Screening

Screening for trauma history can identify trauma survivors and be used as a springboard for psychoeducation and normalization of complex trauma responses. This screening might include detecting adverse childhood experiences, which can help identify young people who are in need of additional supports (a brief screening questionnaire can be found at the National Council of Juvenile and Family Court Judges [n.d.] website). Trauma screening should include questions about recent or current victimization. For example, young people can be asked if they have safety concerns about where they are staying, if they feel unsafe around anyone else, or if they have been recently robbed, physically assaulted, or sexually assaulted. Asking about commercial sexual exploitation should also be part of a standard trauma exposure screening ("Have you ever exchanged sex for money or for something else of value, like shelter, drugs, or food?"). The NCTSN (n.d.2) describes various measures for assessing trauma exposure and complex trauma symptoms. In developing screening procedures, service settings should balance the potential advantages of identifying young people who are at current risk or who may benefit from complex trauma treatment with the potential risks of alienating or overwhelming young people with extensive questions that feel intrusive or may be triggering. Because many young people are reluctant to disclose personal information, particularly trauma exposure, without the development of trust, a trauma screening might occur over time as relationships with service providers are strengthened (NCTSN, 2014).

Complex trauma treatment

Some street-involved youth may benefit from individual or group treatment for complex trauma. Various treatment approaches for youth with complex trauma have been developed that may be appropriate to use with street-involved young people. These approaches include the ARC model and TARGET. The NCTSN (n.d.3) website provides detailed information about different approaches.

Adjunctive services

Adjunctive services may help street-involved youth who have been exposed to complex trauma regulate their emotions. Psychopharmacological treatment may support this regulatory capacity and often plays a more central role for young people who have biologically based conditions. Non-Western healing modalities, such as yoga or meditation, have been shown to reduce stress and promote emotional well-being, and have been used to address complex trauma symptoms.

An ecological approach for trauma-informed services

An ecological approach understands young people within their contexts and provides services that target not only the individual, but also the larger context. For example, in the case of a young woman who is homeless because she has fled a conflictual home environment and who is planning to return home, service plans should consider her larger family context. Psychoeducation, parenting support, and individual therapy may be helpful for family members of street-involved youth. Family or dyadic counselling can address issues in family relationships that contribute to a young person's lack of an effective support network.

IMPLEMENTATION CONSIDERATIONS

> *There is sometimes a misconception that being a trauma-informed, gender-inclusive space is difficult and expensive. For us, the best, most trauma-informed fixes were inexpensive, like making sure doors don't slam hard, that guests don't have to have their backs to open spaces, and that they have multiple ways to leave a situation.*
> —Sam Greenberg, co-executive director, Y2Y, Cambridge, Massachusetts

Organizations and systems serving street-involved youth should recognize and respond to trauma in the lives of the people they serve, adopting specific principles, practices, and policies that create places of safety and connection for young people who have lost much and witnessed more than many people do in a lifetime. As organizations strive to become trauma informed, they should engage in self-assessment and craft a long-term strategy and action plan that involves various dimensions such as staff development and training, the physical environment, policies and procedures, community collaboration, service delivery, and amplifying the voices of young people. Consulting with external experts in trauma-informed services can provide structured support for this type of systems change.

Unfortunately, many organizations serving street-involved youth have few resources and little staff time for conducting formal research or intensive program evaluations. Organizations need easy-to-use evaluation tools to help them measure changes over time in their capacity to provide trauma-informed care. One such measure is the TICOMETER (Trauma-Informed Organizational Meter), an online tool with strong psychometric properties that takes about 15 minutes to complete (Bassuk, Unick, Paquette, & Richard, 2016). The TICOMETER involves ratings from staff at all levels of the organization, then aggregates these data into a composite score that can guide recommendations for training and improvement in specific domains.

Service agencies face many challenges as they strive to become trauma informed. Barriers include limited money for staff training, high staff turnover, and inadequate physical facilities. We have worked with many agencies that have overcome these challenges by focusing their energy and limited resources on transforming their space, policy decisions, and skills and attitudes of their staff—all of which can be done without a massive influx of new funding. Such transformation begins with a decision to recognize trauma as a major thread in the lives of young people experiencing homelessness and continues with a deep commitment to responding to that trauma in ways that promote healing and reconnection.

KEY MESSAGES FOR PRACTITIONERS & AGENCIES

- Many street-involved youth have experienced multiple layers of adversity and trauma, often beginning at an early age, that have affected them at key developmental periods. Therefore, in addition to becoming informed about trauma in general, service providers should also learn about complex trauma and the unique ways in which chronic or repeated early trauma can affect young people and their relationships.
- In addition to understanding the nature and impact of traumatic stress, trauma-informed organizations serving street-involved youth need to:
  - Engage consumers with respect, honouring differences and each person's unique coping efforts;
  - Provide an emotionally safe caregiving environment, with reliable, regulated, attuned service providers;
  - Use an empowerment framework to support each young person's self-efficacy;
  - Ensure access to trauma-specific services; and
  - Consider each young person within the larger contextual environment.

- Any type of change is hard and requires commitment, and this is particularly true of systems change. A guiding framework (e.g., ARC, TARGET), self-assessment, and consultation are important tools in changing the culture and nature of service delivery to ensure that programs for street-involved youth are trauma informed. Regularly assessing and measuring progress and service impact is critical to the success and sustainability of trauma-informed organizations.

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1.5 ECOLOGICALLY BASED FAMILY THERAPY FOR ADOLESCENTS WHO HAVE LEFT HOME

Laura Cully, Qiong Wu, & Natasha Slesnick

CONTEXT & EVIDENCE

Adolescents who access shelters have usually experienced high levels of family conflict and a lack of family support (Ferguson, 2009; Tyler, 2006). Their home environments are often characterized by instability, including a lack of parental protection, chaos in the household, and substance use among family members. Moreover, these adolescents often experience maltreatment, including verbal, physical, and sexual abuse, as well as emotional neglect and rejection (Ferguson, 2009). Studies report that 50% to 83% of youth who are homeless have experienced physical abuse and 17% to 39% have experienced sexual abuse (Edidin, Ganim, Hunter, & Karnik, 2012; Gwadz, Nish, Leonard, & Strauss, 2007). The problems youth face at home are often motivators for leaving home and a barrier to returning. This means that including the family in intervention efforts can optimize positive outcomes.

A family systems approach to intervention understands individual problems as symptoms of the larger interactional problems among family members (Karabanow & Clement, 2004). Although adolescents who have left home report high rates of anxiety and mood disorders and substance use (Pollio, Thompson, Tobias, Reid, & Spitznagel, 2006; Slesnick & Prestopnik, 2005; Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009), very few actively seek formal treatment. Barber, Fonagy, Fulth, Simulinas, and Yates (2005) reported that 22% of adolescents seeking services at shelters accessed mental health services and 6% accessed substance use treatment services. The primary goal of these shelters is to reintegrate adolescents into their homes (U.S. Department of Health and Human Services, 1974). The majority of youth who seek these services return home (Peled, Spiro, & Dekel, 2005; Thompson, Pollio, & Bitner, 2000; Thompson, Safyer, & Pollio, 2001). Family therapy has shown promise in improving family interaction patterns that underlie family conflict (Zhang & Slesnick, 2017) and in easing the transition of adolescents back into the home (Slesnick & Prestopnik, 2005). Studies also indicate significant improvements in individual problem behaviours such as substance use and mental health issues as a result of family therapy (Carr, 2013; Meis et al., 2013).

Integrating family therapy interventions into the services of shelters can facilitate the mission of shelters to reintegrate and support family reunification, as well as ameliorating ongoing individual struggles. One family-based intervention called Support to Reunite, Involve and Value Each Other (STRIVE; Milburn, 2007) was tested with youth who were newly homeless, with the goals of reuniting families and reducing HIV risk behaviours. Compared with youth who received services as usual, those in the STRIVE intervention showed significant reductions in sexual risk behaviour, substance use, and delinquent behaviours (Milburn et al., 2012). Another intervention, ecologically based family therapy (EBFT; Slesnick & Prestopnik, 2005), uses a family systems orientation and was developed for adolescents in shelters (Slesnick, Guo, Brakenhoff, & Bantchevska, 2015; Slesnick & Prestopnik, 2005, 2009). The intervention has been rated as a promising evidence-based practice by the National Institute of Justice (2014) and as a supported evidence-based practice by the California Evidence-Based Clearinghouse for Child Welfare (2016). Studies report that the treatment effects observed for substance use and behavioural problems last longer for youth receiving EBFT compared with those receiving motivational or behavioural individual treatment (Slesnick, Erdem, Bartle-Haring, & Brigham, 2013; Slesnick, Guo, & Feng, 2013). Moreover, family functioning has been found to be significantly improved for families in EBFT compared with those undergoing individual treatment (Guo, Slesnick, & Feng, 2016). Caregivers of adolescents who have left home have shown reductions in depressive symptoms after attending family therapy with their child (Guo, Slesnick, & Feng, 2014). These studies provide evidence for the superior effects of family therapy over non-family interventions.

OVERVIEW OF ECOLOGICALLY BASED FAMILY THERAPY

In general, differences between specific family systems therapy approaches on family and individual outcomes have not been observed, likely because these therapies share an underlying theoretical orientation. Conceptually, EBFT considers the bidirectional influence between mother and child from a family systems perspective. Family systems theory suggests that substance use and related problem behaviours depend on interactive processes within the family system, and that every family member influences and is influenced by other family members (e.g., Bowen, 1974). The concept of mutually interactive processes between parents and children is similarly highlighted in Bell's (1971) control system theory and Patterson's (1982) coercion model. These theoretical models provide a conceptual guide for research, and a significant amount of empirical evidence

supports a closely linked bidirectional relationship between parental psychopathology and child maladjustment (Connell & Goodman, 2002; Kane & Garber, 2004), especially during adolescence (Gross, Shaw, & Moilanen, 2008).

Although this chapter describes EBFT, it is likely that other family systems therapies, regardless of their emphasis, would result in similar positive benefits for adolescents and their families. Typical of family systems therapy, running away (or being pushed out of the home) and related individual and family problems are considered to be nested in multiple interrelated systems. That is, while the family system is considered the most powerful influence on individual members, other systems overlap to create or relieve stress (e.g., school, work, neighbourhood), affecting individual and family adjustment. Although EBFT includes case management to address the systems impacting the family, we focus on the family systems therapy component of EBFT and present commonly observed themes in working with families with an adolescent who has left home.

INTERVENTION COMPONENTS

SESSION LOGISTICS

EBFT involves 12 sessions of family therapy that run for 50 minutes. Frequent meetings early in therapy capitalize on the momentum of motivated family members to meet and work through the crisis of the child leaving home. Treatment is most often provided in the family's home or wherever the youth might be residing (e.g., shelter, foster home). If family members are reluctant to have the therapist come into their home for the sessions, the family should be invited to meet at the clinic.

TRAINING

Thorough training in EBFT involves reading materials, discussion, role play, and co-therapy opportunities with debriefing. New therapists should learn both the theoretical rationale and practical application of EBFT techniques before they conduct their first independent therapy session. Comprehensive training can help increase treatment adherence and competence. Typically, the most difficult aspect for therapists learning family systems therapy is

developing a relational frame, including implementation of relational interventions. That is, the therapist must consider that the individual problems can best be understood and addressed when they are examined from a relational lens. Therapists must be adept at being able to guide family members to this new way of thinking.

ENGAGING ADOLESCENTS & PRIMARY CAREGIVERS

Most adolescents are not seeking psychological services or therapy when they enter a shelter. This means the therapist should not discuss the intervention as therapy. Instead, the therapist taps the youth's motivational goals to facilitate engagement in the intervention. Being called an advocate or ally better describes the therapist's role in the intervention. The advocate supports youth around various issues, for example, school, criminal justice–related problems, and family relationships. To increase engagement, the advocate allows the youth to take the lead and emphasizes the advocate's role as an ally.

Parents or other primary caregivers may be reluctant to meet with the therapist and child given their own substance use problems, negative experiences with the mental health or social services system, and marital or financial stressors. They may feel hopeless, angry, or fearful of being blamed for the current situation or the child's problems. The therapist must take caregivers off the hook by telling them that they will not be blamed for the situation. It can then be explained that the advocate needs their assistance to help the child, and that the child has requested assistance. If the caregiver (or child) refuses to meet together, separate meetings should be scheduled to continue the negotiation process until the family is ready to meet together.

FAMILY THERAPY TECHNIQUES

Instead of considering the adolescent or the caregiver as the problem, the therapist helps the family consider that no one is to blame for the problems. Family therapy uses several techniques to create this shift in thinking among family members. In general, these techniques offer new interpretations of people and events. For example, reframing and relabelling offer a less negative view of a behaviour (e.g., "Maybe John acts that way because he doesn't know any other way to tell you he is worried about you?"). Perspective-taking develops empathy (e.g., "When you say that, how do you think John feels?"). Relational interpretations and

questions draw attention to relational patterns (e.g., "Perhaps you question your ability to hold the family together when John does that?"). The focus of sessions should be on the relationships among family members, ineffective communication, and how harmful strategies or behaviours are used to meet family members' emotional and interpersonal needs. The early sessions focus on developing caregivers' and adolescents' readiness to tap or renew the underlying bond of love and care that can open the way for change. When family members begin to understand problems as residing in family interaction, they are more open to learning and implementing problem-solving and communication skills to resolve conflicts.

COMMON THEMES AMONG FAMILIES

In our work with youth who have left home and with their families, we have observed common situations. In this section, we describe these situations and suggest ways to intervene.

LEAVING THE SHELTER OR HOME

Some adolescents leave the shelter or the home to which they returned after the shelter because of interpersonal stress or family conflict. Other youth leave to spend time with a boyfriend or girlfriend, while others leave with a group of friends. Caregivers can have different reactions. If leaving is not a common event, caregivers might feel terrified, fearing for the child's safety and hoping for an expeditious return home. They might call the caregivers of the child's friends or search for the child in popular hangouts. The therapist should provide support and set up an emergency meeting. This includes addressing caregiver guilt and fear. It also means advising caregivers to call the therapist when the child comes home so a transitional meeting can be arranged. In most cases, caregivers are asked not to discuss the episode until this meeting occurs in order to prevent further conflict, and to maintain the child in the home.

Finally, the therapist should try to obtain permission from the caregiver in the first or second session to allow the adolescent to call the therapist in confidence should the adolescent leave. In most cases, the caregiver will agree to this; in turn, the adolescent will usually agree to let the therapist tell the caregiver that the adolescent is okay. In this way, the therapist can ensure the adolescent is safe and intervene with permission.

TRANSITIONING BACK INTO THE HOME

When the child returns home from the shelter, many families have described a period of peace and harmony. This honeymoon period is often followed by the same troubles and conflicts that occurred before the child left home. The therapist must explore expectations of both caregivers and their child. Caregivers often expect their child to stay in school, abide by an established curfew, and remain free of alcohol and drugs. The child, on the other hand, might expect more freedom and respect from caregivers. If the caregiver or child does not meet the other's expectations, the therapist must facilitate negotiation and compromise by having family members practise perspective-taking, communication, and problem-solving skills.

Problem solving, communication, and coping skills training are also vital when expectations are established and not met. Anger management, including being able to leave the situation and return when emotions are calm, is often a prerequisite to addressing conflict and disappointment. Negative interaction patterns often develop over a long period of time and require redeveloping trust among family members, reconnecting to underlying love and care, practising new skills, changing family members' negative attributions, and having patience. When conflicts occur and the family has not yet reached the necessary non-blaming interpersonal frame, the family should be encouraged to discuss the problem only in therapy. Depending on the nature of the situation, the family can be advised to call the therapist for an emergency session if the issue cannot wait until the next scheduled meeting. For some families, conflict leads to extreme confrontation and to the youth leaving home. Scheduling a therapy session can reduce this possibility and increase the chances that all family members will address conflict and disagreement in a collaborative, problem-solving manner.

CAREGIVERS UNDER INVESTIGATION FOR CHILD ABUSE

If the youth's primary caregiver is under investigation for abuse, the therapist must contact the social worker assigned to the case prior to the first therapy meeting to ensure treatment is appropriate. In some cases, the caregiver is not allowed contact with the child during an investigation. In other cases, treatment is recommended, which requires coordination with the social worker. The social worker might have a plan for the adolescent, and the therapist can help prepare the adolescent and family for it. The plan might include the adolescent returning home or transitioning from the shelter to foster care or to a group home. None of these options necessarily preclude continued work with the youth and caregivers.

Information during a therapy session might reveal that the caregiver has struck or otherwise assaulted the child. Local laws likely require that child protective services be contacted within 24 hours. In less severe cases, if the family consistently participates in treatment, child protective services might follow the family's progress and consult the therapist about the potential for harm of the child.

CAREGIVER REFUSAL TO ALLOW CHILD TO LIVE IN THE HOME

Some caregivers have reached the point where they no longer want their child to live in their home. When authorities become involved, these caregivers might be officially charged with abandonment. If guardianship is removed and no other relatives wish to take it over, the child is placed in state's custody and might be put in foster care. In our experience, without abuse or neglect charges, this is rare. Other options for the child include transitioning into an independent living program (minimum age is usually 16) or being placed in a group home.

Many caregivers with whom we have worked have felt hopeless, frustrated, and angry with their child. They have said they did everything they could for their child and no longer want to be involved in the child's life. Caregivers may be reluctant to have the child back home for various reasons:

- Fear for their own or another family member's safety;
- Fear that the child will negatively influence other children in the home;
- Fear that the caregiver cannot handle the child any longer; and
- Belief that the child would be better off without the caregiver.

Encouraging caregivers to meet alone with the therapist can provide an opportunity for them to vent these emotions and discuss reasons for not wanting their child back home. At some point in the discussion, the therapist should encourage caregivers to meet with the youth and therapist together, without the goal being to transition the youth back home. This serves to respect caregivers' wishes and also opens the possibility of addressing miscommunications, frustrations, and hurt emotions between caregiver and child. Paradoxically, we have had much success in transitioning youth back into the home when a caregiver initially refused to consider the possibility.

IMPLEMENTATION CONSIDERATIONS

We have identified process themes in working with youth who have left home and with their families. The following section describes strategies for addressing common themes that emerge in implementing family therapy with these youth and their families.

YOUTH OR CAREGIVER OFTEN CALLS THERAPIST WITH CRISES

Youth and caregivers can develop a strong connection with their EBFT therapist based on respect and trust. Caregivers often consider the therapist as someone who can help them care for their child and might call the therapist for assistance. Caregivers who feel powerless to influence their child may seek other supports to help them with family management.

Caregivers who call the police during crises with their child should call the therapist instead, except when the crisis involves violence or life-threatening situations. This strategy increases caregivers' confidence and skills in resolving family disputes. A therapist who is called for assistance directs the family to apply the communication and problem-solving skills learned in the sessions to address the current situation. As treatment progresses, the family should be able to resolve conflict without the therapist's assistance.

YOUTH REFUSES TO TALK IN SESSION

It is not uncommon for youth to refuse to talk in therapy sessions. For some, this indicates a reluctance to participate in therapy. For others, it suggests a lack of trust or comfort with the therapist, caregiver, or both. Therapists often feel frustrated when youth remain silent during a session. They wonder whether to allow that silence, do most of the talking themselves, or even end the session early. Many therapists describe struggling in vain to find a topic the youth will open up to. The session becomes nothing more than a series of questions posed by the therapist, met with mere nods or brief answers from the youth.

EBFT therapists have various options for working with quiet youth. The "ungame" is a therapy card game that helps youth open up and provides a format for addressing therapeutic issues. Art boxes are also useful forums for expressing thoughts and feelings nonverbally.

Out-of-office activities include playing basketball or similar sports that can break the ice for many adolescents who are not initially comfortable sitting face to face with a therapist. Taking the youth to fast food restaurants or for ice cream is another strategy to increase comfort and normalize the therapeutic relationship. When the client becomes more comfortable with the therapist, therapy can move indoors, which might be easier for both the adolescent and therapist to discuss relevant issues. Our program does not advocate sitting in the room with quiet teens. Attempting to force communication or sitting in silence with an adolescent client has limited utility. While silence can be a very useful tool for discussing relationship issues, including intimacy and the therapeutic relationship among adult clients, we have not found it particularly useful as a tool for adolescents.

FAMILY CHAOS WHEN MEETING IN THE HOME

Some families have become accustomed to high levels of chaos in the home, such as several family members talking at once, phones and doorbells ringing, children running through the living room, and caregivers doing several things at once. Although a guest in the client's home, the therapist is there to facilitate important work. The therapy process will be well served by the therapist prefacing the first meeting with the importance of the work the family has come together to do. Doing this work requires that all participants devote their attention to the session. This means turning off phones, not answering the door, preparing drinks or food before the session begins, and staying in the room for the entire session. The therapist must strive to maintain the same controls and professional boundaries that would exist in a clinical office.

The therapist must also maintain an atmosphere of calm and safety for highly chaotic families. Although family members will disagree with one another, the therapist must not allow clients to raise their voice in the session or talk over one another. Family members should not be allowed to criticize, blame, or otherwise demean one another in the session. Allowing these behaviours perpetuates a negative interactional style that will not facilitate positive interpersonal change. In addition, it is likely that the family will discontinue sessions because the therapy will be perceived as unsafe and not useful.

Within volatile or chaotic families, one family member might leave the therapy room abruptly and angrily. That person should be encouraged to return to the session and discuss the situation. For some, leaving the room is an appropriate coping response and might be

an improvement over other coping behaviours. That is, some clients might not have the necessary anger management skills to be able to calm themselves down during the session, and leaving is an adaptive way of preventing a "blow out" in the session. Taking a time out is a practical problem-solving strategy in the home, and can be occasionally tolerated in therapy. However, the goal is for clients to calm themselves without leaving the room, and to be able to articulate their frustration to other family members. It is incumbent upon the therapist to determine at what point the client should be encouraged to remain in the room and walk through the steps for discussing the issue at hand in a productive way, rather than being allowed to leave the room.

OTHER CONSIDERATIONS

The safety of family members must always be assessed because having family members together when there is the threat of abuse could be countertherapeutic and unsafe. This concern aside, it is difficult to identify a family situation or presenting problem in which EBFT would not be appropriate. When family members blame other members for their suffering and the suffering of the family, the therapist must work to reframe the cognitive set of the family member until everyone begins to see that the behaviours are interconnected and that each member influences and is influenced by the others. Furthermore, EBFT can be integrated with other evidence-based approaches for treating specific problems, such as emotional dysregulation, self-harm, or suicidal behaviours (e.g., dialectical behaviour therapy), although the efficacy of such integration has not yet been empirically investigated.

CONCLUSION

Family systems therapy reconnects families to underlying bonds of love and care, and guides families toward considering problems in terms of the relational system rather than as a result of individual deficiencies. As such, family therapy addresses many of the risks associated with leaving home. It resolves the current crisis and prevents future ones. Because therapy involves all family members, positive outcomes extend beyond the youth who has left home to include improved interaction and individual functioning among siblings and caregivers. Although family systems therapy is not always offered by community-based programs, the time and cost of additional training and supervision are likely offset by the benefits observed for individuals, families, and society in general.

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1.6 CRISIS RESPONSE WITH STREET-INVOLVED YOUTH

Nicole Kozloff, Yvonne Bergmans, Carolyn Snider,
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INTRODUCTION

Youth who are under-housed or street involved can experience crises that include injury by violence, aggressive behaviours, and thoughts of suicide. These crises can be challenging and frightening not only for the youth experiencing them, but also for service providers who work with these young people. Using a strength-based approach during a crisis helps youth develop personal agency. Personal agency refers to the sense of having control over one's own outcomes (Jeannerod, 2003). Even in the face of shaming messages telling them they cannot change, most street-involved youth are extremely resilient and resourceful. We support them in developing personal agency when we help them make their own changes rather than make changes for them. For example, guiding youth along the decision path toward finding safe shelter, supporting them in taking the key steps themselves, accompanying them as they make the arrangements, and celebrating their success go a long way in helping youth build the skills and confidence necessary to address future risks and crises. Furthermore, promoting personal agency strengthens self-esteem, which is a buffer against a range of negative outcomes in youth who are homeless (Kidd & Shahar, 2008).

This chapter describes basic strategies service providers can use to keep themselves, their clients, and other clients as safe as possible during a crisis. It also discusses how at the same time service providers can affirm clients in their strength and resilience in surviving, and assure them that they will be supported, not abandoned.

INTERVENTION COMPONENTS

INJURY DUE TO VIOLENCE

Violence is the most common reason youth aged 12–24 visit an emergency department and is the leading cause of hospitalization among males aged 20–24 (Macpherson et al., 2005). The incidence among street youth is even higher: one quarter report having been a victim of violence (Boivin, Roy, Haley, & Galbaud du Fort, 2005). Youth injured by violence are at high risk of a subsequent, potentially more serious injury. Over 20% will be injured again within the next year (Parveen & Snider, 2013). A more recent shift to a victim-based approach frames youth violence as a public health issue, rather than a criminal justice one.

For many youth, an injury due to violence can be a turning point. Johnson et al. (2007) found that youth injured by violence are often in a reflective state of mind and are receptive to making changes in their lives. This often can be achieved with the support of a compassionate helper. To take advantage of this receptive state, intervening as early as possible helps to build a relationship with the youth. Some hospital-based intervention programs for youth injured by violence include support workers who meet the youth in the emergency department or inpatient unit to begin developing a relationship (Purtle et al., 2013; Snider & Lee, 2009). Key to intervention is meeting with the youth as soon after the injury as possible, regardless of the organizational framework or whether this is a new or existing relationship.

Early in the crisis, the helper must work with the youth to develop a safety plan. Key discussions include how safe the youth feels, where the youth will be staying after hospitalization, the safety of other residents and staff if they are living in a shelter, and the potential risk of retaliation or "unfinished business." In some cases, the youth may require relocation. The de-escalation strategies introduced below can be used for discussions about retaliation. In some cases, you and the youth may feel it is appropriate to involve the local police to ensure personal safety and that of others. Youth should make the disclosure, with your support, whenever possible, to ensure the bond between you remains and to replant the seed of personal agency even when the youth has been victimized.

The youth's potentially more receptive state during crisis can be a good opportunity to begin a relationship with the helper, or to deepen an existing one. Within this context, risk factors contributing to the injury can be addressed. The wraparound care framework

used in many programs places at-risk youth at the centre of care, and it is they who define what puts them at risk (National Wraparound Initiative, n.d.). Risk factors include a lack of safe shelter, food insecurity, addiction, mental health problems, lack of schooling or work, gang involvement, and family conflict. The helper and the youth work together to develop a system of support for each identified risk factor. Initially, it is important to concentrate on basic needs such as food and shelter; however, over time, longer-term goals can be addressed. Working with youth to change risk factors within their control reduces the likelihood of future violence (Simun, Slovacek, Batie, & Simun, 1996; Spergel & Grossman, 1997).

AGGRESSION & DE-ESCALATION

Aggression includes threatening behaviour and language, harassment, verbal abuse, and physical attacks. It is not uncommon among youth in general, and street youth may be at elevated risk: as many as 62% report a history of severe aggressive behaviour (Booth & Zhang, 1996). While official counts of aggressive incidents involving care practitioners are difficult to determine, they are likely rare. More often, youth become aggressive with one another, and intimate partners are at particular risk (Petering, Rhoades, Rice, & Yoshioka-Maxwell, 2015). It is important for practitioners to be aware of risk factors for aggression, and to understand the aggression cycle and de-escalation techniques that can be used with street youth.

Street youth have often experienced childhood trauma, including sexual and physical victimization (Tyler, Kort-Butler, & Swendener, 2014). Unfortunately, they may internalize aggression as a way of managing unpleasant emotions and coping with their environments. Risks for violence among street youth include a history of arrest and conviction (Booth & Zhang, 1996), and substance use or intoxication (Martin et al., 2009; Petering et al., 2015). The time of highest risk is in the late hours of the night or early hours of the morning (Canadian Centre for Occupational Health and Safety, 2012).

Prevention is key to decreasing aggression in street-involved youth, and those with mental health challenges must have access to supports before a crisis develops (Paton et al., 2016). Using weighted furniture and minimizing clutter help create a safe environment, thereby reducing incidents of aggression. For your personal safety, notify colleagues of your whereabouts, meet higher-risk clients in pairs, and pay attention to your own sense

of safety (Canadian Centre for Occupational Health and Safety, 2012). Furthermore, consider your attire, avoiding long earrings and necklaces, ties, and ID badge strings that can be pulled. ID badge strings with safety clips that break open with pressure are a good alternative. For youth, anger management skills and specific skills for tolerating distressing situations and emotions can help them better manage aggression.

Aggressive behaviour can arise out of emotions such as anger, shame, frustration, and guilt, and often has an unnamed need attached to it. Violent behaviour can cycle through phases of escalation, explosion, and post-explosion (Walker, 1980). You may recognize that a youth is in the escalation phase by paying attention to verbal cues (e.g., swearing, yelling, threats) and non-verbal cues (e.g., pacing, hand-wringing, door-slamming). De-escalation strategies using a range of psychosocial techniques can stop the aggression cycle. Parker and Baker (2012) have identified common themes among de-escalation programs (see Table 1.6-1).

TABLE 1.6-1: COMMON THEMES OF DE-ESCALATION PROGRAMS

DE-ESCALATION COMPONENT	EXAMPLES
Characteristics of effective de-escalators	Appearing supportive, non-judgemental, non-threatening; expressing genuine concern
Maintaining personal control	Appearing calm can help both the youth and you make more effective decisions
Verbal and non-verbal skills	Using a gentle tone of voice, awareness of body language, active listening, careful use of eye contact, care not to invade personal space
Engaging with the aggressive person	Promoting autonomy to demonstrate trust, encourage positive emotions and self-control; avoiding punitive approaches
When to intervene	Balancing early intervention with unnecessary intervention using knowledge of the street youth, meaning of the behaviour, impact on others
Ensuring safe conditions for de-escalation	Balancing adequate staff support with crowding; assessing the area for potential safety risks; moving to a quiet area away from others who are not involved
Strategies for de-escalation	Assessing the person's emotional state using listening and interpretation of non-verbal cues and formulating appropriate interventions that balance support and control proportionate to current risk

Specific techniques that can be used in de-escalation are discussed in the "Implementation Considerations" section. Staff should receive regular training in an accredited program; for example, the Crisis Prevention Institute offers training (www.crisisprevention.com). Understanding and Managing Aggressive Behaviour training is also available (www. umabcanada.com).

There will be situations in which the youth's behaviour poses a risk of harm to others and cannot be managed with verbal de-escalation. In these cases, know your organization's protocols for obtaining external supports, whether it be from trained security guards, crisis services, emergency medical services, or police. After the incident, debriefings with the following people can be helpful:

- Fellow practitioners: to manage staff reactions and help prevent further such events;
- Other youth who were present: to support those who may have their own experiences of trauma and victimization and feel triggered by the event; and
- The aggressive youth, once calm: to identify antecedents to the behaviour and what the youth and the people around him or her could do differently in future situations.

SUICIDE

Hearing a youth tell you "I just want to die" is scary and the first thing helpers often want to do is make it better or make the thoughts go away. Feeling trapped, scared, desperate, or hopeless is not unusual for the person experiencing suicidality, who also wants it to "just go away" (O'Connor & Nock, 2014; O'Connor, Smyth, Ferguson, Ryan, & Williams, 2013; Taylor, Gooding, Wood, Johnson, & Tarrier, 2011).

For youth who are homeless, various experiences can contribute to thoughts of worthlessness, to a feeling that life as they know it "will never end," and to thoughts of suicidality. These experiences include stigma, adversity, poverty, and victimization arising from maltreatment; being considered "different" in terms of gender identity, sexual orientation, and race; and feeling disconnected from family and friends (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; da Silva Cais, Stefanello, Fabricio Mauro, Vaz Scavacini de Freitas, & Botega, 2009; Dieserud, Gerhardsen, Van den Weghe, & Corbett, 2010; Hadland et al., 2015; Kidd, 2004, 2009; Mereish, O'Cleirigh, & Bradford, 2014; Sinclair, Hawton, & Gray, 2010; Wong et al., 2008). Feelings of rejection, abandonment, helplessness, fear, and exhaustion, and efforts of surviving the streets are not unusual.

Using alcohol and drugs, non-suicidal self-injury, and thinking about suicide or making suicide attempts can be ways to cope with or communicate the deep pain and scary thoughts for which there are no words (Butler & Malone, 2013; Sinclair & Green, 2005). As a result, street-involved youth are at high risk of dying by suicide, substance misuse, and violence (Roy et al., 2004).

Understanding suicidality as arising from a core of emotional pain or "psychache"—the unbearable and unresolved psychological pain a person experiences—helps to contextualize an understanding of suicidality (Shneidman, 1993; Sledge et al., 2014). Taking it a step further, the person experiencing the suicidal crisis often does not have a language or understanding of the experience outside of intense feelings that need to be discharged (Bergmans, Gordon, & Eynan, 2017), often through anger (Kidd & Carroll, 2007), whereby "undifferentiated states of high emotional arousal—unstoried emotions—are almost always experienced as disorganizing, distressing, and frightening" (Angus & Greenberg, 2011, p. 21).

Non-suicidal self-injury involves harming oneself with no intent to die (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014). It is a risk factor for a subsequent suicide attempt; however, not everyone who self-injures will go on to make a suicide attempt (Butler & Malone, 2013). Reasons for non-suicidal self-injury are unique to each person, and understanding the meaning and intent from the person's perspective is critical. The behaviour might offer relief, provide a sense of control when the person feels powerless, regulate emotional intensity, communicate of internal distress, or perhaps serve as punishment for being "bad" or "different" (Centre for Suicide Prevention, 2016). It may also be suicide "prevention" or the early stages of trying to cope with making the thoughts of ending one's life "go away." Helpers can make statements that show concern and validation, and that help youth understand the potential consequences of the behaviour; for example, "It looks like you're really hurting inside and I wonder how self-injury is helpful for you?" or "I worry that this behaviour is going to hurt you in a way you may not intend." Similarly, recognizing substance use as a coping strategy can help remove the judgement, blame, and stigma of being an "addict." Asking youth what substances do for them can identify the role of substances in coping or providing the "chemical courage" needed to make a suicide attempt; risk of an attempt increases when depressive symptoms and alcohol are combined. Asking youth if they think they will make a suicide attempt can gauge risk for future attempts.

Suicide ideation refers to thoughts of ending one's life (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Having suicidal thoughts does not mean the person will go on to suicide; however, such thoughts need to be discussed and assessed for risk (Klonsky & May, 2014, 2015). For some, thoughts of suicide are about wanting to end the feelings, seeing no purpose or future for themselves, not wanting to live "like this," taking control, or finding some peace (Bergmans, Langley, Links, & Lavery, 2009). Asking youth what they are trying to "end" or "kill," or what dying will do for them, will help to guide intervention. Being understood, listened to, and heard, and having someone "get" how awful they are feeling is often the need. Talking about hope and future during a crisis can be experienced as invalidating and showing you are not "hearing" the person. Holding your hope for the youth should be a silent intervention. In the words of one youth: "Quite frankly, I don't need your hope when I'm in that place. I need you to understand my hopelessness!"

A suicide attempt is an action associated with some intent to die; higher risk includes three key ingredients: intent, plan, and access to means. We cannot predict who will or will not die by suicide, but we do know that a previous attempt is the strongest predictor to another attempt and eventual death by suicide (Christiansen & Jensen, 2007; Haukka, Suominen, Partonen, & Lonnqvist, 2008; Jenkins, Hale, Papanastassiou, Crawford, & Tyrer, 2002; Wong et al., 2008). A youth may have intent and no plan, or intent and a plan with no means to engage in the plan. You do not know unless you ask. Asking about suicide will not "make" a youth suicidal (Gould et al., 2005). Questions to discern intent, plan, means, or previous attempts could include "Are you thinking of ending your life?"; "Have you thought of a way to end your life?"; "Do you have what you need to end your life"; "Have you ever tried to end your life before?" Given that the intensity of feelings comes and goes, education about reducing access to means is important. Access to means includes excess medications (hoarding/saving pills), having a rope or a gun, and fantasizing about a favourite bridge or rooftop. For some, surveying the area or trying to climb to an edge may be ways of "practising" and reducing the fear of making a suicide attempt. Reducing the fear of dying, a perception of not belonging, and isolation are known risk factors for making a suicide attempt. Often the youth may indicate ambivalence, being committed neither to dying nor living. This does not mean the person has no intent, or does not "really want to die." It is a position of truly not knowing if the person wants to die or live while experiencing the agony. Ambivalence is a state that cannot be taken lightly or ignored (Bergmans et al., 2009; Bergmans et al., 2017; Orbach, Jobes, & Tanney, 2008).

Supporting youth around suicidality

The ability to problem solve is often compromised when emotional crises hit (Williams, Barnhofer, Crane, & Beck, 2005).The intensity of the feelings have "flooded" the thinking part of the brain (Izard, 2002). Often, youth will have no words to identify or describe their emotions; their non-verbal language or behaviour will give you the information to begin the conversation about how terrible things are right now. Safety, validation, normalization, and giving words to the experience of suicidality are the beginning stages of intervention. When seeing tears and hearing statements like "I can't take it anymore," responses like "When I see those tears and hear those words, I can't help but think that the pain is so big and so bad that you're thinking it will never end" can be validating. Normalizing the experience might sound like "You're in a really hard place right now. It's only human to be feeling sad, angry, frustrated, helpless . . . ," using actual situations you know they have experienced. Simultaneously noting the strength and courage it takes to ask for help, survive when homeless, and cope with all the feelings and experiences taps into the person's inherent strengths. Reducing the sense of aloneness and instilling the possibility of hope in despair does not mean creating unrealistic expectations about what is to come. We cannot "make" thoughts of suicide go away; however, we can help youth identify that suicidal thoughts are warning signs that they are experiencing many intense emotions, all of which make sense given their current situation. Reminding them that neither feelings nor thoughts have ever killed a person, but that actions could, allows youth to begin to create awareness and skills to keep safer when they experience intense feelings and thoughts of suicide. Pointing out examples of the youth making safer choices and exhibiting moments of control reflects that you are paying attention. Identifying a genuine appreciation for the fact that they called you for help, are telling you this, that you know they are trying their best in difficult circumstances, lets them know that even when they are feeling they have no control and no choices, they have made safer choices by engaging in these actions.

Using the term "safer" when discussing choices takes away the judgements associated with the words "good" and "bad." Feelings too are neither good nor bad; they are part of the human experience and provide information. Understanding feelings as "comfortable" or "uncomfortable" may help neutralize youths' experience of the feeling. Educating them about the role of emotions might be helpful given that some may have learned that anger is bad or that they have no reason to feel sad when those are feelings connected to experiences over which they may have had little control. Equally as important is realizing that we can have several emotions concurrently. We can feel extremely sad or angry while enjoying chocolate ice cream or while feeling soothed by stroking a pet.

Reaching out is not easy for many youth who have been abandoned, rejected, or hurt, and who are reluctant to trust. They may feel shame or consider seeking help as a sign of weakness (Burke, Kerr, & McKeon, 2008; Everall, Bostik, & Paulson, 2006; Gilchrist & Sullivan, 2006; Wisdom, Clarke, & Green, 2006). Often, youth will minimize their symptoms to appear "normal." Being connected, having social support, and being able to process emotions contribute to an increased sense of agency and personal control for suicidal youth (Everall, Altrows, & Paulson, 2006).

Asking for trust from street-involved youth may be unrealistic. Consider starting from a position of "respect" for the knowledge gained from your experience as a helper, and recognize that there will be suspicion, hesitancy, and caution of "adults" and "professionals." It is not personal—it is a coping strategy.

Street-involved youth can be very transient, but knowing that someone listened and cared about what happened to them in the moment they were being listened to is held in the memory of many youth and can be impactful (Kurtz, Jarvis, Lindsey, & Nackerud, 2000). Small interactions, a skill, a language, a better understanding, and caring can be foundational moments. As long as it is safe for everyone, keep the door open to future conversations should the youth choose to return. It is challenging when someone tells you they want to end their life and then disappears. Concern, fear, and worry predominate in those situations. Talking with a supervisor about next steps to take is critical. Giving yourself permission to recognize what you do not know allows you to be curious and learn more. Sometimes we cannot predict when someone will try to end their life, despite all of our best efforts.

Whether suicidal crisis de-escalation occurs on the street, in a drop-in, or in a shelter, the ultimate concern is your safety, the safety of those around you, and the safety of the client. When a youth discloses suicidality, the ultimate preference is for a quiet space away from others. Sometimes this means a stairwell, a hallway, a bathroom, a park bench. If you leave the premises, make sure a colleague knows where you are and you have a safety check-in system. Sometimes a calm, experienced peer who "knows the pain" can be an incredible asset in the discussion as they will carry more credibility than "the worker." Do not be afraid to call for help. Dealing with a suicidal crisis is far easier when done in tandem with someone else.

Working with a youth who is thinking of, or threatening suicide, is to be taken seriously and assessed. It can be challenging and scary, and leave you feeling incompetent and useless. If you are uncertain, contact a medical professional for a formal risk assessment. Ignoring risk will not make it go away. Document your concerns, intervention, and follow-up plans, and discuss them with your supervisor. To do this work, we need to take care of ourselves through naming our feelings, reaching out to team members, obtaining regular supervision, and asking for consultation. Know that we cannot always prevent a suicide attempt; however, we can continue to believe in the worth and potential of youth after they have survived an attempt, and to believe there is a possibility they can engage with life and live more safely.

IMPLEMENTATION CONSIDERATIONS

Recognize that the more prevention and groundwork that can be laid before a crisis emerges, the greater the likelihood that the duration, frequency, and intensity of episodes will decrease over time. The following suggestions have been organized along the lines of the cycle of violence; however, they can be applied to any crisis situation. At any time, strategies may be interchangeable, or they may not be effective in a given situation for a particular youth. For example, the strategy of focusing on breathing can sometimes cause youth greater distress when they are beginning to escalate.

PREVENTION & DE-ESCALATION

- Reduce emotional arousal and build an alliance through validation: convey that the youth's responses make sense and are understandable within the youth's current life context or situation. Contextualizing and normalizing the experience by offering a name to it can let the youth know that the helper is engaged and paying attention (Linehan, 1993).
- Offer safe alternatives: suggest other activities, grounding strategies, and "face-saving" options, including negotiation of a mutually agreed alternative; positively reinforce non-violent behaviour.
- Facilitate expression: encourage youth to communicate feelings and experiences, and recognize the right to express anger provided the youth can do so without harming self or others.

- Teach grounding techniques: grounding keeps the mind and body connected and in the present; techniques can include naming items in the room, squeezing a stress ball, or saying "heel, toe" while walking.
- Anticipate explosion: ensuring safety for the youth and others is key and may involve removing bystanders or youth to a safe, quiet space and engaging with agency protocol for violence, for example, by involving security, police, or extra staff.

PREVENTION & DEBRIEFING

- Conduct a behavioural chain analysis: guide the youth through a step-by-step description of the chain of events leading up to and following the crisis. This can help test hypotheses about events relevant to generating and maintaining the behaviour, and explore its function and consequences (Miller, Rathus, & Linehan, 2007).
- Engage in shared problem solving: together with the youth, identify events leading to the crisis and determine what has worked before.
- Develop a safety plan (Stanley & Brown, 2012).
- Teach coping strategies and new responses to frustrating situations, and help youth develop distress tolerance skills (Rathus & Miller, 2015). Strategies can include:
  - Changing body chemistry to counteract disabling emotional arousal (e.g., practising paced breathing);
  - Distracting (e.g., activities like going for a walk or texting a friend, or intensifying other sensations by holding or chewing ice); and
  - Self-soothing with senses (e.g., watching a sunset, smelling freshly brewed coffee).
- Develop language for feelings and identify the needs that might be associated with those feelings.

Learning and practising these strategies when not in crisis can make them easier to identify and apply when youth recognize that they are beginning to escalate. This allows youth to take ownership of their own safety and that of those around them. Realistic expectations of availability and skill sets of people in a network are important—knowing who is good for what and when. Identifying expectations and possible outcomes to choices is key.

Working with youth in crisis can be stressful. Just as it is important for youth to identify who in their network can help with what, it is also critical for you to know who you can rely on for support, and the respective roles of the people in your agency in a crisis

situation. It can also help to be familiar with external resources in your community. Familiarize yourself with the standards for documentation and follow-up at your agency. Being prepared for a crisis will help you act more effectively.

KEY MESSAGES

- Walk beside youth as they work through their crisis and help them identify their own strength. A crisis is an opportunity to deepen your relationship and establish trust with a street youth.
- De-escalation techniques will help youth both during crisis and in future potential crises. Being knowledgeable of various techniques is important for the helper and the youth.
- Do not hesitate to involve other caregivers and professionals during a crisis. Ignoring the risk of escalation to repeat injury, aggression, and suicide will not make it go away.

RESOURCES

A suicide prevention toolkit: Self-harm and suicide (Centre for Suicide Prevention, 2016)
www.suicideinfo.ca/wp-content/uploads/2016/10/Self-Harm-Toolkit.pdf

Runaway & homeless youth and relationship violence toolkit (National Resource Center on Domestic Violence, 2013)
www.nrcdv.org/rhydvtoolkit/index.html

Why people die by suicide (Harvard University Press, 2005)

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PART 2

SPECIFIC GROUPS

2.1 SUPPORTING INDIGENOUS YOUTH EXPERIENCING HOMELESSNESS

Suzanne Stewart

INTRODUCTION

Indigenous peoples is a term used in Canada to describe three distinct cultural groups: First Nations (status and non-status Indians), Métis, and Inuit. There are approximately 1.4 million Indigenous people in Canada, representing about 4% of the country's total population (Statistics Canada, 2009). Over 40% are under age 24, and 28% are under 14 (Statistics Canada, 2013). The Indigenous population has become highly urbanized. Since the 1970s, there has been a large migration of Indigenous peoples from rural areas and reserves to cities. More than 600,000—54% of the total Indigenous population— live in cities—and the numbers continue to grow (Statistics Canada, 2009). Urbanized Indigenous youth are the largest and fastest growing youth demographic in the country (Statistics Canada, 2013).

The number of Indigenous people experiencing homelessness varies from city to city, but what remains constant is the significant overrepresentation of Indigenous peoples in the homeless population. Figures from Statistics Canada (2009) indicate a near crisis of homelessness and street-involvement among First Nations, Métis, and Inuit young adults; they represent 5%–60% of the homeless population in any given area. Some data show significant differences in rates of homelessness between Indigenous groups; for example, rates are higher among Métis and Inuit. In Toronto, Indigenous people make up 15%– 20% of the homeless population (City of Toronto, 2008). As the Indigenous community continues to grow, so does the number of young people on the homelessness spectrum. This ranges from youth who stay with friends or family while searching for housing (couch surfing) to those living on the streets (Stewart, 2016).

As a population, Indigenous peoples face multiple housing barriers that are rooted in centuries of colonization. Monette et al. (2009) highlighted this connection: "Aboriginal peoples, who share a common legacy of oppression and resilience, experience some of the worst housing conditions in Canada and have an exceedingly difficult time locating affordable housing" (p. 42). Housing barriers include poverty, lack of access to culturally

appropriate social services and housing, literacy issues, discrimination, addiction, mental health problems, and intergenerational trauma resulting from experiences with residential schools and the child welfare system. Systemic racism affects access to housing and supports (Monette et al., 2009; Walker, 2008).

HISTORICAL CONTEXT OF HOMELESSNESS AMONG INDIGENOUS PEOPLES

Indigenous homelessness has its roots in colonialism and the social determinants of health. Indigenous peoples in North America experienced a profound disruption to their ways of life when Europeans arrived. Prior to this first contact in 1492, the incidence of health and social problems among Indigenous peoples was low (Waldram, 2006). European contact brought a dramatic increase in physical and mental illness and social problems (Kirmayer, Boothroyd, Tanner, Adelson, & Robinson, 2000). Although more than 7 million Indigenous people inhabited North America before European contact, by 1600, almost 90% had died as a direct or indirect result of European settlement. Infectious disease was the major killer, followed by a change in traditional diet (Waldram, 2006). The legacy of colonialism continues today, with high rates of health problems such as diabetes and obesity (Kirmayer et al., 2000), chronic unemployment, low educational achievement, and homelessness linked to intergenerational trauma (Stewart, 2015).

Federal government policies that were established in the 1800s—and that are still in place today—attempted to destroy Indigenous cultures. These policies included the creation of land reserves and residential schools, child welfare apprehensions and adoptions, and strict bureaucratic control. The government forced Indigenous groups off their traditional lands and into government-created settlements, which often grouped bands that had no history of living together (Dickason, 1997). These arbitrary groups were forced to develop new social structures and sustainable ways of life. They were also relegated to land with little or no natural resources—land that was deemed unlivable for white settlers (Royal Commission on Aboriginal Peoples, 1996). This experience of forced homelessness is still felt today in the form of intergenerational trauma and its many effects, including poor mental health and precarious housing and homelessness (Stewart, 2015).

Before European contact, Indigenous communities had effective ways to prevent and treat illness and injury and manage social problems (Young, 1988). Housing and homelessness were not issues. Colonialist policies and practices transferred control of healing and other health and social practices to government-sponsored programs and institutions (Waldram, 2006). These Western medical approaches, which shifted the focus of healing from the community to the individual and from a holistic perspective to a deficit-based disease model, were foreign to Indigenous peoples. It is well documented that Indigenous people are more likely than non-Indigenous people to suffer serious medical complications or die while in the care of medical staff and hospitals; this problem is rooted in culturally unsafe practices by health practitioners that reflect racism and oppression (Smylie & Firestone, 2016).

Residential schools were one the most damaging and painful experiences for Indigenous peoples, and the effects continue to be felt today. The first schools were established in the 1800s by the federal government and were administered by Christian churches. Premised on the belief that Euro-Christian culture was superior, the goal of the schools was to eradicate Indigenous cultures and assimilate Indigenous peoples into the dominant culture: to "kill the Indian in the child" (Truth and Reconciliation Commission of Canada, n.d.). Children were forced from their families and placed in boarding schools, often far from home. Siblings were separated and children were forbidden to speak their native languages. Each child was given a Christian name. Some children were able to visit their families during the summer holidays, but others never returned home. Statistics about school attendance, completion, and deaths in the schools are sparse and unreliable because the federal government and the churches destroyed or hid information and survivors of the residential schools were warned never to talk about their experiences. Thus, official data may underestimate the number of children involved and the extent of the trauma they experienced. Records indicate that from the 1870s until the 1990s, about 150,000 children attended residential schools; at least 3,000 died, and the identities of 500 of these are unknown (Canadian Press, 2013). Diseases such as tuberculosis and influenza were a major cause of death, followed by malnutrition, drowning, and exposure. Many children were victims of physical and sexual abuse, and many died by suicide or from exposure when they tried to run away (Truth and Reconciliation Commission of Canada, 2015).

Although the residential schools are now closed, they have left a legacy of intergenerational trauma that extends beyond the survivors of the schools. Many children are born into families and communities that have been struggling with trauma and its social, economic, and health effects for years. When children were sent to the residential schools, leaving

entire communities with no children, parents and grandparents received no support for dealing with the grief and loss; the Indian Act prohibited traditional spiritual practices, which were punishable by incarceration or even death. An Indian Agent of the Bureau of Indian Affairs was assigned to each reserve to supervise residents and report violations of the Indian Act. Children in the residential schools also received no support in dealing with separation from their families and communities. Not only were these children stripped of their Indigenous identity; they also lost the opportunity to learn skills related to positive parenting and relationships, healthy eating, and substance use, and basic life skills they would need as adults to secure housing and manage money.

Historical child welfare system policies and practices are another colonial aggression that continues to affect the social determinants of health and well-being of Indigenous peoples. From the 1960s until the 1980s, about 20,000 Indigenous children were removed from their families by child welfare workers and placed in foster care or put up for adoption (Humphreys, 2015). The Sixties Scoop, as the practice has been called, resulted in the overrepresentation of Indigenous children in the child welfare system (Maurice, 2014). In 1977, Indigenous children accounted for 44% of children in care in Alberta, 51% in Saskatchewan, and 60% in Manitoba (McKenzie & Hudson, 1985). Children were placed with white families against the will of their birth families and communities, with little or no basis for apprehension other than being Indigenous. Children were cut off from their culture, identity, families, and communities; parents lost their children with no legal recourse (Maurice, 2014). In many cases, children were sent to adoption agencies in other provinces, or to Australia, Europe, and America. Birth certificates were locked in a federal government vault and made inaccessible to adoptees (Truth and Reconciliation Commission of Canada, 2015).

Residential school and child welfare policies and practices amounted to cultural genocide whose effects persist among Indigenous individuals, families, and communities. The many impacts—mental, physical, emotional, and spiritual—of these policies and practices can be understood as social determinants of homelessness. For Indigenous peoples, their journey toward homelessness began when they were forced from their birth families and communities.

HOMELESSNESS, IDENTITY, & BARRIERS TO HOUSING AMONG URBAN INDIGENOUS POPULATIONS

Being housed—or not—is one way we establish meaning and identity in our lives. It also affects domains that contribute to quality of life, such as work, school, and physical and mental health. Risk factors contributing to homelessness and street involvement in urban areas include Indigenous identity, being a member of an ethnic minority, living in a single-parent family, and identifying as female (City of Toronto, 2011; Menzies, 2009). In recent decades, many Indigenous people have moved to cities to access culturally based services and housing and to pursue work and educational opportunities (Belanger, Weasel Head, & Awosogo, 2012; Gaetz, 2010; Wente, 2000). However, many youth who migrate do not access services that are available for them, and instead become involved in a street lifestyle (Canadian Mortgage and Housing Corporation, 2001). Many end up homeless, which takes them even further from their traditional cultural identities. Street life often pulls these young people into the sex trade and into substance use and addiction (Ward, 2008).

Many barriers exist to supporting street-involved Indigenous youth. A study that involved in-depth interviews with urban Indigenous people who had experienced homelessness or were currently homeless revealed major issues around accessing mental health and social services (Stewart, 2016). These issues included racism and stigmatization, conflicting mainstream and Indigenous approaches to health and healing, concurrent disorders, and a need for harm reduction services in homeless shelters and transitional housing. A strong relationship between homelessness and multiple oppressions such as racism was revealed through reports by Indigenous people who accessed shelters and mental health services that they were denied housing. They also reported being stigmatized based on mental health and substance use—the stereotype of the "drunk Indian." These findings support those of an earlier study which found that Indigenous identity and substance use or mental health problems were barriers to housing (Stewart et al., 2013).

A tension exists between Indigenous cultural protocols and the harm reduction approach within the shelter system (Stewart, 2016; Stewart et al., 2013). Indigenous people report a need for a continuum of harm reduction services in shelter and housing services, which ranges from wet shelters, which allow alcohol and drug use, to abstinence-based shelters (Stewart, 2016). It is important for Indigenous Elders and healers to recognize that some people will not be able to follow cultural protocols around substance use and engaging in cultural practices, for example, having to be abstinent for a few days to attend a traditional

ceremony. Elders and healers must work with Indigenous people wherever they are at with respect to substance use and their healing journey because engaging with the culture is often the mechanism for healing and recovery, and for moving out of homelessness.

In 2009, the City of Toronto conducted a street needs assessment, whose results indicated a need for an Indigenous homelessness strategy, which would involve increasing research and funding to improve Indigenous-specific services. Such a strategy would reduce the number of Indigenous youth at risk of or experiencing homelessness. Research has found that tailored programming is effective, but it has had limited success in Toronto (Belanger et al., 2012). This may be due to limited implementation encapsulating Indigenous knowledge; that is, failing to reflect the population's needs, perceptions, and preferences around a homelessness prevention strategy that acknowledges Indigenous peoples' unique histories and social determinants of health (Stewart et al., 2013).

HOMELESSNESS & HEALING

Healing from mental health and addiction issues is a big challenge facing Indigenous people who are homeless. There is a strong relationship between homelessness, healing from the trauma of colonization, and recovery from mental health and addiction issues. Many Indigenous people explain that they ended up on the street as a result of complex issues that include poverty, physical disability, emotional distress, and intergenerational trauma, and that substance use often is a way to cope with these stresses (Stewart et al., 2013). Substance use is also a way to connect and relate with others and to create community and belonging—essentially, a spiritual and cultural home (Stewart, 2016). What makes recovery unique for this population is that it often involves engagement with cultural communities and reconnecting with Indigenous identity. Ultimately, successful housing is related to recovery from addiction and mental health issues, which, in many cases, correlates with the development of cultural identity.

INTERVENTION COMPONENTS

Culturally appropriate mental health and addiction interventions for Indigenous people experiencing homelessness are based on a paradigm shift away from mainstream concepts of health and well-being to a holistic framework that emphasizes relationships. Mainstream

approaches to counselling, such as cognitive-behavioural therapy and motivational interviewing, have shown success with Indigenous clients when they include several key components: these culturally adapted interventions are culturally based, are grounded in a holistic framework, focus on relationships, and incorporate cultural context into mental health assessment (Rowan et al., 2014).

CULTURALLY BASED INTERVENTION

Cultural connection promotes healing among Indigenous people. It needs to be formally included at all levels of mental health and addiction service (e.g., programs, interventions, research, policy). Providing culturally based services means understanding that Indigenous and mainstream approaches to health and well-being differ in some ways and finding points of convergence from which to develop or adapt services. Incorporating an Indigenous worldview into interventions can strengthen the therapeutic alliance, reduce treatment dropout rates, improve outcomes, and support client change. While practice will vary across professional settings, what remains constant is the need to create space for respect and to deliver interventions that reflect Indigenous worldviews and approaches to healing. This can be challenging because there are fundamental differences between Indigenous and mainstream approaches to working with clients. For example, in contrast to the mainstream therapeutic dyad, which involves the client and the therapist, it is rare for an Indigenous Elder or healer to work with a client in isolation; rather, Indigenous healing often includes the extended family and community to promote the interconnectedness necessary for good mental health (Duran, 2007). This way of working is challenging in typical mental healthcare settings, where rigid rules exist about client confidentiality and family involvement in treatment. With the emphasis that Indigenous cultures place on community, another challenge in treatment is working with clients who are not in touch with their birth or adoptive family, or are not connected to an Indigenous community, be it their own or one that exists nearby. However, it is important to seek opportunities to include important community or family members in assessment and treatment despite any barriers.

DEVELOPING A HOLISTIC FRAMEWORK

Hybridism is an epistemological model that has emerged out of postcolonial thinking. It acknowledges that there can exist two or more ways of knowing, without one having to dominate the other. In a healthcare context, hybrid treatment interventions integrate mainstream and Indigenous paradigms and practices of healing (Duran, 2007). It means bringing together the best of differing worldviews or practices to best meet clients' needs. For example, a hybrid approach acknowledges spirituality, a component of healing that is missing from mainstream mental health interventions (Stewart, 2008). Practitioners of hybrid approaches do not merely demonstrate cultural sensitivity; they are actually able to think in both mainstream and Indigenous ways. In practice, mental health professionals create a space where the expression of different ways of knowing and healing is accepted as valid and equal. Hybridism allows the practitioner and the client to jointly explore the client's identity, culture, and worldview in order to clarify the client's needs and determine the appropriate interventions for facilitating healing. Essentially, bringing together the strengths of each perspective culminates in a holistic approach to addressing the client's needs (Duran, 2007).

FOCUSING ON RELATIONSHIPS

Building relationships is an important component of culturally based interventions with Indigenous people. By demonstrating empathy and positive regard and by using appropriate humour, practitioners forge trust with clients. Self-disclosure can be another way to strengthen the therapeutic relationship because Indigenous cultures value reciprocity. This disclosure, of course, should be guided by professional ethics to ensure it is used to promote the therapeutic alliance, not the practitioner's own needs.

ACKNOWLEDGING CULTURAL CONTEXT IN MENTAL HEALTH ASSESSMENT

No psychometric measurement tools exist that are specific to Indigenous populations. Instead, assessment tools are normed for non-Indigenous populations, and none are more or less culturally appropriate. Standardized assessment tools include the Minnesota Multiphasic Personality Inventory, Wechsler Adult Intelligence Scale, Structured Clinical Interview for

DSM-IV I & II, Drug Abuse Screening Test, and Michigan Alcohol Screening Test, as well as trauma assessment tools. The effectiveness of these tools with Indigenous people requires that clinicians have the skill to gather information and interpret results within a cultural context. This means taking into account the client's personal story of colonialism and the wider context of colonialist history, and not making clinical judgements from a solely Western lens. This cultural context can be acknowledged by using a holistic perspective for understanding symptoms and behaviours, and by developing a concept of identity that includes cultural values, family, and impacts of colonialism. Culturally competent assessment may involve consulting with keepers of Indigenous cultural knowledge such as Elders and healers as part of the information-gathering process. These perspectives can be included in the conclusions and recommendations of the assessment and in treatment plans. The following questions can be useful in compiling a client's clinical history:

- Indigenous identity:
  - Can you tell me about your identity as an Indigenous person?
  - What is your cultural background?
  - How does being _____ (cultural identity) impact your_____ (experience/ mental health/forensic history/parenting/symptoms/treatment/homelessness)?
- Racism and oppression:
  - Have you ever experienced racism? Discrimination? If so, how and when? How does this affect your current situation?
- Intergenerational trauma:
  - Have you or has anyone in your family attended a residential school? Have any of you been involved in the child welfare system or foster care, or been adopted?
  - How has this affected your life? Your mental health issues? The development of your cultural identity?
- Working with Indigenous Elders or healers:
  - Have you ever seen a traditional Indigenous Elder or healer?
  - Would you like to?

IMPLEMENTATION CONSIDERATIONS

Using a Western paradigm of practice with Indigenous peoples has been criticized as a form of continued colonial oppression (Battiste, 2007; Gone, 2004; Stewart, 2008, 2009). Indigenous clients may not trust mainstream mental health practitioners and treatment due to historical and ongoing experiences of trauma and oppression. Working with these

clients requires clinical assessments and interventions that are culturally competent and safe. These considerations apply across the spectrum of services, including interpreting assessments within a cultural context, providing cultural competence training, offering clinical supervision, and consulting with Indigenous communities and knowledge keepers. Shelters and transitional housing that offer mental health and social services as part of the housing process can integrate Indigenous practices into standard services. These services usually involve addiction counsellors, psychologists, and physical health professionals, as well as social service staff who help clients around literacy and life skills, vocational development, and education. These mainstream staff and services can be expanded to include Indigenous practitioners and practices, such as Elders, healers, traditional teachers, and ceremonies. Failing to recognize the unique needs of Indigenous people who are homeless means that services will be ineffective at best and harmful at worst.

KEY MESSAGES

What does being homeless mean? An academic definition would describe homelessness as the condition of not being housed or having a fixed address. But in an Indigenous context, defining homelessness requires a more holistic view. Homelessness for many Indigenous people may not simply mean lacking physical housing; it may also include feeling spiritually and culturally bereft. For example, not having a stable or clear sense of cultural identity as an Indigenous male or female or as a two-spirited person can perpetuate colonial harm that contributes to homelessness. These individuals may continue to feel as though as they are homeless even when they have housing, or they may act in a manner they would when they were homeless (e.g., engage in substance use) because their cultural identity is not coherent to them and does not match their living environment.

Homelessness is not always easy to discuss. It often elicits strong emotional reactions— pity and sympathy, disdain, anger, blame, fear. In the consciousness of the average Canadian thinking about people who are homeless, particularly Indigenous people, a blame the victim mentality prevails. Non-Indigenous Canadians misunderstand the Indigenous experience of homelessness at best and are ignorant or blatantly racist at worst—this attitude is particularly evident when clinicians must serve Indigenous people who are homeless.

In this chapter, I have tried to impart an Indigenous, culturally based understanding of homelessness and provide guidance to mental health professionals for ethical and effective ways to work with this population. Doing this work means understanding historical factors that underlie and mediate the cycle of Indigenous homelessness, and exploring practices that best support youth who are homeless in getting off the streets and finding stable housing. The ultimate goal is to end homelessness for all Indigenous people by supporting those who were failed by the Canadian social service system that helped put them out on the streets in the first place.

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2.2

RESPONDING TO THE NEEDS OF LGBTQ2S YOUTH EXPERIENCING HOMELESSNESS

Alex Abramovich

Gay kids in a shelter that is predominantly straight are very vulnerable; they're in a very hard position and it makes it almost impossible for them to get on their own two feet. It's just as simple as that. They're in a position where they can be harassed and discriminated against so easily at every turn and that's especially true for trans people. There are just so many issues that arise when a shelter isn't properly prepared to house trans people.

—Adam, 25 years old

INTRODUCTION

As a wealthy nation, Canada enjoys one of the highest standards of living in the world. Yet there are truths about our country that are unfathomable: we have an unaddressed homelessness crisis among lesbian, gay, bisexual, transgender, queer, questioning, and two-spirit (LGBTQ2S)[1] youth; widespread homophobia and transphobia are a daily reality; and, because of this, LGBTQ2S youth experiencing homelessness often report feeling safer on the streets than in shelters (Abramovich, 2016).

National data on the prevalence of LGBTQ2S youth experiencing homelessness are lacking; however, it was estimated almost two decades ago that 25%–40% of youth experiencing homelessness identify as LGBTQ2S (Josephson & Wright, 2000). Recent data on the prevalence of youth homelessness in Canada include the National Youth Homelessness Survey, the first pan-Canadian study of young people experiencing homelessness, which involved 1,103 respondents from 47 different communities across 10 provinces and territories (Gaetz, O'Grady, Kidd, & Schwan, 2016). The survey reported that 30% of

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[1] The acronym LGBTQ2S is used in this chapter to represent gender and sexual diversity and refers to a wide range of gender and sexual identities. The terms trans and queer are used interchangeably with LGBTQ2S. Trans (transgender) is used as an umbrella term to describe people who do not conform or identify with the sex assigned to them at birth. Queer is a multifaceted term that has been reclaimed by LGBTQ2S people as an identity category for those who do not identify with binary terms that describe sexual, gender, and political identities (Jagose, 1996).

young people self-identified as LGBTQ2S and 6% self-identified as transgender, two-spirit, or non-binary. Identity-based family conflict resulting from a young person coming out as LGBTQ2S is a major contributing factor to youth homelessness and the main cited cause of homelessness among queer and trans youth (Abramovich, 2012; Abramovich & Shelton, 2017; Choi, Wilson, Shelton, & Gates, 2015; Cochran, Stewart, Ginzler, & Cauce, 2002).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) classified homosexuality as a mental disorder until 1973 (Cooper, 2004). The DSM-5 continues to pathologize and label those who fall outside of the gender binary with "gender dysphoria," formerly called "gender identity disorder" in the DSM-IV. The pathologization of identities that do not fit into heteronormative and cisnormative[2] categories has led to stereotypes, stigma, homophobia, and transphobia, all of which negatively impact the health and well-being of LGBTQ2S individuals (Meyer, 2003).

Minority stress theory (Meyer, 2003) indicates that gender and sexual minority individuals often experience chronic stressors related to their stigmatized identities, such as victimization and discrimination (Russell & Fish, 2016). The added stress and stigma of not having a safe place to call home make it especially difficult for LGBTQ2S youth experiencing homelessness, and negatively impacts their mental health, resulting in a dramatically high risk of mental health issues, including depression, anxiety, substance use, and suicide (Cull, Platzer, & Balloch, 2006; Frederick, Ross, Bruno, & Erickson, 2011; Quintana, Rosenthal, & Krehely, 2010).

LGBTQ2S youth experiencing homelessness are a diverse population of young people with intersecting identities. Intersectionality impacts their lives and mental health because they are frequently subjected to multiple forms of discrimination and marginalization, such as homophobia, transphobia, and racism, making it especially difficult to access housing, support, and healthcare services.

This chapter focuses on solutions and implications for practice and provides concrete intervention components and implementation considerations. It is meant to support practitioners in creating safe, inclusive, affirming, and LGBTQ2S–competent programs and services. The quotes presented in this chapter were collected through a qualitative, participatory, film-based

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[2] Cisnormative refers to the assumption that every person's gender identity matches with the sex the person was assigned at birth.

study, which focused on LGBTQ2S youth homelessness and access to mental health services, and are shared as a way to exemplify the impact of the issues presented.

It is not enough to encourage young people to be themselves and promise them "it gets better"; we have an ethical and moral responsibility to make it better now.

We cannot afford to wait.

INTERVENTION COMPONENTS

The following sections describe core intervention components to consider when working with all youth, especially LGBTQ2S youth experiencing or at risk of homelessness.

CREATING POLICIES & STANDARDS FOR LGBTQ2S-AFFIRMING & CULTURALLY COMPETENT SERVICES

Mandatory staff training

- Develop guidelines for mandatory and ongoing LGBTQ2S cultural competence training during the first three months of hire for all front-line staff, physicians, clinicians, management, and volunteers. This will help build the capacity of existing youth-serving organizations to support LGBTQ2S youth in a safe and affirming manner.
- LGBTQ2S cultural competence training should include, but not be limited to:
  - Language/terminology: help staff develop more understanding and clarity regarding LGBTQ2S terminology; the importance of asking certain questions in a sensitive manner; and navigating discussions with respect, comfort, and ease.
  - Homophobia and transphobia: increase understanding and awareness of the causes and impact of homophobia and transphobia, as well as how to identify and intervene when such incidents occur, and how to create safe, secure, and affirming spaces for LGBTQ2S young people.
  - Transgender awareness: train staff to understand the needs of transgender and gender-expansive youth and how to support and reduce barriers for transgender and gender-expansive service users.
  - Systems navigation: ensure staff members are aware of all local LGBTQ2S programs and services for client referrals when necessary.

Developing a standardized intake process

The expectation that every young person will fit into the gender binary makes the shelter system, housing programs, and healthcare facilities especially difficult places for LGBTQ2S youth to navigate, which is why it is important to include LGBTQ2S-inclusive language and questions on all intake forms.

Instead of asking people to identify themselves as male, female, or other, include the following questions in the intake procedure and on key forms:[3]

How do you describe your sexual identity? Check all that apply:

[ ] Gay

[ ] Lesbian

[ ] Bisexual

[ ] Queer

[ ] Pansexual

[ ] Questioning

[ ] Two-spirit

[ ] Straight/heterosexual

[ ] Asexual

[ ] Identity not listed (please specify) _____

How do you describe your gender identity? Check all that apply:

[ ] Cisgender woman*

[ ] Cisgender man*

[ ] Trans woman

[ ] Trans man

[ ] Two-spirit

[ ] Gender queer

[ ] Gender fluid

[ ] Androgynous

[ ] Non-binary

[ ] Identity not listed (please specify) _____

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[3] From *A focused response to prevent and end LGBTQ2S youth homelessness* (p. 26), by A. Abramovich, 2015, Edmonton, AB: Government of Alberta. Copyright 2015 by Government of Alberta. Adapted with permission.

*Cisgender refers to someone who identifies with the sex assigned to them at birth (e.g., someone who was assigned female at birth and identifies as a woman).

What gender pronoun do you use (e.g., he/him, she/her, they/them): _____

What name do you go by: _____

Increasing access to services for transgender and gender-expansive youth
- Make services accessible to transgender, two-spirit, and gender-expansive individuals in their self-defined gender.
- Ask all clients for their name and pronoun, rather than assuming. Respect and accept each client's self-defined gender identity and gender expression, including name and pronouns, which may differ from what is listed on their health card or government ID.
- Equip services with the appropriate resources and knowledge to refer youth to transition-related treatment and needs (e.g., hormone therapy, legal name change, counselling).

CREATING A WELCOMING PHYSICAL ENVIRONMENT

- An important component of creating LGBTQ2S-affirming and competent services includes ensuring that young people see themselves reflected in all aspects of the programs and services that are offered. Creating a system where young people can see themselves reflected allows them to feel safe and included.
- Ensure services are equipped with single-stall, gender-inclusive washrooms (this may be in addition to gendered washrooms); washrooms often can be easily converted with the appropriate signage.
- Ensure that services, programs, and clinics are supplied with appropriate and diverse resources regarding coming out, LGBTQ2S health, and safe sex for youth accessing services, including pamphlets, fliers, and posters on walls.

ESTABLISHING A FORMAL GRIEVANCE PROCEDURE

- Implement an internal grievance process so clients can lodge formal, anonymous complaints. Clients must be informed of the procedure during the intake process (or first appointment), and the grievance procedure should be posted in a conspicuous area.

DEVELOPING AN INTEGRATED APPROACH TO MENTAL HEALTH SERVICES IN SHELTERS

- We must begin working toward a more integrated approach to youth homelessness, where mental health supports and trauma-informed care are central to the support offered in shelters, housing programs, and the services that LGBTQ2S youth access.
- Offering mental health services in shelters and housing programs allows youth to connect with services when they need them most. Community-based approaches and mental health services that are embedded in housing programs and shelters may be easier for LGBTQ2S youth to connect with because they may be viewed as less institutional settings that do not label or pathologize youth in the way that traditional mental health services do.
- Effective and supportive mental health services for LGBTQ2S youth largely depend on building trusting relationships between youth and service providers, and ensuring that gender and sexual identities are affirmed, not pathologized.

INVOLVING YOUNG PEOPLE IN KEY DISCUSSIONS & PLANNING

- Rather than adopting the common "one size fits all" approach, programs and policies must reflect the diverse population of youth experiencing homelessness and accessing services. Fostering meaningful youth engagement is particularly pertinent to the delivery of mental health services that are LGBTQ2S-competent and affirming. By including the voices, perspectives, and experiences of LGBTQ2S youth, service providers are able to tailor their services to meet the unique needs of this population of young people and create services that work best for them.
- LGBTQ2S youth experiencing homelessness must be included in key discussions, planning, and the development of solutions. They should be recognized as knowledge producers who are the experts of their own experiences.

OFFERING SPECIALIZED LGBTQ2S SERVICES & PROGRAMS

- Support the delivery of population-based services and programs for LGBTQ2S youth that foster an intersectional approach, including LGBTQ2S health clinic hours and drop-in services.
- Offer cultural and population-specific programming that provides LGBTQ2S youth with cultural connectedness and access to cultural traditions and practices. This includes Indigenous youth, youth of colour, and newcomer youth.

PREVENTING CHRONIC HOMELESSNESS

- Develop a prevention plan that emphasizes strategies for early intervention; raising awareness; and programs for children, youth, and families. Also develop programs for reunifying families when it is safe and possible to do so.
- Reunifying LGBTQ2S youth with their families is not always possible; however, it is important that programs broaden their definitions and understanding of family when working with LGBTQ2S youth. For example, queer and trans youth experiencing homelessness often create their own families when it is not possible for them to be in contact with their families of origin. The families they create have often been reported to be stronger support systems for queer and trans youth, allowing them to feel a sense of belonging and participate in community (Connolly, 2005; Cooper, 2009).
- It may not always be possible to prevent LGBTQ2S youth from becoming homeless; however, youth-serving systems can help prevent youth from experiencing chronic homelessness.

IMPLEMENTATION CONSIDERATIONS

All youth-serving systems, including shelters, housing programs, and healthcare services, must become LGBTQ2S–culturally competent and prepared to work with all young people, regardless of their gender or sexual identity. Ensuring that young people's identities are reflected in all aspects of a program creates a more standardized model of care, which helps youth know what to expect when entering a service. It also encourages services to collect data that capture people's diverse identities. As outlined above, there are different ways youth-serving systems can create standardized models of care and safe

and affirming environments for LGBTQ2S youth, including implementing mandatory LGBTQ2S cultural competence training and developing inclusive policies and standards that do not perpetuate cisnormativity and heteronormativity. Creating training guidelines (e.g., mandatory, ongoing, within first three months of hire) holds staff and services accountable in ways they may otherwise not be. For example, during a recent interview, a child and youth psychiatrist spoke at length about the importance of holding psychiatrists and services accountable:

> *If you're not held accountable you end up treating the easiest patients or you treat the people who cause the least resistance and you can see that in the shelter system. If you are going to accept money to provide services you have to be accountable and maybe we have to look at different ways of the shelters being accountable, in addition to okay, you get so much, so much for each filled bed at night, what about the other stuff? What about the image you provide to the community you know? Are you a safe shelter for all of the youth on the street and not just the ones without mental health issues or ones without gender issues?*
> —Child and youth psychiatrist

Updating existing services and creating new and improved specialized services and programs may assist in preventing the negative mental health outcomes often associated with the discrimination and stigma that LGBTQ2S youth often experience when they access services, as described by one youth:

> *It's a very hard decision to make. . . . Would you want to go somewhere where you are in danger, but you're allowed to identify however you want, or would you want to go somewhere where you're told how you have to identify, but be a little safer?*
> —Meister, 24 years old

Service providers can support the delivery of specialized population-based programs by integrating such services in their clinics on a regular basis, as well as hiring LGBTQ2S-competent staff. These are the types of actions that will undoubtedly increase societal understanding and help eliminate social stigma toward LGBTQ2S people, leading to positive mental health outcomes for young people experiencing homelessness.

Structural, institutional, and societal changes take time, but we can do our best to ensure that LGBTQ2S youth experiencing homelessness have safe places to turn to for support and that all youth-serving systems have policies in place to protect LGBTQ2S youth from homophobic and transphobic discrimination and violence.

All of the core intervention components highlighted in this chapter foster a standardized model of care for youth-serving agencies, which is necessary in creating accepting, affirming, and supportive environments for youth. Enforcing youth-serving organizations to conform to the same set of formal rules and regulations will influence service providers to consistently follow standards and create a level of standardization within the youth-serving sector.

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2.3 ENGAGING WITH NEWCOMER YOUTH EXPERIENCING HOMELESSNESS

Cheyanne Ratnam, Ann Fitzpatrick, & Helen Thang

INTRODUCTION

There is a growing body of literature on homelessness in Canada, with research addressing such areas as youth at risk of homelessness, homelessness among adults and families, and homelessness among immigrants and refugees. Low-income groups are most likely to experience housing issues and homelessness, with visible minorities, recent immigrants, and single parents disproportionately represented (Polanyi et al., 2016). The national At Home / Chez Soi study of the Housing First model found that immigrants and refugee adults are especially vulnerable to becoming homeless as a result of the discrimination they experience when seeking employment and housing, and also tend to experience housing instability in the form of residential crowding, sometimes referred to as hidden homelessness (Zerger et al., 2014). Current literature has explored the impacts of immigration and settlement on adults and families, but to a lesser extent on the youth population (Preston et al., 2011; Raising the Roof Foundation, 2009). Limited research in Canada has focused specifically on newcomer youth, their pathways to Canada, pathways to homelessness, the barriers these youth face, and the solutions they see as most important to achieving success.

HIDDEN IN OUR MIDST & WHAT'S THE MAP?

In 2014, Hidden in Our Midst, a Toronto-based study led by the Centre for Addiction and Mental Health (CAMH) and the Children's Aid Society of Toronto (CAST), sought to fill a knowledge gap regarding experiences of homelessness among newcomer youth in Toronto (CAMH & CAST, 2014a). A follow-up project called What's the Map?[1] focused on disseminating the findings to social services, practitioners, and government decision makers. Both initiatives built on leadership of young immigrants and refugees who were

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[1] What's the Map? was a youth-led initiative with support from the Children's Aid Society of Toronto, the Wellesley Institute, and the Centre for Addiction and Mental Health, with funding from the Laidlaw Foundation. The project represented phase 2 of the Hidden in Our Midst research project and involved knowledge dissemination of study findings.

born in the Global South[2] and who have lived experience with homelessness after arriving in Canada. These youth played a partnership and leadership role alongside the interagency partners and community advisory committee members that were initially convened to support the Hidden in Our Midst study.

This chapter is informed by the cumulative learnings from the Hidden in Our Midst and What's the Map? projects. The chapter aims to increase understanding among social service practitioners of the complex issues facing newcomer youth who experience homelessness in Canada. It strives to increase the capacity and commitment of organizations and practitioners to meaningfully engage newcomer youth at the casework, organizational, and systemic levels to better address the unique needs of youth, build on their strengths, and improve individual outcomes. We also share some models and tips on meaningful youth engagement from our experiences with the two projects.

SUPPORTS TO PREVENT & REDUCE HOMELESSNESS AMONG NEWCOMER YOUTH

Hidden in Our Midst explored service gaps and barriers experienced by newcomer youth who are homeless and sought to map out recommendations to improve supports and outcomes for this group. The study surveyed 74 newcomer youth aged 16–24 who immigrated to Canada and have experienced homelessness since their arrival. They completed a demographic survey and participated in qualitative focus groups or interviews to unpack their experiences engaging with service systems. The study also included a short survey that was completed by 39 agencies across the City of Toronto to identify supports and gaps in service to newcomer youth experiencing or at risk of homelessness (CAMH & CAST, 2014a). This community-based research project engaged an advisory committee of community partners serving youth who are homeless and newcomer populations, as well as 10 youth peer researchers. Results of the research were widely disseminated in Toronto and nationally (Keung, 2014). A research infographic was designed with the leadership of the peer researchers (CAMH & CAST, 2014b).

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[2] The term "Global South" refers to both low- and middle-income developing countries.

WHAT WE HEARD FROM YOUTH PARTICIPANTS

The demographic survey revealed that nearly two-thirds of participants immigrated from Africa or the Caribbean, over one-third identified as LGBTQ2S, half had a grade 12 education or higher, and over one-quarter have held refugee claimant status (CAMH & CAST, 2014a). Participants reported experiences of trauma and physical and sexual abuse. Their top reasons for immigrating to Canada included family reunification, education, danger in their homeland, and employment opportunities.

In the qualitative interviews and focus groups, youth described resistance to arranged marriages, challenges living with a host family in Canada, and family conflicts stemming from differences in parent and child expectations around the practice of religious and cultural values in Canada. Participants also highlighted different cultural expectations and understanding of what constitute physical abuse and acceptable forms of child discipline. Some participants were afraid of shaming their parents by leaving home or seeking service supports. Participants described their efforts to navigate services as a confusing maze and identified many barriers to accessing basic supports such as health care and education. Some felt that service providers underestimated their strengths and capacities, while others reported having experienced racism when seeking housing and employment. These findings offer a glimpse of some of the additional challenges that situate newcomers among the most vulnerable of youth who are homeless.

INTERVENTION COMPONENTS

This section outlines four intervention considerations based on our learnings in the What's the Map? project.

ENGAGEMENT MODELS FOR WORKING WITH NEWCOMER YOUTH

One of the most commonly used models of youth engagement in mainstream services involves including youth on advisory committees, and in consultations, focus groups, and other forums. One concern about these engagement practices is that these organizations

often work from a "for youth" philosophy that engages youth in a tokenistic manner. The following features characterize the "for youth" engagement process:

- Youth are not given meaningful leadership roles to improve the services they use.
- Youth engagement is a token effort to present the appearance of listening to and including youth, but is not meaningful or genuine.
- Youth do not receive full information when they are given advice.
- The lack of diversity among the youth chosen to be representatives often leads to a process of selecting the "cream of the crop," who present the most professional skills and are higher functioning.

In contrast to this model, the Hidden in Our Midst and What's the Map? projects strived toward a "with youth" philosophy. One tool that organizations can use to enhance engagement with youth who are newcomers and/or experiencing homelessness is Hart's ladder of engagement (Hart, 1992), which is widely used to showcase the spectrum of youth engagement models (see Figure 2.3-1).

FIGURE 2.3-1. HART'S LADDER OF ENGAGEMENT

Organizing/governing/control	Empowerment/meaningful engagement
Lived experience initated, leadership	Empowerment/meaningful engagement
Lived experience initiated, partnerships	Empowerment/meaningful engagement
Adult/organization initiated, shared decision making	Tokensim moving toward engagement
Informed dialogue	Tokenistic
Assigned but informed	Tokenistic
Tokenism	Non-engagement/participation
Decoration	Non-engagement/participation
Manipulation	Non-engagement/participation

An ideal approach is for organizations that work with youth to aspire to and adopt practices that reflect the top of the engagement ladder. This could be achieved in part by engaging and hiring youth who have lived experience and familiarity with system services, and by providing training and opportunities to lead projects, strategize, and contribute to decision-making activities.

Practitioners working with newcomer youth who are homeless should seek to build on each person's skills, knowledge, and life experiences. It is important not to assume that these youth lack educational or professional credentials and experience, attained in either their homeland or Canada. Youth can be impacted negatively by stereotypes, low expectations, and negative assumptions, especially if they have already experienced marginalization and discrimination as a newcomer to Canada or as a racialized person.

YOUTH ENGAGEMENT CASE STUDY: WHAT'S THE MAP?

What's the Map? is an example of a project that aspired to the activities at the top of Hart's (1992) ladder of engagement. It was led, initiated, and organized by youth with lived experience of homelessness and being a newcomer to Canada. This project was led by two young women with lived experiences as immigrants and of homelessness in Canada. It was developed in partnership with CAST, the Wellesley Institute, and CAMH, with funding from the Laidlaw Foundation.[3] The What's the Map? project tag line was "Newcomer youth leading the call to action: Designing a support system that works." The goal was for a group of young leaders to raise awareness of the needs in the newcomer youth community and effect change in service provision, which included improving cross-sectoral policies, programs, and system coordination to ensure services engage newcomer youth more effectively, especially those who are refugees or lacking status in Canada.

What's the Map? collaborated with youth with lived experience, who were the primary project implementers and decision makers. The partner agencies played a support role by managing funds; providing space for meetings, programming, and events; mentoring project managers; and assisting with mediation, training, and strategic planning.

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[3] Additional support and mentorship was received from the Office of the Ontario Provincial Advocate for Children and Youth. Over a dozen organizations, including child welfare, mental health, legal clinics, settlement, youth and family services, housing advocacy, and research and health promotion, provided support on the community advisory committee of What's the Map?

The project managers recruited 10 young leaders aged 18–24 who worked together for one year. These youth were given leadership opportunities and contributed to outreach and training of social service providers, government policy makers, political leaders, and decision makers. This project also helped them address some of their own personal challenges and stresses through social connections, orientation to the City of Toronto with their peers, assistance with service system navigation, and other support from the project managers.

The following characteristics set What's the Map? apart from other youth engagement models:

- Youth had lived experiences of homelessness and migration to Canada from low- and middle-income countries.
- Project participants represented a diverse range of personal, academic, and professional backgrounds; gender and sexual orientation identity; racial, cultural, and ethnic backgrounds; and diverse pathways to Canada.
- Youth were called project leaders and managers, not clients or customers.
- Youth assumed power, influence, and responsibility for project deliverables, and received advice rather than direction from interagency partners.
- Youth presented Hidden in Our Midst research findings and What's the Map? recommendations at national and local conferences and met with government and agency decision makers, as well as front-line service providers.
- Facilitated mentorship opportunities existed between youth in addition to mentorship from service provider staff.
- Youth retention rates were high throughout the 12-month project period and youth provided positive feedback.

Keeping youth engaged with What's the Map?

What's the Map? was successful in engaging and retaining six of the 10 young leaders and the two co-managers until the end of the project. The project achieved success in various areas:
- It provided consistent leadership, with two project managers coordinating activities.
- A recruitment call for applicants included merit-based selection criteria; a diverse group of project leaders was hired.

- Meaningful orientation and training opportunities were provided for youth, which included:
  - Sharing information on Hidden in Our Midst research findings;
  - Developing facilitation skills;
  - Building advocacy strategies;
  - Doing digital/online video production;
  - Creating policy-making processes; and
  - Attending conferences and developing presentations about mental health, housing, homelessness, newcomer/refugee issues, and youth equity.
- Youth were validated by policy and agency decision makers based on their lived experiences, expertise, and communication of recommendations.
- What's the Map? received invitations to present at conferences and other events, with opportunities shared among project managers and young leaders.
- Relationship building among youth happened through work on project deliverables and skill development for all youth involved; all of this was "real work," not token engagement.
- Multiple communication platforms were used, including a What's the Map? Facebook page, text messaging, phone calls, face-to-face meetings; Google Docs was used to collaborate on documents.
- Monthly What's the Map? leadership meetings provided an opportunity for youth to chair and present at meetings and to give input on agendas and plans.
- Joint meetings and relationship building with agency members on the community advisory committee occurred, where stories and reports on work were shared.
- Participants received financial supports, including transportation assistance, child care for youth with children, and honorariums above minimum wage to recognize time and expertise.
- Through these presentation and advocacy experiences, youth were able to build confidence over the course of the project.

ENGAGING YOUTH ACROSS THE SOCIAL SERVICE SYSTEM

In this section, we will share interventions for improving practitioner and service system engagement of newcomer youth who are homeless across the social service system. The What's the Map? project disseminated and dialogued with multiple agencies and policy decision makers about the Hidden in Our Midst recommendations to better engage these youth at all levels of the service system: at the casework and individual agency service-planning levels, and in systems planning and coordination in larger service systems.

Engagement at the casework level

Although there has been a shift toward youth collaborating with caseworkers to map out their anticipated service plans and personal goals, there is a need to embed this principle in all services for newcomer youth who are homeless. Too often, casework with young people is based on a medical model where the caseworker or counsellor is the "expert" and the young person is the "client" who receives advice. Case planning must extend beyond the scope of the first agency a youth seeks out in order to develop a holistic plan based on the youth's identified goals. There should be an effort to work with and empower youth to coordinate the range of supports they require.

Engagement at the agency service-planning level

Inclusion of youth with lived experience of homelessness who are newcomers or refugees or who lack status in Canada can be an effective way to shape more responsive service planning and design. From logistical considerations, such as the time and location of programming, to policy and program content, service planning can be improved with input from the target population. In addition, youth with lived experience of homelessness can provide vital information on barriers to participation and methods of outreach. Hiring and involving youth in program development and delivery must be coupled with mentorship and other supports. Peer models of self-help support and expanding social connections between youth with lived experience of homelessness can also contribute to positive outcomes and capacity building among newcomer youth who are homeless.

Engagement in system-wide planning and coordination

It is important for those in decision-making positions in social services to include newcomer youth with lived experience of homelessness to inform systems-wide planning, policy development, coordination, and integration. These young people have firsthand experience of navigating complex systems, services, and legal frameworks across federal, provincial, and municipal service delivery models. In Hidden in Our Midst and What's the Map? youth highlighted gaps and opportunities for service systems and agencies to meet the needs of youth more effectively, and to ensure their dignity, personhood, and individual realities are respected and better understood. Youth made the following recommendations:

- Develop national, provincial, and municipal cross-sectoral networks to integrate, design, and improve programs.
- Develop accessible multi-service agencies or "one-stop" hubs for newcomer youth supports.

- Implement anti-oppression and anti-racism service standards and audits.
- Develop accessible online resources and networks for newcomer youth.

Case study: What's the Map? cross-sectoral forum

What's the Map? project managers, youth leaders, and agency partners organized a successful forum on newcomer youth homelessness with a focus on conversations and solutions across cross-sectoral services and government bodies. This event was attended by over 100 stakeholders from multiple sectors, including housing, mental health, youth justice, education, health, youth shelters, immigration, settlement, and child welfare. Representatives from federal, provincial, and municipal levels of government participated.

The forum was able to fill a gap by bringing together diverse organizations, agencies, sector stakeholders, and service systems that touch on the lives of newcomer youth who are homeless but that tend to operate in silos. Young people shared stories and examples of challenges they have encountered in navigating the service system and of the need to address access barriers. These stories echoed findings from the Hidden in Our Midst research: youth described feeling marginalized and facing multiple barriers when trying to access services from various organizations, sectors, and systems concurrently. Connections made at the forum resulted in follow-up meetings with project leaders, managers, and decision makers.

INCREASING SERVICE ACCESS FOR NEWCOMER YOUTH

Improving service accessibility must go beyond providing information in plain language or multilingual formats. Many newcomer youth are part of the hidden homelessness population and may experience additional barriers to accessing mainstream services because they lack legal immigration status in Canada (CAMH & CAST, 2014a). Organizations, sectors, and systems need to find creative ways to increase outreach, access, and safety of youth around services.

Youth involved with Hidden in Our Midst and What's the Map? recommended that newcomer youth with lived experience of homelessness would benefit from user-friendly information that is accessible online so they would not have to seek services in a physical location. Similar to the need to develop policies that can positively impact the most people, there is a need to generate and implement multiple ways of disseminating information and engaging with diverse people so their needs are met in ways that safeguard and benefit them.

CULTURAL HUMILITY IN WORKING WITH NEWCOMER YOUTH

Youth involved in What's the Map? proposed cultural humility as a best-practice approach to replace cultural competence. Cultural humility aligns with meaningful anti-oppression and anti-discrimination policies, practice, and policy frameworks. Cultural competence is the ability to successfully acquire all information necessary in order to make accurate references to a culture. An anti-oppression and anti-racist approach considers interlocking factors and intersecting oppressions such as race, age, religion, gender, and sexual orientation, whereas cultural humility is a knowledge exchange process which acknowledges that the person you are working with is an expert in their own life.

Waters and Asbill (2013) described the following factors that guide a lifelong process toward cultural humility:

- Commitment to critical self-reflection, evaluation, and critique;
- Desire to fix power imbalances in the relationship, seeing the client as the "expert" in their life in terms of history, identity, preferences, symptoms, and strengths; and
- Aspiring to develop partnerships with people and groups that advocate at a systemic level to address inequality and community needs that go beyond an individual casework level.

IMPLEMENTATION CONSIDERATIONS

BUILDING RELATIONSHIPS & PRACTISING CULTURAL HUMILITY

- Check in with newcomer youth throughout all casework activities to ensure your services are not a mismatch.
- Provide resources and opportunities that are integrated within services to engage youth on an ongoing basis, not simply during "one-off" events or opportunities.
- Seek to understand the diverse strengths and potential of newcomer youth.
- Engage newcomer youth with peer support models.

EMPOWERING NEWCOMER YOUTH TO LEAD INTERVENTIONS

- Engage youth with decision makers at all tables.
- Involve family where appropriate; accommodating families in intervention work may require developing multilingual capacities among staff; even if youth are proficient in English, their parents may not be.

FOCUSING ON PREVENTION

- Educate and empower youth to locate and access services in your local community or closest urban centre.
- Engage newcomer youth to assist with outreach activities.
- Support newcomer youth who are homeless to advocate and secure supports with determinants of health such as housing and income security.
- Prevent homelessness through education among peers and newcomer youth regarding landlord and tenant laws and access to housing help centres.
- Partner with newcomer youth, faith groups, and agencies to develop prevention supports for immigrant and newcomer families, and focus on addressing intergenerational conflict. In the Hidden in Our Midst study, youth cited conflict with family and abuse within the family as key reasons they first entered into a situation of homelessness. During the focus groups and interviews, some youth described conflicts with family or parents as arising from different expectations and views on cultural traditions.

- Promote information to newcomer youth about their rights to be protected from abuse, assault, and exploitation.

ALLOCATING RESOURCES FOR MEANINGFUL ENGAGEMENT & SUSTAINABILITY

- Dedicate staff resources and funds to hire youth as leaders, trainers, and peer supports.
- Ensure sufficient budget funds for honoraria, travel, refreshments, and child care for youth who are hired to support project activities.
- Offer capacity- and skills-development resources around conflict resolution, mental health training, understanding system navigation, and group facilitation skills.

KEY MESSAGES FOR PRACTITIONERS

- Seek to engage the voice and expertise of newcomer youth at all stages of the service continuum via casework, program planning, and systems planning.
- Make the following commitments:
  - Identify ways in which your organization can improve coordination with other agencies and groups to improve services for newcomer youth who are at risk of or currently experiencing homelessness.
  - Build staff learning; critical reflection; and anti-oppression, anti-racism, and cultural humility frameworks when working alongside newcomer youth.
  - Promote staff and organizational leadership around preventing homelessness among newcomer youth and be a champion in your organization or agency.
- Develop a plan to improve engagement with youth in your agency/department with the involvement of young newcomers. Use the following activities to promote engagement:
  - Look at the existing model of engagement and identify gaps and opportunities that can be addressed through participation by newcomer youth.
  - Adopt a peer-positive approach to all casework and programming for newcomer youth and families (Northwest Toronto Service Collaborative, n.d.).
  - Allocate resources to make your model sustainable: young people should have their time and expertise recognized through financial compensation.
  - Use the capacity among newcomer youth who are homeless to be leaders, trainers, and peer supporters in your organization.

- Connect and coordinate supports or pilot projects with other organizations that are engaging with youth or newcomers.
- Participate in or build a community of practice.
- Explore prevention supports for newcomer youth who are homeless that include family involvement and informal support networks (e.g., faith communities, cultural communities).
- Collect and understand your organizations' service and demographic data in relation to your municipality and other jurisdictions. Ensure you are reaching these populations and meeting their unique cultural and linguistic needs.
- Recruit youth to assist with outreach initiatives.

CONCLUSION

This chapter highlighted the issue of homelessness among young newcomers as a priority service area and shared learnings from our research and project experiences. Findings from the Hidden in Our Midst study of homelessness among newcomer youth in Toronto indicate that newcomer youth are a diverse population on the basis of country of origin, ethnic and racial background, sexual orientation, educational attainment, and pathways into homelessness. Some newcomer youth arrive as unaccompanied minors with limited or no family connections in Canada; others have experienced family breakdown in the process of migration and settlement; still others who identify as LGBTQ2S face additional barriers and risks upon arrival. These were some of the narratives that emerged from our work in Hidden in Our Midst and What's the Map? Front-line agencies, organizations, and systems across all levels of government serving newcomer families and youth require multiple tools that build on their current knowledge base and complement existing organizational practices and leadership. The ongoing and meaningful engagement of newcomer youth who are homeless in research, program, and policy initiatives will continue to enrich the effectiveness of service delivery and improve individual outcomes.

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2.4 ANTI-RACIST PRAXIS WITH STREET-INVOLVED AFRICAN CANADIAN YOUTH

Julian Hasford, Peter Amponsah, & Treisha Hylton

INTRODUCTION

People of African descent have a long, troubled, yet inspiring history in Canada, marked by tensions between anti-black racism and resistance, and by the establishment of a dynamic and diverse diaspora. In this chapter, we discuss how race and racism influence the experiences of street involvement and mental health among African Canadian youth. We also offer a few analytical and practical tools for practitioners to consider for engaging street-involved youth from an anti-racist perspective.

According to the 2011 National Household Survey, African Canadians make up approximately 3% of the country's population and are among the fastest growing racialized groups in urban areas in southern Ontario, Quebec, and Nova Scotia (Statistics Canada, 2013). Although we use "African Canadian" as a broad term to refer to anyone of indigenous sub-Saharan African ancestry, the term encompasses a population with tremendous diversity in terms of ethnicity, culture, class, language, religion, sexual orientation, and gender identity.

A large body of evidence indicates that race and ethnicity profoundly affect how people experience mental health (Williams & Williams-Morris, 2000) and homelessness (Springer, Lum, & Roswell, 2013). Factors such as racism, culture, and stigma amplify the stressors that lead to mental illness and homelessness. They also limit access to resources that buffer such stressors and reduce the quality of interactions with social and health services. Although relatively little race-based data exist on homelessness or mental health in Canada, some evidence suggests that African Canadians are overrepresented among street-involved youth (Gaetz, 2002; Springer et al., 2013), particularly in some parts of the Greater Toronto Area.

Systemic racism is one of the most pervasive sources of stress experienced by street-involved African Canadian youth. It involves patterns of behaviour, practices, and policies within institutions that produce structural disadvantages for racialized peoples (Ontario

Human Rights Commission, 2017). Systemic racism exacerbates the factors that are generally known to increase the risk of mental health problems and homelessness; these factors include poverty, familial adversity, and child welfare involvement (Kidd, 2013). African Canadians experience significantly higher rates of poverty than other racialized groups (Galabuzi, 2006). This situation is compounded by discrimination in employment (Block & Galabuzi, 2011) and housing (Teixeira, 2008). In addition, African Canadians face major inequities in the child welfare system (Ontario Association of Children's Aid Societies [OACAS], 2016), education system (James & Turner, 2017), and criminal justice system (Sapers, 2016; Wortley & Owusu-Bempah, 2011).

Community and family dynamics also influence how African Canadian youth experience mental health problems and homelessness. The legacy of colonization and slavery is a source of historical trauma, which has disrupted the intergenerational structures and relations of many African families (DeGruy, 2005). It plays an important role in young people's pathways to homelessness (Kidd, 2013). For many contemporary African Canadian families, these strained relations are compounded with the stressors of immigration and settlement, which can lead to family conflict (OACAS, 2016). Moreover, homophobia and heterosexism faced by lesbian, gay, bisexual, trans, and queer African Canadian youth within their families, communities, and broader society have been identified as another significant source of marginalization (Springer et al., 2013).

Studies also suggest that African Canadians may be more likely to avoid or delay seeking help from mental health services due to cultural stigma related to mental illness and to mistrust of mainstream health professionals (Corrigan, 2004; Ferrari et al., 2015; Whaley, 2001). Lack of access to culturally relevant services further increases the criminalization and marginalization of African Canadian youth; untreated mental health issues end up being addressed through the criminal justice system (John Howard Society of Ontario, 2015; Rankin & Winsa, 2013).

INTERVENTION COMPONENTS

Various frameworks and strategies are available to front-line service providers who engage with African Canadian youth. Historically, these strategies have often involved multicultural or cultural competence approaches that emphasize understanding the cultural traits and values of "other" non-white racialized groups, and tailoring practices accordingly (Bishop,

2015; Katz, 2003). While such approaches may seem promising for agents of social justice, they can limit the effectiveness of work with racialized youth when they fail to address issues of power, historical oppression, and mistrust within helping relationships, or when they neglect to include culturally grounded intervention approaches (DeGruy Leary, 2005). In this section, we suggest a number of approaches to intervention that challenge practitioners to critique racism and oppression, to be critically reflective about their own power and privilege, and to use the assets of African communities to engage young people.

ANTI-RACIST PRAXIS

Praxis refers to a process whereby practitioners gain a deeper understanding of themselves and their environment through ongoing action and reflection (Freire, 1968/2000). It has become an important component of professional practice in fields such as social work (Nylund, 2006), education (Dei, 1996a), and youth work (White, 2007). Anti-racist praxis is a framework for professional practice that involves "an action-oriented strategy for institutional systemic change that addresses racism and other interlocking systems of social oppression" (Dei, 1996b, p. 4). It offers an alternative to predominant rehabilitative models, which can be reactive and limited to addressing basic needs such as education, employment, and "life skills" (McKenzie-Mohr, Coates, & McLeod, 2012), while failing to address the everyday impacts of racism and trauma that black youth who are homeless experience. Theory is a critical component of anti-racist praxis because it provides conceptual tools for naming, analyzing, and disrupting racism. We begin this section by describing a few key conceptual tools that practitioners can use to inform their anti-racist work, drawing on perspectives from critical race theory (Delgado & Stefancic, 2012) and black feminism (Collins, 2000).

A central concept of anti-racist praxis with African Canadians is the notion of anti-black racism, which acknowledges that black Canadians face a unique type of racism that differs in kind and extent from that faced by many other groups and that merits distinct forms of intervention (Benjamin, 2003). The unique nature and implications of anti-black racism have been acknowledged by the United Nations (Working Group of Experts on People of African Descent, 2016) and the Government of Ontario (Lewis, 1992), and have been the foundational analytical focus of community activism for decades (see below). Practitioners can examine anti-black racism in their settings by observing whether there are differences in the experiences or outcomes of African Canadians within their organizations and by reflecting on what might be root causes of such differences.

A second important concept—one of the tenets of critical race theory—is the critique of colour-blindness, the ideological belief that society consists of a multicultural utopia where race does not matter and merit determines life chances (Dei, Karumanchery, & Karumanchery-Luik, 2005). Anti-racist theory recognizes that racism is a permanent and embedded feature of Western capitalist democracies, and therefore advancing social justice requires a critical examination of the racial impacts of laws, policies, programs, and practices (Delgado & Stefancic, 2012). When developing or implementing policies or programs, practitioners can counter colour-blind assumptions by explicitly reflecting on the implications of race on the policy or program.

A third key concept of anti-racist praxis is intersectionality (Collins, 2000), which involves understanding how multiple forms of identity, such as race, class, gender, and ability, intersect to create unique experiences of oppression (and privilege). An intersectional anti-racist approach examines the role of institutions in producing racial, gender, sexual, and class-based inequalities within larger society. In working with black youth who are homeless, it emphasizes the importance of tailoring interventions and avoiding those that use a "one size fits all" approach. Practitioners can ensure they integrate an intersectional lens by engaging youth in frequent discussions about various aspects of their identity, particularly during program planning and evaluation.

A fourth key concept in anti-racist praxis is microaggressions, which are everyday verbal, nonverbal, and environmental insults, intentional or unintentional, that communicate derogatory or negative messages based on a person's racial identity (Sue et al., 2007). Youth workers should be mindful of the personal and systemic consequences of microaggressions. They need to be vigilant and prepared to interrupt the links between daily personal and relational experiences and systemic anti-black racism.

ALLYSHIP

A co-worker asks you what you were up to this weekend. You tell her you were at a seminar to help you practise talking about racism. She looks startled and says, "I wouldn't need that. I'm colour-blind. I don't see race, only the human race." What do you say?

You're hanging out after work with some co-workers at your drop-in centre and you're talking about the recent violence in the community and measures to adopt for safety. There

is a group of co-workers who are agreeing with the need for racial profiling for security. One person, who has been fuelling the conversation, is getting very emotional and turns to you and says, "I mean, wouldn't YOU want black people to be searched?" How do you respond?

Many people who work in social services occupy privileged or dominant social locations. Social location refers to a person's affiliation or categorization within intersecting webs of oppression and privilege, which include, but are not limited to, race, age, gender, sexual orientation, class, and religion. These affiliations confer on the person a certain set of social roles and expectations, power, and privilege (or lack thereof) (Baines, 2007). Although the vast majority of practitioners enter the field with sincere passion and commitment, their work with people from marginalized groups can often present tensions due to differing social locations, and as a result, risks reproducing oppressive societal power relations (Carniol, 2005; Lundy, 2011; Mullaly, 2002). More recently, the literature on anti-racism and social justice has emphasized the role of allies and allyship in advancing this work (Bishop, 2005; Mullaly, 2009).

An ally is a person who works from an awareness of their social location in relationship to others, who recognizes the privilege they receive from society's patterns of injustice, and who takes responsibility for changing these patterns (Bishop, 2015). Although there have been contending views over the use of the term ally, the general consensus is that allyship is both an identity and a behaviour, founded on practitioners' critical reflexivity and conscious, moment-to-moment choice to challenge inequity and the status quo on behalf of marginalized groups (Fook & Gardner, 2007). McKenzie (2014) has distilled allyship to a few key concrete actions:

- "Shut up" and listen. There is a tendency for people from dominant groups, who have been socialized to be accustomed to having their voices heard, to speak before listening empathically to people from marginalized groups. Allies should cultivate the professional habit and self-awareness for active listening.
- Educate yourself. Allies who are committed to anti-racist practice should proactively educate themselves about anti-black racism and whiteness, drawing on ample resources that are available through the Internet and the community.
- When it's time to talk, do not talk over the people you claim to be in solidarity with. The voice of allies is critical in moving conversations about racism forward, and in engaging people from marginalized groups. However, when they speak, allies should do so from a position of humility and be mindful of not dominating the voice of "others." This contributes to creating safe and inclusive spaces and relationships for clients.

- Accept feedback/criticism about how your "allyship" is causing more harm than good without whitesplaining/mansplaining/whateversplaining. There will be moments when racialized clients express critiques of allies for subtle, inadvertent racism, such as microaggressions or minimizing the experiences of racialized people. Critically reflexive allies should maintain a stance of humility and be open to (and seek out) feedback from those they aim to help.

- Support groups, projects, and organizations run by and for marginalized people so their voices get to be the loudest on the issues that affect them. Authentic empowerment involves enabling people from marginalized groups to exercise self-determination in matters that affect them. Allies can engage in anti-racist praxis by supporting efforts of black-led organizations through actions such as fundraising, getting the word out, recruiting other allies, and doing advocacy.

- Do not expect marginalized people to provide emotional labour for you. Reflecting on and challenging racism and oppression is intellectually and emotionally difficult work that often falls on the shoulders of racialized peoples, who often have the fewest resources to engage in such struggles. Allyship should involve a shared commitment to shoulder some of the intellectual and emotional labour by challenging racism when allies encounter it in their personal and professional lives.

AFROCENTRIC APPROACHES

There is emerging evidence about the effectiveness of culturally relevant youth interventions that are based on values, principles, and concepts that are different than those grounded in Eurocentric values, norms, and traditions (Griner & Smith, 2006; Harvey & Hill, 2004). Afrocentric (similarly known as Africentric or African-centred) thought was pioneered in the West in the 1970s and '80s by the African American scholar Molefi Kete Asante (2003). Afrocentricity was based in a critical reflection on the place that people of African descent held within Eurocentric society, which often involved being relegated to the periphery. Asante proposed a "re-centering" of the African:

> *Afrocentricity is a mode of thought and action in which the centrality of African interests, values, and perspectives predominate. In regards to theory, it is the placing of African people in the center of any analysis of African phenomena. . . . In terms of action and behavior, it is a devotion to the idea that what is in the best interest of African consciousness is at the heart of ethical*

behavior. Finally, Afrocentricity seeks to enshrine the idea that blackness itself is a trope of ethics. Thus, to be black is to be against all forms of oppression, racism, classism, homophobia, patriarchy, child abuse, pedophilia, and white racial domination. (p. 2)

According to Asante (2003), the development of a strong Afrocentric identity could transform a person's worldview and build resilience by reclaiming African languages, names, symbolisms, and traditional practices. It is in a similar spirit that in the 1960s, Maulana Karenga developed the Nguzo Saba, a set of seven Afrocentric principles and values, and created the pan-African holiday Kwanzaa, a global, seven-day (December 26–January 1) celebration of family, community, and culture, using concepts from the Swahili language. Karenga (2016) describes Kwanzaa:

During the holiday, families and communities organize activities around the Nguzo Saba (The Seven Principles): Umoja (Unity), Kujichagulia (Self-Determination), Ujima (Collective Work and Responsibility), Ujamaa (Cooperative Economics), Nia (Purpose), Kuumba (Creativity) and Imani (Faith). Participants also celebrate with feasts (karamu), music, dance, poetry, narratives and end the holiday with a day dedicated to reflection and recommitment to The Seven Principles and other central cultural values. (para 2).

For Karenga (2016), it is not enough to think African; there has to be an enactment of these values in the African person. Currently, Afrocentrism and its related frameworks have influenced approaches to service delivery in areas of social work (Schiele, 1996), psychology (Akbar, 1991), and education (Dei, 1996a). A notable example of Afrocentrism in Canada is the Africentric Alternative School in Toronto, which has been giving young African Canadian students a grounding in an African-centred curriculum since 2009, despite persistent resistance and uncertainty about the school's role and future (James, Howard, Samaroo, Brown, & Parekh, 2015).

Rites of passage

An Afrocentric intervention that shows particular promise in engaging youth is rites of passage programs (Harvey & Hill, 2004). Unlike mainstream rites of passage programs, such as those offered in youth shelters, this form of intervention is rooted in a tradition common to many African cultures, during which adolescents are assisted by elders and the community in their transition to adulthood. These programs incorporate traditional

practices, education, rituals, and arts such as drum and dance (Harvey & Hill, 2004) that draw upon principles of the Nguzo Saba. Rites of passage programs are aimed at consciousness-raising, and provide people of African descent with alternative spheres of reality that emphasize healthy living, community responsibility, and eldership respect. Although relatively little research has examined the impact of rites of passage interventions with street-involved youth, evidence suggests that these programs can have a positive impact on other youth involved with the criminal justice and child welfare systems (Gilbert, Harvey, & Belgrave, 2009).

During the rites of passage process, participants explore the following questions (WoodGreen Community Services, 2016) that re-centre the African identity:

1. Who am I? What values, history, traditions, and cultural precepts do I recognize, respect, and continue?
2. How did I come to be who I am? What were/are the forces, events, and people that have come together to frame who I am?
3. Am I really who I think I am? To what extent do I understand, internalize, employ, and reflect the cultural authenticity of my origins?
4. What is my life purpose?

Youth practitioners can support street-involved African Canadian youth by connecting them with rites of passage programs, or by inviting community elders to their spaces to inform young people about rites of passage opportunities.

FAITH-BASED FAMILY MEDIATION

There is growing interest within human services in using restorative practices as a way to promote justice, problem solving, and healing by bringing victims, wrongdoers, and community together to resolve conflict. Some practitioners suggest that faith-based, restorative approaches to family mediation are an important emerging strategy for working with African Canadian street-involved youth and their families. This type of intervention builds on the central role of faith-based organizations in the lives of many African Canadians (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000) and on the fact that clergy and other faith community members are often the first point of contact for mental health services (due, in part, to distrust of mainstream service providers). Youth

workers can explore these options by speaking with youth about their connections to faith communities and their openness to using them as a resource.

It is important for faith-based family mediation to use trauma-informed and intersectional lenses because trauma and social identities often underlie pathways to homelessness for youth. Many of these youth have been traumatized by homophobia and heterosexism in their homes and religious institutions. Indeed, religious beliefs have been a source of marginalization and exclusion of many young people, particularly for those who identify as LGBTQ2S. This means that practitioners who engage in faith-based restorative practice should ensure that faith organizations are committed to inclusive, anti-oppressive values and provide safe and respectful spaces for restorative practices.

IMPLEMENTATION CONSIDERATIONS

ADVOCACY & STRUCTURAL CHANGE

Implementing anti-racist praxis requires that we expand our analysis of mental health problems and homelessness beyond individuals to the systems that produce inequities. This expanded analysis has implications for service providers: What is the role of front-line practitioners in changing systems and structures? How can practitioners do so through anti-racist praxis? To effectively respond to these challenges, youth workers must be willing to extend their role beyond front-line service delivery to become system advocates and community organizers, and to engage in policy development (Skott-Myhre, 2006). Youth workers possess a wealth of knowledge and wisdom about the impacts of systems on the lives of young people. They are well positioned to act for social change, especially by engaging young people in advocacy efforts.

POLICY DEVELOPMENT

Youth workers can have considerable influence on policy development. Social policies, such as those related to housing and homelessness, child welfare, and criminal justice, have profound impacts on the lives of African Canadian street-involved youth, often in ways that deepen their marginalization. Creating more just and responsive policy,

therefore, can have a tremendous impact on large populations of the young people with whom we work. There are many ways in which the average youth worker can get involved in policy development. They can participate in community consultation processes and join public advisory committees or the boards of community agencies and councils (e.g., African Canadian Legal Clinic, Tabono Institute). They can also join think tanks (e.g., Broadbent Institute, Canadian Centre for Policy Alternatives) or partner with universities to conduct and disseminate research about the effects of policy on young people.

COMMUNITY MOBILIZATION & ACTIVISM

Sometimes incrementalist, accommodationist approaches to policy change are too slow to generate the kind of social change required for equity. Community activism (or social action) can be an effective method for naming and drawing public attention to issues of institutional racism and for pressuring government or other authorities to act. This kind of activity often involves work that extends beyond the formal paid professional roles and responsibilities of most youth practitioners, and can pose professional, political, and ethical challenges to the practitioner. However, we believe it remains a critical component of anti-racist praxis. One of the most effective anti-racist grassroots activism initiatives in recent history is the Black Lives Matter movement, whose activities have generated international conversations about race, and which has sparked systemic change in some local areas. There are many approaches to activism, including direct action through protest or acts of civil disobedience. There are also artistic forms of activism, such as music, graffiti, and street theatre. Youth workers can also engage in more indirect forms of activism, such as sharing information, signing petitions, and writing news articles or opinion pieces. Social action can be an effective way to empower marginalized young people.

KEY MESSAGES FOR PRACTITIONERS

- Working with African Canadian youth requires a shift in perspective from service models to critical reflectivity and praxis.
- Practitioners should try to connect young people with culturally relevant resources and assets within African Canadian communities.

- Anti-racist work requires the role of front-line workers to expand to include advocating structural- and systems-level change.

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2.5 ECOLOGICALLY BASED TREATMENT FOR MOTHERS EXPERIENCING HOMELESSNESS WHO HAVE CHILDREN IN THEIR CARE

Aaron Murnan, Jing Zhang, & Natasha Slesnick

CONTEXT & EVIDENCE

The majority of families that are homeless are headed by single mothers who have an average of two young children in their care. These mothers are especially vulnerable because they struggle to meet the basic needs of their children and themselves. In addition to the stress of homelessness, they also often struggle with substance use, and physical and mental health problems (Slesnick, Glassman, Katafiasz, & Collins, 2012). Moreover, the harshness of homelessness creates parenting difficulties. Mothers stressed by hunger, threats to safety, and lack of social support are challenged to respond effectively to their children's needs (David, Gelberg, & Suchman, 2012). Despite the great need for acquiring intervention services, mothers who are homeless may be reluctant to access substance use treatment due to fear of having their children removed from their care (National Alliance to End Homelessness, 2006). In most cases, however, housing is the primary and most immediate need of these mothers.

Taking a Housing First approach, ecologically based treatment (EBT, Slesnick et al., 2012) is one of the first integrative treatments for mothers who are homeless and use substances and have young children in their care that combines housing with supportive services (including case management and substance use / mental health counselling). The Housing First approach acknowledges housing as a basic human right and argues that housing support should be offered to people who are homeless independent of adherence to mental health treatment and sobriety (Tsemberis & Asmussen, 1999). Tsemberis, Gulcur, and Nakae (2004) found that compared with the continuum of care approach, in which housing has prerequisites of treatment or sobriety, the Housing First approach leads to superior housing outcomes; for example, individuals obtained housing earlier and were able to maintain it without compromising substance use and psychiatric symptoms. Moreover, research shows that housing is associated with improvement around substance use issues (Padgett, Stanhope, Henwood, & Stefancic, 2011) and improved subjective quality of life (Patterson et al., 2013). As such, by integrating housing and supportive services, EBT is likely to improve individual and family outcomes of mothers who are homeless and have young children in their care.

EBT focuses on increasing successful experiences, which is expected to lead to an increased sense of personal control, and subsequently, improved individual and family outcomes (Slesnick et al., 2012). A treatment development study funded through the National Institute on Drug Abuse provides evidence for the effectiveness of EBT in addressing mothers' substance use and children's problem behaviours, as well as improving housing stability. The study involved 60 mothers experiencing homelessness who had a biological child aged 2–6 in their care. Mothers ranged in age from 18 to 41, with an average age of 26. Of the mothers, 75% were African American, and 75% were single and had never been married. The average child age was 3.7 years, and 48% of the children were female. The study found that compared with mothers receiving services as usual through a crisis shelter, those receiving EBT exhibited a faster decline in the frequency of alcohol use and a quicker increase in housing stability (Slesnick & Erdem, 2013), as well as significant reductions in the child's problem behaviours (Guo, Slesnick, & Feng, 2016). These findings support the effectiveness of EBT in improving housing stability, as well as other outcomes.

A Housing First philosophy does not require individuals to access shelters prior to housing. Research shows that youth who are homeless do not access resources meant for them, including shelters (Kelly & Caputo, 2007). With shelters as the primary avenue for exiting street life, alternatives that work for those who refuse to access shelters, and for those communities in which shelters are not available, are needed. Therefore, EBT has the potential to be replicated and generalized to those communities that do not have shelters, and to those youth who are unlikely to access them.

INTERVENTION COMPONENTS

Based on the treatment development study described above, EBT, which is our version of housing plus supportive services, includes three primary components: rental assistance, strengths-based case management (SBOA), and the community reinforcement approach (CRA) to addressing substance use and mental health issues (Meyers & Smith, 1995). Once housing is obtained, women receive at least one case management session and one CRA session each week. These two components of intervention are integrated and inform each other. Case management aims to support women as they traverse the system of care to secure needed resources and services. The purpose of case management has been described in this way: "to assist consumers in identifying, securing, and sustaining the

range of resources, both environmental and personal, needed to live, plan, and work in a normally independent way in the community" (Rapp & Goscha, 2006, p. 44). In particular, case management sessions focus on helping women meet their basic needs and the needs of their children, including obtaining government assistance and engaging with needed supports that foster financial independence. Without the provision of transportation, it is unlikely women will successfully engage with service providers; therefore, therapists offer transportation to various appointments. Alternatively, CRA helps clients identify and engage in alternative reinforcing activities that compete with maladaptive behaviours such as substance use. CRA complements case management; for example, a CRA goal of reducing substance use can be supported when a client obtains health insurance through case management. One master's level counsellor conducts all three components of the intervention in order to promote a strong therapeutic relationship and reduce the confusion and inefficiency associated with coordinating between multiple providers.

SESSION LOGISTICS

EBT includes up to 20 therapy sessions and 28 case management sessions provided over a period of six months. Additionally, the program pays the security deposit and three months of rent directly to the landlord, as well as three months of utilities. Leases are signed by the tenant, with efforts taken to obtain month-to-month or three-month leases to avoid a potential eviction on the client's record. Frequent meetings in the initial stages of intervention are encouraged to capitalize on women's motivation to exit homelessness. On average, women in the evaluation study met with their therapist 23 times. Meetings can be held in nontraditional settings, including parks, libraries, or wherever the client is staying. Flexibility in meeting location removes barriers associated with transportation and better accommodates women's needs.

HOUSING

In the early stages of EBT, therapists spend a significant amount of time helping mothers identify affordable housing options and providing transportation to view the rentals. Rental considerations should include proximity of the apartment to bus lines and employment opportunities, as well as neighbourhood safety. In addition, therapists need to ensure certain barriers are addressed prior to the housing search, as described here:

- Landlords require valid identification to complete a lease, and most women will not have government-issued identification. Failure to assist women in obtaining identification quickly can result in the loss of housing opportunities because most landlords will not hold properties while women acquire these documents.
- Some women hold unrealistic expectations for the condition of the apartments. Apartments in the $400 to $600 range are typically very basic, old, and small, and may be located in a low-income neighbourhood. This disappointment can be addressed by reframing the apartment as a "stepping stone" and an opportunity for women to "get back on their feet." Once the client has income stability and has established herself as a reliable tenant, she will be able to find better housing options.
- Women's rental choices will be limited by past evictions, a criminal record, and lack of current employment. To address these barriers, therapists should identify several landlords who are open to providing women with a "second chance" by being flexible on their housing requirements. The creation of this list of landlords can save time in the search process and reduce women's experiences of rejection and disappointment.

SUPPORTIVE SERVICES FOR MAINTAINING HOUSING

Once women and their children have moved into their apartment, the intervention focus shifts toward developing strategies to maintain housing beyond project support. Women's ability to secure financial support is critical. Employment, education, and government assistance (e.g., cash assistance, subsidized child care) are options that can increase success. While rental assistance is offered for three months, supportive services continue for six months to help ensure mothers' success.

Employment

Most women will state that they want employment. They may require assistance with transportation to pursue employment opportunities, completing employment applications, and preparing for interviews. Some women will be anxious or intimidated by the interview process. Therapists can alleviate this anxiety by practising the interview through role play. Women will develop confidence through practice, and will be prepared to respond to difficult questions regarding their lack of previous work experience or criminal history. Women should always be encouraged to disclose their criminal/arrest record on applications with prospective employers. Some women will not disclose this information, which can lead to losing their employment later. In addition, women's substance use can

manifest as a lack of motivation and poor follow-through. Because of this, substance use treatment may need to take priority, if the woman is willing. Similarly, for women with criminal records, temporary agencies and local felon re-entry employment programs offer employment options, as these agencies regularly place individuals with employers who are willing to overlook criminal records. Women will likely require assistance from their therapist in navigating these challenges and processing related frustrations and anxieties.

Education

While most women will choose employment, some may prefer to attend a local community college, high-school equivalency program, or vocational training program. Many of these educational options provide adequate funding through stipends, grants, or loans, which may provide enough income for women to become self-sufficient. Women will likely need assistance navigating the admissions process, enrolling in classes, and completing applications for school and federal student aid (in the United States, through the Free Application for Federal Student Aid). Once in school, women may also want assistance with developing time management and organizational skills. Therapists should be prepared to offer assistance in helping women achieve any and all tasks that promote their ability to progress toward their goals and maintain housing.

Government assistance

Regardless of whether women select employment or education, for some, their initial wage or stipend may not cover their expenses. Therefore, women are also encouraged to enrol in government assistance programs for low-income families that offer resources such as cash/utility assistance, rental assistance, subsidized medical care, food assistance, and subsidized child care. In many cases, enrolment in government assistance goes hand-in-hand with successfully balancing the responsibilities of working and being a single mother. For example, acquiring affordable child care prevents women from losing their job as a result of not coming to work due to unreliable babysitters. Employment wages or educational stipends in conjunction with government assistance further promote women's self-sufficiency beyond treatment.

SUPPORTIVE SERVICES FOR ADDRESSING SUBSTANCE USE & MENTAL HEALTH ISSUES

Addressing problems with substance use and mental health is also critical because unaddressed problems can undermine success. For many mothers who are homeless, substance use may be their only means to cope with the stress associated with homelessness, parenting, and problems with mental health, such as anxiety or depression. However, substance use can be a major obstacle to many of the women's goals because it can interfere with motivation, and the ability to maintain employment or stay in school. Drug use is also a barrier for positions that require drug testing. CRA helps women develop alternative coping strategies and process feelings about previous victimization experiences and trauma that may be linked to substance use. Many women have not fully processed these experiences, and the opportunity to discuss these topics in a safe and non-judgemental environment is often a new experience. Therapists can offer alternative perspectives on substance use and trauma experiences, as well as offering insight into how these experiences may have impacted the woman's life.

Some women may not be interested in seeking substance use treatment and may have little motivation to change their substance use behaviours. When women are uninterested in discussing their alcohol or drug use, therapists should address other goals that are more salient to the women. Once a therapeutic relationship has been established, the therapist should offer gentle connections between substance use and the client's identified goals. For example, the therapist can help the client identify the impact of substance use on her struggle to obtain employment, as well as processing anxiety about the interview or the job itself, as substance use may help her cope with these emotions.

Many mothers who are homeless have untreated psychiatric problems that interfere with successful employment, education, or reductions in substance use behaviours. Psychiatric evaluations are often difficult to schedule at locations that offer reduced-cost services. These facilities are typically over-burdened and have long waits. Also, many women are reluctant to attend psychiatric appointments out of fear ("I am not crazy!" or "What if they lock me away?") or unwillingness to wait for an extended period of time. Therapists are encouraged to transport women to the appointments and wait with them. At times, therapists may need to advocate for women to ensure they receive adequate attention and the requested service.

SUPPORTING THE CHILDREN

The children in our project ranged in age from 2 to 6 years. These children are too young to participate in talk therapy with their mothers, but therapists focus on helping mothers reduce parenting stress and improve their parenting skills if they indicate they need this assistance. Parenting intervention can include strategies for discipline and cognitive intervention for understanding or reframing the intentions of children. Therapists often help find appropriate child care so the mother can attend school or work. It is important to counsel mothers not to leave their children with parents or significant others who mistreated the mother in the past because people who were abusive to the mother may also be abusive to her children.

The welfare of the children improves as mothers engage in EBT. Mothers learn to better meet the basic needs of their children (e.g., shelter, food, clothing, safety), which are largely unmet prior to intervention. Ensuring that basic needs are addressed can also reduce the likelihood of children being removed from their mother's care and placed into the foster care system. Once housed, mothers are able to better regulate their children's exposure to high-risk situations for abuse. Furthermore, as mothers learn to manage their substance use and better cope with parenting stress, they are better able to meet the emotional needs of their children. In addition to the improved mother–child relationship, children often become more connected with other nurturing environments, such as school and child care programs, which may facilitate improved growth and development.

TERMINATING THERAPY

Reaching the end of therapy can be particularly challenging for women because they have developed a therapeutic bond with the therapist. To prepare women for this time, the therapist should remind them throughout the intervention when treatment will end. Termination can elicit strong feelings of sadness. In many cases, the therapist may be one of few supportive people in the woman's life and the first who has provided unconditional positive regard. Women should be encouraged to process these feelings in session with their therapist. Also, as the day approaches, therapists should work with women to develop a plan for addressing ongoing needs after treatment ends. If it is determined that women need additional support to meet their goals, they should be connected to other services prior to termination. Therapists should seek to overlap services with new service providers to facilitate the transition.

IMPLEMENTATION CONSIDERATIONS

The themes below describe strategies for commonly observed challenges associated with intervention approaches for mothers who are homeless.

BUILDING TRUST

Initially, many women will be reluctant to engage with their therapist at all, largely due to prior negative experiences with service providers. Focusing on housing and other case management activities (e.g., obtaining identification) at the early stages of the intervention aids the development of trust. As trust develops, women will be more likely to divulge sensitive information and engage in therapy. Once a strong therapeutic relationship is established, women often allow their therapist to initiate conversations about more sensitive topics, such as trauma, parenting, mental health, or substance use.

BALANCING TIME SPENT WITH WOMEN

Therapists may question how much assistance is too much and may believe that women are not learning to do things on their own. It is important to consider the temporary nature of the therapeutic relationship and that therapists ultimately need to help women become self-sufficient. That is, a balance must be achieved in which the therapist offers assistance and support as needed, but that over time, the client is able to process and address events independently. At the early stages of the intervention, therapists should devote more time and provide more assistance to women; otherwise, many women will miss appointments and fail to complete important tasks. For example, therapists can make phone calls with women, provide transportation to appointments and interviews, and in some cases, attend appointments with women. Therapists should withhold judgement about perceived dependence and focus instead on ensuring women experience success, which is expected to bolster their confidence and self-efficacy. Once women experience success, they will be more willing to complete other tasks with less help from the therapist. Therapists can gradually reduce the amount of assistance they offer as women develop greater confidence and skills.

CRISIS MANAGEMENT

Crises frequently occur throughout the course of intervention with mothers who are homeless. Given that homelessness is itself a crisis and usually the culmination of several related crises, continued crises should be expected. Common crises include domestic violence, open warrants for arrest and the consequent arrest, inability to pay rent, utilities being shut off, and losing custody of children. Women may feel completely helpless and overwhelmed in these moments, and the therapist must help the client regain a sense of self-efficacy. Breaking down the steps that are under the client's control can help make a seemingly overwhelming situation manageable.

CONCLUSION

EBT offers mothers who are homeless and who have children in their care a unique opportunity to get back on their feet. Women develop skills to meet their basic needs as well as the needs of their children, and receive assistance in connecting with other services offered within the community. This approach engages women in therapeutic dialogue they otherwise would not experience. Women have the opportunity to process previous trauma and victimization, sometimes for the first time. Additionally, supportive services offer an opportunity to receive assistance for mental health issues or substance use that can otherwise undermine women's attempts to improve their quality of life. Intervening with mothers who are homeless poses unique and difficult challenges for treatment providers'; however, EBT has shown great promise in meeting the immediate and longer-term needs of these families.

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2.6 DEVELOPING A TRAUMA-INFORMED MENTAL HEALTH GROUP INTERVENTION FOR YOUTH TRANSITIONING OUT OF HOMELESSNESS

Nina Vitopoulos, Leysa Cerswell Kielburger, Tyler Frederick, & Sean Kidd

CONTEXT & EVIDENCE

Young people who are homeless experience converging and amplified risk due to their developmental stage, as well as the stress, risk behaviours, and associated trauma that often accompany becoming or being homeless. They tend to be immersed in environments characterized by multiple adversities over their lifetime and it is generally agreed that the mental health of these youth is poorer than that of youth who are housed. Most youth report that their mental health problems began before they left home (Craig & Hodson, 1998; Karabanow et al., 2007). Life on the street and the adversity that accompanies homelessness exacerbate these pre-existing mental health issues. Youth not only lack the basic necessities of shelter and food (Tarasuk & Dachner, 2005), but they also face constant and pervasive threats to their safety and well-being in the form of physical and sexual assault and other types of victimization (Karabanow et al., 2007; Whitbeck et al., 2000). Research has found almost universally high levels of mental health issues among youth who are homeless, with rates ranging from 48% (Kamieniecki, 2001) to as high as 98% (Hodgson et al., 2015; Merscham, Van Leeuwen, & McGuire, 2009). The impact of trauma is particularly salient. Coates and McKenzie-Mohr (2010) found that over 50% of youth who are homeless experience severe effects of traumatic stress.

Most youth with mental illness who are homeless do not receive any form of treatment (Kamieniecki, 2001; Slesnick & Prestopnik, 2005). The barriers to accessing care are readily apparent in the low capacity of community service agencies to provide care for individuals with more severe mental illness. Youth who are homeless also face barriers to psychiatric care (Kidd, 2013). Studies suggest that these youth are often reluctant to access healthcare services because of difficulty navigating the healthcare system, few clinic sites, lack of coordination among service providers, inconvenient operating hours, and long waitlists (Edidin, Ganim, Hunter, & Karnik, 2012).

Currently, the dominant approach to intervention is crisis response, often in the form of general drop-in and emergency shelter services, which, as McKenzie-Mohr et al. (2010) point out, tend to use reactive approaches focused on meeting basic needs and providing education, employment, and skills training (Klodawsky, Aubry, & Farrell, 2006), with the goal of placing these youth into responsible and productive roles in society.

There exists only a small group of studies examining the impact of shelters, drop-in centres, and intervention approaches on youth mental health (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009), and evidence of the effectiveness of these interventions is generally lacking or unclear (Kidd et al., 2016). While some specific interventions show promise, in general, models that are effective with other marginalized populations have not demonstrated clear benefit for youth (Altena, Brilleslijper-Kater, & Wolf, 2010; Slesnick, et al., 2009). Furthermore, intervention models that target homelessness itself as the core problem (with a focus on housing, employment, and school engagement) are criticized for overlooking the influences of trauma and mental health on the situations and choices of youth. The implications of these challenges are clear, evidenced by very high mortality rates in this population, with drug overdose and suicide as the leading causes of death (Rew, Taylor-Seehafer, & Fitzgerald, 2001).

While few studies have investigated the efficacy of interventions targeted at the broader mental health and wellness needs of youth who are homeless, even less is known about youth who are in the process of transitioning out of homelessness. Many youth experience protracted and complex pathways out of homelessness, with significant challenges in securing decent quality of housing, employment, and engagement in education. For example, one study found that 24% of those recently housed experience a loss of stable housing in a one-year period (Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014); the remainder struggle greatly with social isolation, complex trauma symptoms, poor physical health, and other challenges (Kidd et al., 2013). The more protracted the process of transitioning out of homelessness, the greater the difficulty youth have in achieving a decent quality of life and a sense of engagement in non-homeless communities, relationships, and self-concepts (Kidd et al., 2016). To date, only a very small and under-developed literature exists on the development and feasibility of comprehensive, evidence-informed, accessible interventions for youth who are homeless and youth attempting to exit the homelessness cycle.

OVERVIEW

This chapter describes the development and delivery of a mental health group intervention for young people, aged 16–26, who are in their first year of transitioning from homelessness to independent living. This intervention was developed as a piece of a broader pilot intervention that sought to develop a feasible, integrated set of supports for youth within their first year of transitioning to stable housing. The group intervention described is a particularly relevant effort in this transitional time when the pressures of daily survival have to some extent

ameliorated, and most youth are struggling to address mental health challenges and develop new coping mechanisms relevant to non-street contexts. The intervention aimed to provide mental health support to a population of youth who often have difficulty engaging with traditional mental health services, despite experiencing significant changes in daily living, increased social isolation, and ongoing mental health needs, as well as having histories of maltreatment and complex trauma. This endeavour is particularly timely given the recent wave of Housing First for youth initiatives that have arisen globally, which highlight the need for developmentally appropriate and practical social and mental health supports to coincide with basic housing for youth (Gaetz, 2014; Hodges, Ferreira, Israel, & Mazza, 2006).

INTERVENTION DEVELOPMENT PROCESS

Key aspects of the challenges faced by youth transitioning to housing include loneliness, maintaining hope, psychological distress, and challenges establishing a sense of meaning, purpose, and place through the transition process. Participants in the Kidd et al. (2016) study reported experiencing mental health challenges, and the re-emergence of symptoms of complex trauma, in particular. In response to these identified needs, as well as in an attempt to maximize often finite clinical and community resources, we aimed to design a weekly group intervention. Given the evidenced high need for but chronic lack of mental health services for these youth, as well as the extremely limited knowledge base on the efficacy of mental health interventions with this population, this group intervention represents a novel investigation into the development and delivery of mental health services for youth who are transitioning from homelessness to housing.

The development process for the intervention included a review of current literature in the area of clinical intervention with precariously housed youth, as well as the broader emerging adult intervention literature, in order to identify promising evidence-based materials. Using a broad team consultation method, which included experts in the fields of youth homelessness, mindfulness, and dialectical behaviour therapy, as well as our broader intervention staff (i.e., peer mentors, case managers, researchers), and our community organization partners, key intervention domains and materials were vetted and prioritized. This process identified 10 key intervention domains with multiple modules in each. The group development process continued throughout the provision of the group, as participants' requests and needs were integrated into group content. Several significant development considerations and their integration into group structure and content are mapped out in Figure 2.6-1.

FIGURE 2.6-1: HOUSING OUTREACH PROGRAM COLLABORATION WELLNESS &
MINDFULNESS GROUP DEVELOPMENT

CONSIDERATIONS IN GROUP DEVELOPMENT	COMPONENTS OF GROUP INTERVENTION

Context of Youth Transitioning from Homelessness to Housing

Youth averse to formal mental health interventions/ clinical spaces due to past experiences and fears of discrimination against them

Youth reluctant to visit shelter settings after having made transition to housing

Ongoing struggles meeting basic needs (i.e., food, ongoing housing challenges)

Youth experiencing continued crises and chaos after moving into housing

uth experiencing initial mistrust and requiring relationship development to engage in services

Setting is community arts hub that offers diverse arts programming and evening meals following group; transit cost provided

Open format to encourage flexible participation around youths' changing needs and schedules

For initial group sessions, short YouTube videos were created introducing facilitators and session topics

Weekly email/text/phone communication from co-facilitator introducing group content

Peer mentors attended initial groups to enhance comfort and build connection

| CONSIDERATIONS IN GROUP DEVELOPMENT | COMPONENTS OF GROUPS INTERVENTION |

System Considerations

Limited financial resources for individualized mental health services → Group intervention format

Long access times and waitlists to traditional mental health services

Youth Mental Health/Wellness Needs

Loneliness and social Isolation

- DBT–Interpersonal effectiveness
- Social support assessment
- Boundaries
- Attachment styles

Difficulties in familial and social relationships and conflict management

- CBT–Recognizing and describing emotions
- DBT–Emotional regulation
- Managing and expressing anger

Difficulty recognizing and managing emotions (i.e., sadness, anger, fear)

Mindfulness approaches

Harmful crisis coping behaviours (i.e., substance use, self-harm, avoidance)

- DBT–Crisis management skills
- Self-care

Experiencing hopelessness, self-stigma, and the "why try" effect

- Self-stigma exercises
- Self-esteem exercises

After effects of complex trauma – symptoms and alterations to world view

- Trauma psycho education

Challenges managing basics of independent living

- Practical workshops on goal setting, time management, and budgeting

INTERVENTION COMPONENTS

SESSION LOGISTICS

Sessions were 90 minutes long, including a 15-minute break for provided meals. The group was held in a non-clinical setting, in our case, a community arts hub, in order to limit barriers to participant engagement, including stigma associated with receiving treatment in formal settings such as hospitals and agencies serving youth who are homeless, associations to previous challenging experiences with formal service settings, and triggers that can attend contacts with youth post-transition. The group was open, meaning that any participant could attend any given week and attendance was voluntary. Other than the criteria for involvement in the broader intervention (aged 16–26, formerly precariously housed, and currently stably housed), there were no inclusion or exclusion criteria based on mental health or cognitive functioning.

TRAINING

Co-facilitators of the intervention were a post-doctoral–level clinical psychologist with specific expertise in trauma, and a master's-level mindfulness therapist who was completing her doctoral training in clinical psychology. Given the degree of youth participants' complex clinical needs (i.e., often multiple mental health comorbidities; high incidence of complex trauma; ongoing instability in relationships, housing, and mental health), it was essential that clinicians had a high level of professional training in mental health care. Training in approaches to trauma-informed care and treatment was a particular asset as group discussions and relational dynamics often necessitated a trauma-informed approach. Future iterations of this group should be facilitated by at least one mental health specialist (i.e., psychologist, psychiatrist, experienced master's-level social worker) with expertise in trauma. Our group benefited from the expertise of a mindfulness therapist with experience engaging youth and adults from diverse contexts in mindfulness practice. With at least one mental health specialist as lead facilitator, co-facilitators can be other care professionals who interact with youth in different contexts (e.g., case managers, nurses, peer support workers) and can be supported by a lead facilitator.

GROUP FORMAT

Participant-generated group guidelines (3–5 minutes to review/discuss/revise; 20–30 minutes to develop initially). During the group's first sessions, group participants developed a set of group guidelines that could be modified in subsequent weeks. These guidelines were reviewed at the beginning of each session and participants were given the option to add, modify, and discuss any guidelines on the list.

Optional participant check-in (10–20 minutes, depending on group size). Participants were given time for a flexible narrative exploration of past and present challenges and successes following the practice principles of process-oriented group psychotherapy (Yalom & Leszcz, 2005).

Interactive teaching and application of wellness skills (30–40 minutes). An eclectic group of evidence-based coping skills based on dialectical behaviour therapy (Linehan, 2015) and cognitive-behavioural therapy frameworks, as well as other topics of relevance and interest to the group (self-care, self-esteem, trauma psychoeducation, self-stigma, practical skills such as budgeting, goal setting, and time management) were delivered weekly. Research suggests that among at-risk youth and individuals experiencing complex trauma, emotion regulation, interpersonal effectiveness, and mindfulness coping strategies are feasible and effective (Cloitre et al., 2011; Kerrigan et al., 2011; McCay et al., 2015).

Mindfulness-based intervention (15–20 minutes). Easy to engage in mindfulness activities were offered at each session. They were chosen each week to relate to the wellness skill presented in the session. After each mindfulness practice, the group debriefed the experience of the practice, as well as its potential utility in daily life. Mindfulness-based interventions have previously been demonstrated as feasible with youth who are homeless (Grabbe, Nguy, & Higgins, 2012).

GROUP CONTENT

Much of the content was developed in advance of the group, based on broader research on effective group intervention and specifically with young marginalized populations. Several additional topics were developed based on the suggestions and needs of participants. For example, the practical skills sessions (budgeting, goal setting) were not initially planned but were developed in response to suggestions by participants. Table 2.6-1 outlines session topics, rationale for inclusion, and selected references.

TABLE 2.6-1: GROUP TOPICS, RATIONALE FOR INCLUSION, & SELECTED REFERENCES

DIALECTICAL BEHAVIOUR THERAPY	
Group topics	**Rationale for inclusion**
Interpersonal effectiveness Relationship skills/Arguing 101 (GIVE and DEARMAN skills); validating self and others; keeping your self-respect in conflict (FAST skills); saying "no" and setting boundaries	The need for enhanced interpersonal effectiveness skills permeated across life domains for many participants. Participants regularly identified ongoing difficulty with managing conflict and maintaining boundaries across relationships and circumstances.
Emotional regulation Wise, reasonable, and emotional mind; self-care/ accumulating positive experiences; PLEASE skills for self-care; distracting and soothing coping skills	Coping with emotional distress, particularly feelings of frustration, anxiety, and sadness, was an important goal for many participants. Maintaining mental and physical balance, building positive experiences, and coping with difficult emotions were emphasized.
Crisis management Quick coping techniques (TIPP skills); identifying a crisis and STOP skills; healthy vs. unhealthy coping	Sessions on crisis management were intended to build and expand participants' repertoire of skills and coping techniques for dealing with emotional crises. Skills that were immediate, hands-on, and easy to use were a predominant focus.
References Deschene (2013); Miller, Rathus, & Linehan (2007); Linehan (2015); McCay et al. (2010); Rathus, Miller, & Linehan (2015)	
COGNITIVE-BEHAVIOURAL THERAPY	
Group topics	**Rationale for inclusion**
Emotion awareness Recognizing and describing emotions and experiences (thoughts, feelings, behaviours): myths and facts about emotions; anger, sadness, happiness, fear	Sessions focused on myths and facts about emotions, as well as identifying thoughts, feelings, bodily sensations, and behaviours associated with the experience of emotions. Participants often discussed "turning off" and lacking awareness of their emotional states. Sessions focused on the importance of being able to identify and understand one's emotions and parsing one's experience into its component parts (thoughts, emotions, body sensations, behaviours).
Managing and expressing anger Anger management strategies; barriers to expressing anger (conflict styles); conflict resolution	Participants discussed difficulty managing anger when threatened or in conflict, as well as difficulties feeling safe expressing anger. Sessions centred on practical tips for expressing anger in an assertive and safe way.
References Centre for Mindfulness Studies (2015); Centre for Mindfulness Studies & Jaime C. Bulatao, SJ Center for Psychology Services (2015); Kendall, Choudhury, Hudson, & Webb (2002); Wilansky-Traynor & Warling (2011)	

OTHER MODULES	
Group topics	**Rationale for inclusion**
Self-care Maintaining life balance; self-care checklist; pleasurable activities; nourishing/depleting activities	Sessions focused on maintaining both essential self-care (i.e., safety and health), as well as wellness-based self-care to maintain mental and physical health. Sessions aimed to help participants maintain balance, reduce stress, and shift from managing crises of survival to managing daily stress and balancing daily responsibilities.
Relationships Social support assessment; relationship boundaries; relational styles (attachment styles)	Activities focused on participants observing and identifying both strengths and weaknesses in their current social relationships. This included discussions of how relationship to others may change throughout participants' transitions away from homelessness and into housing.
Self-esteem Identifying and acknowledging positive traits; Howard's rules of unconditional self-worth; positive affirmations	Sessions took a strengths-based approach to identity exploration as emerging adults. These sessions focused on identifying and acknowledging participants' personal strengths and discussions of negative vs. positive thinking patterns.
Self-stigma Myths and facts about homeless youth; the "why try?" effect	Self-stigma may serve as a risk to social isolation, as well as a significant barrier to engagement in needed services. Sessions focused on correcting myths about homelessness and youth to reflect participants' truths.
Trauma-specific Posttraumatic stress psychoeducation	A psychoeducational session helped participants better understand the body's response to trauma, as well as symptoms of posttraumatic stress disorder (PTSD) and complex PTSD.
References Bartholomew & Horowitz (1991); Centre for Mindfulness Studies (2015); Corrigan, Larson, & Rusch (2009); Fisher (2009); Home Alive (2015); Najavits (2002); Schiraldi (2001); Teen Talk (2016); Yanos, Lucksted, Drapalski, Roe, & Lysaker (2014)	

PRACTICAL SKILLS	
Group topics	**Rationale for inclusion**
Goal setting Setting goals (SMART goals); long- vs. short-term goal setting; time management	Sessions focused on practical ways to plan for both short- and long-term goals. Applied practices with real goals were used. Challenges and barriers to goal setting and achievement were also discussed.
Budgeting Mindful money management; budgeting game	Practical budgeting tips along with a real-world based budgeting game were presented at the request of participants.
Guests/workshops Ask a criminal lawyer anything; ask a formerly precariously housed youth anything; mindfulness drumming and photography workshops	These engaging workshops were open to the broader community and highlighted novel mindfulness or art activities, or specific areas of knowledge identified as relevant to participants.
References Academic Success Center (n.d); Blair (2015); Locke & Latham (2002)	

MINDFULNESS	
Group topics	**Rationale for inclusion**
Introduction to mindfulness What is mindfulness?; seven attitudes of mindfulness	Participants received an introduction to mindfulness practice and its benefits.
Mindful movement Light stretching; walking; confidence and power pose	Movement-based mindfulness practices were often easier for participants to engage in because they involved activity. At times, movement could also be experienced as overwhelming. Participants were asked to "take care of their bodies" and only do movements that felt comfortable.
Short mindfulness practices Loving-kindness practice; taking in the good practice; three-minute breathing space; mindful self-compassion; SOBER practice (for urges); STOP practice	Easy to engage mindfulness practices lasting one to three minutes were offered and discussed across several sessions to introduce mindfulness practice and its utility in daily life.
Mindful communication Mindful speech; mindful listening	Mindful communication tied in well with interpersonal effectiveness groups and offered strategies for attentive and careful communication.
Mindful awareness Five senses exploration (touch, smell, taste, sight, hearing); mindful eating; sense and savoury walk	These activities focused on awareness of the environment and sensory experiences. The aim was to build participants' capacities to remain in the moment and to focus on the present.
References Bowen, Chawla, & Marlatt (2010); Burggraf (2007); Center for Mindfulness Studies (2015); Center for Mindfulness Studies & Jaime C. Bulatao, SJ Center for Psychology Services (2015); Germer (2009); Goldstein (2012); Hanson (2005); Segal, Williams, & Teasdale (2013)	

IMPLEMENTATION CONSIDERATIONS

MEETING BASIC NEEDS BEFORE ENGAGING YOUTH WITH MENTAL HEALTH INTERVENTION

In order for youth to be able to able to engage in any meaningful way with a mental health group intervention, it is necessary that their basic needs are met, such as nourishment and shelter (long-term residence or shorter-term shelter housing). The intervention must take place in a safe and secure environment, where youth are not fearful for their physical or emotional safety. Youth in immediate crisis or whose primary needs are not met will very likely struggle to engage and benefit from this intervention. Likewise, the group format is generally inappropriate for youth who are actively intoxicated. That being said, it is likely that substance use, management of withdrawal symptoms, and urges to use substances will be clinical needs for some group participants. Facilitators should be prepared to discuss and offer strategies to manage these needs. The current intervention generally took a harm reduction approach and welcomed youth at various stages of substance use recovery.

PROVIDING OPPORTUNITIES TO BUILD RELATIONSHIPS

Often, participants were enrolled in the larger project for many months before attending their first group. Some expressed reluctance to attend initially because they were unfamiliar with the setting, group leaders, and fellow participants. Participants indicated that having an already trusted connection introduce them to the group, often a case manager, or having the opportunity to meet with group facilitators individually before attending the group helped establish safety in the group. Some participants commented that short videos, hosted by the co-facilitator of the group, allowed them to check out who was running the group and eventually make the decision to attend.[1] Once participants were enrolled in the larger project, the weekly communication via text, phone, and/or email was maintained, reminding them of weekly group and topics covered. Generally, frequent communication and opportunities to build personal connections and trust prior to beginning the group improved chances of engagement. Future iterations of this group could implement individual orientation sessions for participants, as is often done before commencing more formal group treatment.

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[1] For an example of a video, see www.youtube.com/watch?v=TuIB7hX87iw&t=22s

TAKING A FLEXIBLE APPROACH TO SERVICE DELIVERY FOR YOUTH IN TRANSITION

Due to the open style of the group, attendance was difficult to predict on any given week. It was common for participants to go through phases of engagement, disengagement, and re-engagement depending on other aspects of their lives, such as school and work commitments, mental health, and their general management of life events and responsibilities. Many participants who attended the group frequently for several months at a time eventually "graduated out" of the group by moving into job and school programs that, understandably, dominated most of their time. Many of these participants maintained a sense of connection with group co-facilitators after they had stopped attending the group, either through ongoing individual therapy work or via email/phone check-ins and updates on their continued transitions (i.e., moving away for work/school, beginning a new job, participating in training programs). Given that youth transitioning from homelessness were undergoing, by necessity, shifts in multiple life domains over the course of their involvement in the intervention, we found that a flexible approach to service provision was essential.

USING A TRAUMA-INFORMED FRAMEWORK & KNOWLEDGE

Many participants had been formally diagnosed with or would likely meet formal criteria for PTSD or complex PTSD. Given the high rates of maltreatment and traumatic stress among youth who are homeless (Coates & McKenzie-More, 2010; Kidd et al., 2016), the intervention was developed using a trauma-informed framework. Participants quite often asked questions about the impact of trauma and about trauma-related symptoms, even during the presentation of topics that did not seem to be related to trauma. Particularly in sessions about identifying and expressing emotions, relationships, and interpersonal effectiveness, participants wanted to know how and why trauma-related symptoms develop, and how to cope with them.

Youth often discussed experiences of further retraumatization and marginalization within service contexts that were not trauma informed. In response to participants' expressed needs, we developed psychoeducational group sessions that focused on trauma.

Our trauma-informed approach involved other features:

- Both co-facilitators had backgrounds in trauma-informed care and/or trauma-specific treatment.
- Group rules encouraged participants to take safe breaks from topics if they needed to.
- There was a strong focus on present-minded coping techniques to help participants manage trauma-related reactions and symptoms.
- Individual support was available for participants outside of the group setting.

Facilitators who are trained and able to engage with participants around trauma are an essential component of trauma-informed group interventions with youth who are homeless.

SOLICITING FEEDBACK & USING RESOURCES THAT ENGAGE YOUTH

Participants indicated that most material presented in the group was relevant to their lives. They were regularly prompted for suggestions to ensure that topics were meaningful and interesting. In the pilot intervention, practical transition-specific groups focused on goal setting, time management, and budgeting were developed based on participant requests. Participants were responsive to this; for example, following a budgeting group session presented in game format, one participant independently modified the game to better capture the life experiences of young people transitioning to independent housing. A mixture of pre-planned and adapted topics helped balance group content and engagement.

Weekly sessions were designed to include highly engaging materials that spanned various modalities, such as games, role play, and humorous or inspirational videos illustrating skills and topics. Clips from popular movies and TV shows illustrated the use of particular skills. Through role play, participants learned and practised interpersonal effectiveness skills. They also engaged in playful hands-on activities across sessions. For example, a budgeting game taught real-world skills in a fun and engaging manner. An activity that required the group to pass multiple objects to one another around a circle emphasized the importance of balance in various life domains. Sessions involved accessible mindfulness practices that engaged the senses (e.g., making and eating ice cream sundaes, listening to music, smelling teas). They also included movement and mindfulness activities practised in novel settings, such as a large urban park.

MANAGING INDIVIDUAL DIFFERENCES & CRISES

The pilot intervention took an open format, with no mental health inclusion or exclusion criteria. This meant that participants often had different clinical needs and profiles. For example, some participants had active substance abuse needs while others did not, and, at times, clear differences in cognitive and learning profiles were evident. As a result, participants sometimes struggled to relate to one another's experiences or had to catch up on group material through repetition or re-explanation. In addition, a few times a participant's level of distress was challenging to address and contain in a group context. These challenges emphasized the critical need for two facilitators to lead the group, with one attending to the participant in need of extra support while the other focused on leading the other participants. Despite these occasional challenges, participants were consistently respectful, patient, and kind with one another.

Grounding strategies were also used to contain and support participants experiencing high levels of distress. For example, facilitators invited distressed participants to take care of themselves by remaining in the room in the position (e.g., lying down, sitting, standing) or space (e.g., near or at some distance from the group) that most suited them in the moment, or by leaving the room to enter a safe nearby space where facilitators could later check in with them. We also used post-group check-ins and communicated with participants' broader care teams for ongoing monitoring. Future iterations of the group could involve an initial screening process to determine whether participants' individual mental health needs could be addressed in a group setting or whether individual treatment would be more appropriate.

OFFERING A GATEWAY TO SERVICES

In our experience, the open-format group seemed to serve as a gateway to accessing additional formal mental health services for about half of our participants. Many participants went on to engage in individual therapy, while others attended mindfulness and dialectical behaviour therapy groups at partner community organizations. Several participants reported having begun their own daily mindfulness practice as a result of their group experience. Many went on to make connections to broader programming such as peer-led social activities, as well as arts and community activities via partner organizations. Given that youth who are homeless are often reluctant to trust service and

mental health professionals, this style of "no pressure" open-format engagement seems to help them develop the trust and confidence to participate later on in more individualized, in-depth, and closed-format services.

KEY MESSAGES FOR PRACTITIONERS

Young people transitioning from precarious housing can be engaged in mental health and wellness group activities. It is too often believed that young people experiencing homelessness cannot or will not effectively engage in mental health and wellness care. Our experience indicates that this is not true. While there are challenges to constant and consistent engagement, a flexible approach to intervention with these youth, who by necessity are undergoing multiple transitions in several life domains at once, is essential.

Relationship building is key. The more opportunities for introductions and relationship building that participants have before attending the group, the higher the likelihood of engagement. We strongly recommend individual orientation meetings with potential participants in future iterations of this group. Short summary videos of group content, as well as weekly outreach from and access to group facilitators through email, text, phone, or web are also effective ways to build relationships.

Trauma-informed groups, practitioners, and broader systems are essential given the pervasiveness of trauma-related mental health difficulties and symptoms among young people who are homeless. Both research and our experience with this group intervention highlight the significant trauma-related needs of young people experiencing homelessness. Our participants often discussed experiences of further retraumatization and marginalization within service contexts that were not trauma informed and that these experiences often served as a deterrent from seeking out community, mental health, and housing services. Participants often discussed and asked questions about the impact of trauma in their daily lives. This means it was essential that facilitators be well trained to address these issues. Trauma-informed approaches to self-care, grounding, and participant safety are critical to group interventions.

Group interventions may serve as a stepping stone to other services and care. Our experience indicates that attendance in an open-style group may be the gateway into other mental health and wellness services, including more formal group treatment and

individual therapy. As young people experiencing homelessness are often hesitant to trust mental health and other service professionals, this kind of "no pressure" engagement and introduction to mental health and wellness care helped many participants build the trust and confidence they need to go on to engage with more individualized and in-depth services.

CONCLUSION

Given the complex needs, varied levels of acuity, and ongoing challenges faced by young people experiencing the cyclical nature of homelessness and transitions to independent living, the delivery of mental health services to this population has traditionally been viewed as quite challenging and has typically been inconsistent and idiosyncratic, if it has existed at all. Certainly, typical methods of measuring intervention feasibility and effectiveness are extremely challenging to implement with this population. As such, systematic trial-and-error efforts for service provision, such as the one we have described, are often the critical first level of investigation into effective treatment models. Future investigations will examine the design and feasibility of the group for unique populations (i.e., settings with a predominantly Indigenous clientele), as well as the effectiveness of the group as a briefer (8–12 sessions), stand-alone intervention for youth who are homeless or who are transitioning with support from community-based shelters and service organizations.

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PART 3

CONTEXTS & CONSIDERATIONS

3.1 PREVENTING BURNOUT AMONG SERVICE PROVIDERS

Leysa Cerswell Kielburger, Patricia Rockman, & Patricia Baranek

INTRODUCTION

According to many Canadian surveys and studies, workplace stress is a serious health and economic burden, with estimated costs between $3.2 billion and $11.7 billion per year (Hassard et al., 2014; Mental Health Commission of Canada, 2010). Employees who experience high workplace demands, low control, high effort, and low reward are more likely to suffer adverse consequences of a psychologically unsafe workplace (Great West Life Centre for Mental Health, 2016). The problem is particularly acute in the health, non-profit, and social services sectors, which have high job demands and few supports. These sectors also have the highest rate of absenteeism across all employment sectors in Canada. Reasons for absenteeism include high stress levels, psychological disorders, anxiety, and burnout (Stewart, 2013).

Non-profit agencies in the homelessness sector are dealing with a unique population of marginalized individuals who often have serious mental health and addiction concerns. Given this challenging work, ensuring the physical and mental health of service providers in these agencies is critical to the welfare of clients. As with other service providers, those who work with youth who are homeless often experience stress and direct and vicarious trauma, which can put not only themselves but their already traumatized clients at risk. Moreover, research shows strong relationships between chronic stress and disease, including coronary heart disease, high blood pressure, some forms of cancer, rheumatoid arthritis, diabetes, irritable bowel syndrome, stroke, and ulcers (Bickford, 2005).

Stress and trauma are often side effects of front-line youth work. While these issues cannot be totally eliminated, strategies and practices are emerging to deal with them. Interventions that have been shown to reduce stress, burnout, compassion fatigue, and vicarious trauma are psychoeducational and skill-based, and involve training in mindfulness, cognitive-behavioural therapy, and psychological first aid. Mental fitness, self-care practices, and robust social supports serve as protective factors.

This chapter presents the perspectives of front-line workers and discusses strategies to promote their mental and emotional fitness. It also describes implementation considerations and key messages for front-line workers.

BURNOUT AS AN ORGANIZATION-LEVEL ISSUE

Burnout among service providers is related not only to individual factors, but also to the organizational and structural environment in which people work. Despite reduced funding, decision makers at non-profit organizations are reluctant to cut services. This means the workload of already poorly paid and overworked staff grows without an increase in wages. This "currency of caring" is subsidizing agencies' services that formerly were funded by government. Due to increased workloads, unstable employment, low salaries, poor or non-existent employee benefits, lack of training, and rigid organizational cultures and policies, service providers report feeling unsupported by employers, even more so than in the past (Waegemakers Schiff & Lane, 2016).

Yet it is important for service agencies to address stress and trauma among staff. These issues lead to costs for the organization in the forms of absenteeism, compassion fatigue, high staff turnover, and inefficiencies, all of which affect the organization's performance and productivity (Anderson, 2000). Since service providers are a substantial and growing economic force that continues to be at high risk for stress-related conditions, it is critical to help them develop strategies for reducing stress and promoting mental health.

PREVALENCE OF BURNOUT AMONG SERVICE PROVIDERS

A study of front-line workers from 13 agencies in the homelessness sector in Calgary, Alberta, found the following:
- 25% suffered from burnout and compassion fatigue.
- 36% reported symptoms of posttraumatic stress disorder (PTSD) compared with 9% in the general Canadian population (Waegemakers Schiff & Lane, 2016).

A survey of youth service providers in Toronto revealed the following:

- 100% reported negative health effects due to grief and trauma in their work (96% stated they suffer mental health issues such as generalized stress, depression, and anxiety).
- 33% reported having no strategies for coping (family and friends were the most commonly identified forms of support).
- 92% identified changes in organizational practices as a necessary remedy (e.g., time off, managerial support, professional development).
- Other suggested forms of support included counselling (58%), speaking to others with similar experience (54%), and using direct peer support–type models (21%) (Frontline Partners with Youth Network, 2006).

DEFINING BURNOUT & RELATED CONDITIONS

Research has identified three dimensions of burnout among service providers (Baker, O'Brien, & Salahuddin, 2007; Demerouti, Karina Mostert, & Bakker, 2010; Maslach, Schaufeli, & Leiter, 2001). These dimensions feature:

- A reduced sense of personal accomplishment: feeling a diminished sense of self-efficacy and of the meaningfulness of one's role;
- Depersonalization: having a detached attitude toward clients and work; and
- Emotional exhaustion: feeling physically and emotionally depleted and unable to give of oneself.

Vicarious or secondary trauma refers to the emotional and physical reaction to being exposed to the emotions and stories of trauma victims (Waegemakers Schiff & Lane, 2016). Front-line workers report levels of PTSD symptoms that are four times that found in the general population (Waegemakers Schiff, Bell, Lane, & Dadani, 2015). Symptoms include dissociation, flashbacks, sleeplessness, and sadness, anger, vigilance, and irritability. Compassion fatigue is another risk. It differs from burnout in that it is internally directed, featuring feelings of helplessness and hopelessness about one's capacity to provide adequate care to others (Waegemakers Schiff & Lane, 2016).

PERSPECTIVES FROM THE FRONT LINES

A study examining the experience of service providers working with marginalized youth in Toronto (Skinner, 2013) identified the following factors that contribute to the health and wellness of service providers:

- Seeing one's personal experience of burnout and stress in a broader context;
- Having acknowledgement from peers that stress and burnout are not individual experiences or personal failures, but rather a common systemic issue and symptoms of a larger resource challenge;
- Creating the space to connect with both peers and funders to help service providers externalize these experiences, rather than personalizing them;
- Feeling invested in by the employer;
- Working in an environment where personal and organizational values align;
- Having access to support networks within and outside of work; and
- Having ongoing access to therapists and social workers, particularly those who integrate anti-oppression and social justice into their therapeutic practices.

Increasing the number of tools, skills, and strategies service providers have to draw on helps build their capacity and confidence to handle issues as they arise. Access to training and supports is important for health and well-being and translates into better quality client care (Skinner, 2013).

These strategy recommendations do not replace the need for adequate support and solutions from government. However, service providers find a collective organizational response to the issues affecting their communities to be empowering and encouraging; an example of this affirmation would be when the organization acknowledges systemic issues facing street-involved youth and the collective effort extends beyond service providers' individual efforts (Skinner, 2013). The powerful practice of channelling a personal experience into collective action overcomes isolation and offers a united voice for change, creating a new narrative for action to reduce stress and prevent burnout in the workplace.

STRATEGIES FOR PROMOTING MENTAL & EMOTIONAL FITNESS

Just as our physical fitness requires care and attention, mental and emotional fitness is equally important to overall health and well-being; it increases resilience and flexibility to respond to the demands of our environment. It involves developing skills to build a foundation for focus, concentration, and emotion regulation, adapting these skills to specific contexts, and applying them across various life domains (Mental Fitness Institute, n.d.). Dedicating a short time each day to mental and emotional fitness shows significant benefits to mind, body, and overall health.

MINDFULNESS-BASED INTERVENTIONS

The Centre for Mindfulness Studies in Toronto provides specialized mindfulness training to healthcare and social service professionals and to the general public. It has conducted research and evaluations among service providers, organizations, and clients to understand what strategies for addressing stress-related issues work best.

Mindfulness-based cognitive therapy

Mindfulness-based cognitive therapy (MBCT) combines mindfulness practices with the tools of cognitive therapy. It was originally developed to prevent depressive relapse (Segal, Williams, & Teasdale, 2013). Various applications of this group-based modality have been evaluated extensively, and it is now being applied to many conditions, including stress and burnout. The ultimate goal of MBCT is to improve the ability to cope with difficult mind and mood states; reduce distress through increasing awareness; regulate affect, behaviour, and attention; and increase the capacity for intentional responses and actions. This intervention also offers a low-tech approach to wellness and healing that creates sustainable community-based mental health training and services (for service providers and clients) that are accessible, feasible, equitable, and cost effective.

MBCT comprises three kinds of training:

- Learning to regulate attention by focusing on bodily sensations, breath, or thoughts as objects of attention. This includes noting the tendency of attention to habitually move and then repeatedly bringing it back to the intended focus.

- Observing the transient nature of all experience, including thoughts, emotions, and bodily sensations; developing curiosity about them; and reducing experiential avoidance when these thoughts or sensations are unwanted or distressing. In observing the coming and going of experience, participants learn that thoughts may have a momentum of their own, be misleading, and be based on interpretation versus reality.
- Developing an open and receptive stance to experiences, including those that are distressing, and learning to recognize early one's reactivity to thoughts and events.

Through this training, participants decrease automatic maladaptive behaviours and increase skillful responding to stressors, low mood, and anxiety. They learn how negative emotions and destructive thoughts about the past or future can take hold. Instead of being immersed in habitual rumination or worry, participants can pause and return their attention to the present, attending to the effect difficult emotions have on body sensations. Participants learn to identify and label emotions and thoughts as they arise from a less immersive stance, one that is less fraught and more resilient. They tap into the direct experience of the here and now, rather than focusing on their interpretations, explanations, and conclusions about experience. Participants develop enhanced self-awareness, attention, emotion, and behaviour regulation. They learn to be less judgemental and to cultivate compassion for themselves and others.

An example of the beneficial effects of this training is a project of the Centre for Mindfulness Studies that involved 49 service providers from 17 social service agencies in Toronto. In the first phase, which focused on managing stress through mindfulness, service providers learned mindfulness-based strategies to support themselves and their colleagues in the workplace, which they could then teach to other colleagues to reduce stress and enhance wellness. The success of this training was evident in various ways: service providers were better able to cope with stress; clients received care from service providers who felt less stressed; and agencies witnessed less burnout and compassion fatigue and greater workplace satisfaction.

In the second phase of the project, 26 service providers from the same agencies were trained to deliver MBCT to clients. They identified the following professional gains from the training: stronger communication skills and relationships with colleagues; better ability to support clients through improved or restored compassion; another clinical skill they could use to help clients; professional development and leadership skills; and mindfulness practice for themselves and colleagues, resulting in an organizational shift

in the way business is done. Service providers also reported personal gains, namely an increased sense of well-being and improved quality of life, and reduced personal stress, anxiety, and depression. Ultimately, the intervention not only boosted the mental health and well-being of service providers; it also helped to build capacity in critical mental health services within community-based agencies.

SELF-CARE

Self-care has been described as "an ethical imperative for professional helpers" (Cox & Steiner, 2013, p. 52). Along with systemic change, self-care offers strategies to support health and wellness in the workplace. Strategies include space to connect with peers and supervisors; support spaces to unpack oppression, racism, and privilege; support retreats; and professional development training focused on self- and community care (Skinner, 2013). Self-care can also focus on physical, psychosocial, emotional, spiritual, and professional or workplace dimensions of health and well-being (Cox & Steiner, 2013).

Self-care is a shared responsibility among all members of the service team. It involves three pillars: awareness, balance, and connection, as described by Marrow, Benamati, Decker, Griffin, and Lott (2012):

- Awareness of one's needs, limits, resources, and emotions;
- Ability to balance work and play and take care of oneself as well as others; and
- Taking time to connect with oneself and others.

Taking responsibility only for the job functions that are in one's control and adopting a positive attitude toward the work, even in the face of challenges, are also important aspects of self-care (Marrow et al., 2012).

Another way to think about self-care is as a triad featuring escape, rest, and play (Zlotnick, 2013). The seven essential mental activities outlined in the "Healthy Mind Platter" (see Figure 3.1-1) help the brain function at its best, strengthening its internal connections and our ability to connect with others (Rock & Siegel, 2011). Developing an effective self-care practice has also been shown to correlate with the ability to teach stress reduction and coping strategies to youth (Marrow et al., 2012).

FIGURE 3.1-1: THE HEALTHY MIND PLATTER

Sleep Time **Physical Time** **Focus Time** **Time In**

Down Time **Play Time** **Connecting Time**

VICARIOUS TRAUMA: NURTURING HOPE & MEANING

Vicarious trauma is a dynamic process that occurs as a result of how we interact with our living and working situations (Pearlman & McKay, 2008). Various factors increase the risk of vicarious trauma, including personality and coping styles (e.g., tending to avoid problems or difficult emotions), life circumstances, personal history, social support, work style, and a lack of spiritual resources (Pearlman & McKay, 2008). Transforming vicarious trauma involves nurturing a sense of hope and meaning (Pearlman & McKay, 2008). Pearlman and McKay identify the following ways to connect with our sense of purpose and life perspective:

- Reminding ourselves of the importance and value in working with youth;
- Staying connected with colleagues, friends, and family;
- Paying attention and noticing the "little things" that brighten our day, and "taking in the good" (Hanson, 2005);
- Taking time to celebrate, reflect, and mourn, and marking other important transitions with people we care about through rituals or traditions;
- Identifying and challenging our cynical beliefs; and
- Adopting a growth mindset (see Table 3.1-1) and investing in growth-promoting activities, such as hobbies.

TABLE 3.1-1: COMPARISON OF FIXED & GROWTH MINDSETS

FIXED MINDSET	GROWTH MINDSET
Intelligence is static.	Intelligence can be developed.
Leads to a desire to look smart and therefore a tendency to: ■ avoid challenges ■ give up easily due to obstacles ■ see effort as fruitless ■ ignore useful feedback ■ be threatened by others' success	Leads to a desire to learn and therefore a tendency to: ■ embrace challenges ■ persist despite obstacles ■ see effort as path to mastery ■ learn from criticism ■ be inspired by others' success

It is also important for service providers to take stock of the work they do. A higher caseload of trauma survivors puts them at a higher risk of vicarious trauma (Marrow et al., 2012). Maintaining a variety of work responsibilities may allow them to balance their time with clients. Trauma-informed training can also improve the ability to respond to trauma survivors. Preventing vicarious trauma starts with awareness and creating an action plan (see *Understanding and Addressing Vicarious Trauma* in the Resources list for a sample action plan).

GOAL DEVELOPMENT SKILLS & COGNITIVE-BEHAVIOURAL THERAPY STRATEGIES

Goal development skills and cognitive-behavioural therapy (CBT) strategies can help service providers with stress reduction in the workplace. Setting SMART goals—goals that are specific, measurable, achievable, relevant, and time-bound—helps service providers prioritize their focus to maintain health and well-being (Doran, 1981). CBT strategies address common cognitive distortions (i.e., black-and-white thinking, catastrophizing, mind reading) that commonly arise when a person is distressed, and help to "untwist" thinking in order to achieve a more objective view. Meichenbaum (2007) identified the following useful perspectives and behaviours:

- Realizing we are not alone by noticing and normalizing our "storytelling narratives";
- Adopting an attitude of acceptance (this is not resignation, but a willingness to have what is present) and appreciation; and
- Refraining from taking on the responsibility to "heal" clients.

Resilience includes a mindset that involves various cognitive and affective factors (Reivich & Shatte, 2002). Meichenbaum (2007) has also identified the following ways to nurture resilience:

- Monitoring our thinking;
- Noticing rumination, automatic thinking, and other "thinking traps" (e.g., self-blaming) and redirecting our attention;
- Identifying our "hot thoughts" or deeply held beliefs that may cause an automatic reaction (these are often tied to an intense emotion);
- Challenging our beliefs or assumptions and engaging in perspective taking;
- Developing the ability to stay focused and calm or to recover quickly from distressing emotional states; and
- Practising these skills regularly for more resilient behaviours and thoughts.

Meichenbaum (2007) and others (e.g., Berg & De Jong, 1996) have described another important aspect of resilience: eliciting our resources and strengths by asking ourselves the following questions:

- How have I managed?
- How would I like to be managing?
- What are my strengths and resources—internal/external?
- How do I cope or solve problems?

By reflecting on these questions, we realize that we can manage and identify the resources we use to do so. Making concrete goals and maintaining a solution-focused view may help interrupt an automatic problem-saturated view.

Reframing a challenge or problem may help us consider new possibilities, even resulting in new actions and choices. A common reframe might involve a shift from thinking "I'm stuck" to "It's a challenge to find a solution" (Berg, 1994; Rockman, 2015). Reframing introduces an alternative meaning, expanding beyond a limiting frame of reference. Challenging unhelpful thinking can involve strategies like finding evidence for or against a thought and considering the advantages or disadvantages of thinking in a particular way. Working with our thinking is important because it can greatly affect mood and behaviour. Monitoring and modifying our thoughts and cognitive distortions helps to change our mood, behaviour, and thinking, which can lead to enduring change. We can use various cognitive strategies and goal-setting techniques to create a structured, goal-oriented approach to taking care of ourselves so we can then better care for others.

SELF-ASSESSMENT FOR WELL-BEING

It is important to ask ourselves: How do I know when I am not doing well? Various measures are available that monitor professional quality of life, compassion satisfaction, fatigue, and burnout, including the Professional Quality of Life Scale (ProQOL; Stamm, 2009). Self-assessment is important because our goal is to manage the risk of mental health problems, not to avoid them until they escalate and become overwhelming. We must understand the signs and symptoms of traumatic stress in order to prevent and manage vicarious trauma (Waegemakers Schiff & Lane, 2016). Early identification and treatment also reduce long-term negative impacts.

Some common early warning signs and symptoms that may indicate we are not doing well include difficulty managing emotions and boundaries and making good decisions; loss of hope and meaning; and relationship problems (Pearlman & McKay, 2008). Although these may be happening to us personally, they can also affect our families, friends, organizations, and clients. Pearlman and McKay highlight signs that a person is not well in the workplace:

- Making impulsive decisions without adequate reflection (i.e., inappropriate relations with clients);
- Making mistakes that are not cost effective or time efficient and that may put others at risk;
- Taking on too much work, which the team or agency is ill prepared to complete (or complete well);
- Failing to fulfill commitments;
- Taking excessive unplanned time off;
- Blaming others instead of seeking understanding and productive collaboration; and
- Infecting colleagues with cynicism or lack of motivation.

THE ROLE OF THE SERVICE AGENCY

Agencies play a major role in preventing burnout. They do this by creating a meaningful workplace that cultivates self-care and professional development opportunities and by providing social supports to create solidarity among colleagues (Karabanow, 1999). On the peer and collegial level, helpful practices include developing a support network that includes, for example, colleagues and supervisors; using a buddy system, especially for

new staff; providing regular debriefing and opportunities to connect with team members informally; and creating community-building activities (Meichenbaum, 2007). Training supervisory staff to support these practices and help staff find value in their work is key. It is important to remember that while strategies aimed at the individual are important for managing stress, preventing burnout and other mental health problems, organizations and the larger system need to work collectively, in innovative ways, to support service providers who treat one of our most precious and vulnerable resources—youth.

IMPLEMENTATION CONSIDERATIONS

Individual service providers and agencies should consider various elements when developing and implementing burnout prevention strategies (National Implementation Research Network, 2013; Stirman et al., 2012; Torrey, Bond, McHugo, & Swain, 2011). Below are key considerations:

- Begin with an awareness campaign because burnout and related issues often are unacknowledged.
- Involve opinion leaders, champions, early adopters, and other relevant stakeholders because building a well-rounded implementation team is key.
- Adapt interventions to meet the needs of agencies and service providers.
- Reduce the training-to-implementation lag time.
- Keep it simple, concrete, and measurable.
- Keep it well defined and manageable.
- Keep it behavioural (including attitudes and actions).
- Keep it cost effective.
- Do it in stages.

On the individual level, having a positive attitude about the intervention as well as job stability support implementation capacity (Stirman et al., 2012). On the agency level, having access to sufficient resources and adequate funding, along with the support of key stakeholders, are important factors related to the sustainability of the intervention (Stirman et al., 2012).

There are various ways in which organizations can help to prevent or reduce burnout and promote well-being among clinical staff (Barrenger, Stanhope, & Atterbury, 2015; Meichenbaum, 2007; Pearlman & McKay, 2008; Richardson, 2001; Waegemakers Schiff & Lane, 2016; Wilson, 2016). Here are some strategies:

- Take a proactive approach to preventing burnout;
- Balance service providers' caseloads;
- Provide access to ongoing supervision, education, training, retreats, and individual/group therapy;
- Promote a culture of self-care for individuals and teams (including a self-care room);
- Invest in staff well-being and ensure adequate safety measures are in place;
- Demonstrate appreciation of staff;
- Promote forums for staff participation and incorporate staff feedback and suggestions for organizational improvements;
- Support a psychologically healthy workplace (e.g., employee orientation, training, recognition, inclusivity, flexibility, effective communication);
- Provide adequate salaries, physical and mental health insurance, and time off (including "mental health days");
- Promote a culture that celebrates achievements, withholds judgement, gives the benefit of the doubt, emphasizes the positive, and softens the negative;
- Cultivate a sense of meaning and purpose among service providers in support of the agency's mission to serve youth; and
- Develop external professional connections, including partnerships with other agencies to foster a sense of collective purpose toward a common service goal.

Adequate funding and staff resources can be a constant struggle and source of stress and frustration. An implementation team is necessary to promote a sustainable intervention and the organization's change process in a timely, goal-oriented manner (Fixsen, Blase, Duda, & Brown, 2012; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The agency might consider joining or starting a network of organizations working toward the same goal to collaborate and leverage resources the agency may not have (e.g., a more integrated referral system). Often, finding a creative solution to limited resources requires shifting direction or taking risks, which may recharge the workplace with a renewed sense of hope and vitality (Richardson, 2001).

KEY MESSAGES FOR PRACTITIONERS

- Many strategies and tools are available to prevent burnout among service providers, so select the ones that resonate most with you and your agency. Start small and be concrete with your SMART goals and strategies.

- Self-care is possible using cognitive, emotional, and behavioural tools. These include mindfulness for attention, emotion, and behaviour regulation; cognitive-behavioural strategies for changing thinking and actions; and solution-focused strategies to develop an action plan to get where you want to go. Unless you have a path to your destination, it will be difficult to know when you have arrived.

- Identify and use internal and external resources, including champions and opinion leaders, to increase awareness of the need for burnout prevention strategies, mental health promotion, and treatment for service providers.

- Whenever possible, integrate self-care, stress reduction, and mental health supports into the culture and fabric of your organization. Get your organization on board and build your implementation team. If this is not possible, form a collective. Collectives provide support, solidarity, and a voice for change.

RESOURCES

Compassion Fatigue Awareness Project
www.compassionfatigue.org

Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers
(Health Canada, 2001)
https://vtt.ovc.ojp.gov/ojpasset/Documents/OS_Vicarious_Trauma_Guidebook-508.pdf

Healthy Mind Platter
www.mindplatter.com

Mental Fitness Tips (Canadian Mental Health Association)
http://cmha.ca/resources/mental-fitness-tips/

Professional Quality of Life Scale – Compassion Satisfaction and Compassion Fatigue – (ProQOL) Version 5 (2009)

www.proqol.org/uploads/ProQOL_5_English.pdf

Taking in the Good

www.wisebrain.org/TakingintheGood.pdf

Understanding and Addressing Vicarious Trauma (Headington Institute, 2008)

www.headington-institute.org/files/vtmoduletemplate2_ready_v2_85791.pdf

Ways to Avoid Compassion Fatigue (State University of New York School of Social Work)

http://socialwork.buffalo.edu/content/dam/socialwork/home/self-care-kit/exercises/ways-to-avoid-compassion-fatigue.pdf

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

Amanda Noble & Carol Howes

INTRODUCTION

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

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

CHALLENGES IN SUPPORTING YOUTH WHO ARE HOMELESS

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

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

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

PROVIDING MENTAL HEALTH CARE IN A DROP-IN SETTING

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

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

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

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

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

INCREASING TRAINING OPPORTUNITIES

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

RESILIENCE: A STRENGTHS-BASED APPROACH

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

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

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

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

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

BUILDING PARTNERSHIPS

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

PARTNERSHIPS WITH UNIVERSITIES

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

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

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

Dialectical behaviour therapy

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

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

Motivational interviewing

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

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

PARTNERSHIP WITH MENTAL HEALTH ORGANIZATIONS

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

KEY MESSAGES FOR PRACTITIONERS

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

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

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

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

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

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

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

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

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3.3 STRENGTHS-BASED OUTREACH & ADVOCACY FOR NON-SERVICE-CONNECTED YOUTH EXPERIENCING HOMELESSNESS

Natasha Slesnick & Elizabeth Van Hest

CONTEXT & EVIDENCE

Much of what is known about youth who are homeless is obtained from those engaged through service programs, such as drop-in centres or shelters. This means that much less is known about youth experiencing homelessness who are not engaged in services as they are excluded from most studies. This is a significant concern because some reports indicate that youth who are not connected to services represent the majority of youth who are homeless: less than 10% access community resources meant to serve them (Kelly & Caputo, 2007). Furthermore, service-disconnected youth are different from those who already access services; they have more unmet needs and more severe substance use and mental health problems (Kryda & Compton, 2009). Efforts to connect youth to services are essential to prevent a range of public health consequences associated with homelessness, including premature death.

Studies with adult populations consistently show that those with access to a social service worker or who use community services are more likely to exit homelessness (Zlotnick, Tam, & Roberston, 2003). One study showed that the more connections youth had with formal and informal social systems at the beginning of the study, the more likely they were to have a decreased number of homeless days and to start with fewer homeless days prior to the study period (Slesnick, Bartle-Haring, Dashora, Kang, & Aukward, 2008). In general, the longer youth experience homelessness, the more likely they are to experience substance use, victimization, and mortality, and the harder it becomes to exit street life (Ferguson, Bender, Thompson, Xie, & Pollio, 2011; Scutella, Johnson, Moschion, Tseng, & Wooden, 2013). This underscores the importance of engaging youth with services.

Studies often define outreach as contacting or engaging individuals within non-office settings to services. Outreach is considered an effective strategy for identifying and engaging hidden populations, such as youth who are homeless, with services. Because most studies report conducting outreach in shelters, emergency rooms, and other service locations, efforts to identify and engage youth who are homeless and not connected with

services are rare. Even so, some studies report success connecting high-risk and hidden adults with HIV-prevention programs (Bradford, 2007; Sohler et al., 2007) and connecting adults with severe mental illness who are homeless with housing services (Gilmer, Manning, & Ettner, 2015; Tsemberis & Elfenbein, 1999). Arguably, youth who are disconnected from services are one of the most vulnerable populations, and identification and engagement in services may be an effective way to interrupt continued homelessness and its associated risks. Outreach to identify youth is the first step, but the relationship between the young person and the outreach worker can extend beyond a finite contact with ongoing advocacy.

Strengths-based outreach and advocacy builds on the success of other evidence-based outreach and advocacy approaches for vulnerable populations (Rapp & Goscha, 2006). It is also consistent with supportive services offered in housing first approaches. It has been adapted for use with service-disconnected youth who are homeless and includes ongoing advocacy for six months (Slesnick et al., 2016). The outreach worker takes responsibility for securing needed services for the youth and remains a support as the youth traverses the system of care. This approach is most similar to the strengths model in which the role of the outreach worker falls somewhere between a therapist and a broker (Rapp & Goscha, 2006). The strengths model, developed at the University of Kansas School of Social Welfare, is based on the premise that "the purpose of case management is to assist consumers in identifying, securing, and preserving the range of resources, both external and internal, needed to live in a normal, independent way in the community" (Johnsen et al., 1999, p. 331). The strengths model also includes the following components:

- Dual focus on youth and environment;
- Use of paraprofessional personnel;
- Focus on youths' strengths rather than deficits; and
- High degree of responsibility given to youth in directing and influencing the intervention they receive from the system and the outreach worker or advocate. That is, youth determine what they want assistance with, and what they are willing to do to reach their goals, without pressure from the advocate.

The outreach worker is described to the youth as an "advocate" who will assist them with their goals and help them negotiate and interface with the community. Advocates assist youth regardless of the level or type of service connection. If a youth is not interested in linkage to a particular service or program, the advocate still continues to engage and meet with the youth. Similarly, youth who connect with services continue to meet

with their advocate. Building new relationships and traversing various systems of care can be difficult and stressful for youth who are homeless, and one consistent ally can ease relationship demands and facilitate service engagement and continued service use (Tsemberis & Elfenbein, 1999).

INITIAL RESEARCH OUTCOMES FOR STRENGTHS-BASED OUTREACH & ADVOCACY

A pilot feasibility study that tested the efficacy of strengths-based outreach and advocacy showed favourable outcomes (Slesnick et al., 2016). The study involved 79 youth who had experienced three months of continuous homelessness and who had no service connection in those three months (no shelter, drop-in centre, or substance use/mental health service access). Youth were approached about the study outside of service settings. Ages ranged from 14 to 24, with an average age of 21. Of the participants, 53% were male and 43% were non-white. Over 50% reported childhood physical, sexual, or emotional abuse.

All youth received six months of advocacy and were assessed at baseline and three, six, and nine months post-baseline. They met with their advocate an average of 14 times, indicating a high degree of engagement. More meetings with the advocate were associated with more service use and better overall outcomes. Only five youth did not meet with their advocate. The study found that most youth preferred drop-in centres (81% accessed them) to shelters (13%). In summary, strengths-based outreach and advocacy was associated with high rates of service use, and more service use was associated with better psychosocial outcomes. Some evidence was offered for self-efficacy as the underlying mechanism associated with improved outcomes. Positive interactions with the outreach worker and other service providers may have increased self-efficacy, which was associated with improved physical and mental health outcomes over time (Slesnick, Zhang, & Brakenhoff, 2017). This pilot study confirms the viability of identifying and engaging service-disconnected youth who are continuously homeless into services, and the positive effects of outreach and ongoing advocacy. We describe the intervention in the following section.

INTERVENTION COMPONENTS

OUTREACH

Strengths-based outreach and advocacy incorporates outreach strategies described and operationalized by other successful programs. That is, several key principles associated with successful outreach have already been identified. Principles are general and can be integrated into the outreach activities of homelessness programs regardless of their underlying theoretical orientation or specific outcomes focus. As an example, the Detroit outreach model (Andersen et al., 1998) identifies the following key outreach components:

- The success of the outreach program depends on the quality of the outreach worker. Workers should have a high degree of empathy and understanding to enhance bonding with youth. Before our program hires new outreach workers, they accompany staff members or the supervisor doing outreach and, under observation, approach youth.
- Outreach workers meet youth on their turf (leave the van) and do more than distribute materials. Depending on the resources available to the program, staff members may need to use their own vehicles on outreach trips and ensure appropriate insurance coverage.
- Outreach workers identify where the target population hangs out. They befriend staff at soup kitchens, laundromats, and fast food restaurants, and elicit support in reaching the target group.
- Developing trust takes time and repeated contact. Outreach workers must be patient.
- Incentives, food, and cash, increase engagement.
- Outreach workers should have phones and travel in pairs. Risks to staff should be clarified at hiring because all potential risks cannot be removed, and some workers may not be willing to accept risks associated with the intervention. Training should also include strategies to identify and reduce risk.

ADVOCACY

The advocacy component of strengths-based outreach and advocacy is based on procedures identified as effective in case management models with vulnerable populations. Yet implementation of the outreach and advocacy with service-disconnected youth who are homeless requires a great deal of sensitivity to the developmental stage and unique

psychosocial and emotional needs of each youth. Anecdotally, successful strengths-based outreach and advocacy requires high levels of social and emotional skills and intuition among outreach workers and advocates. When project advocates enter the lives of youth, they are often one of the only—perhaps the only—positive, supportive relationship in that young person's life. The overall goal of the advocacy intervention is to help youth who are homeless improve their life situations by stabilizing living conditions and promoting independence and skill sets—and for these improvements to last. The advocate searches for youth in the library, sandwich lines, soup kitchens, homeless camps, parks, and wherever youth might congregate. While some youth require many contacts with the advocate before they are willing to engage, other youth engage with the advocate even on the first meeting, requesting help and detailing a list of needs. Patience in the engagement process is essential, as is the expression of unconditional positive regard. Youth are more likely to accept and enter into an ongoing relationship with the advocate if they feel the advocate genuinely cares about them. Once the youth agrees to meet with the outreach worker at another time, advocacy has begun.

The intervention tested by the first author was limited to six months, but the period of advocacy can be flexibly determined with the youth. In practice, it would not need to be limited to six months, depending on agency resources. However, positive outcomes were observed with the six-month intervention. Each advocate typically had a caseload of 15 clients. The focus is on various system levels and includes basic needs (housing, safety, food, medical care, financial situation, child care), life skills to function in a larger social system (e.g., dealing with paperwork procedures at various governmental and community agencies), as well as developing a satisfying social support system. Youth usually need more than a list of resources; they need assistance and support when interacting with community agencies. Advocates can expect to meet with youth at least three times per week in the first few weeks, and should be available by phone at all times. Housing and obtaining identification and employment are usually the top priorities of youth, followed by transportation, education or trade school, and mental health or medical stabilization.

The five core functions of the advocate include:
- Assessment: determining the youth's current and potential strengths, weaknesses, and needs;
- Planning: developing a specific service plan for each youth;
- Linking: referring or transferring the youth to all required services;
- Monitoring: continually evaluating the youth's progress; and
- Advocacy: interceding on behalf of the youth to ensure equity.

The advocate uses the Youth Goals for Advocacy checklist of primary needs and relevant tasks to address the youth's goals (see Appendix). Based on the identified needs and priorities, the advocate and the youth develop a plan of action. The plan should be SMART—specific, measurable, achievable, realistic, and timely (Morrison, 2010). The advocate links the youth with other organizations and service providers as needed and evaluates the youth's progress frequently, at least every other week. Achievements and difficulties are discussed, which may lead to modifications to the action plan. The advocate must be familiar with services in the community, and a resource manual listing services in the community should also be available.

The following section describes the content of advocacy meetings. Advocacy sessions are flexibly determined; there is no set formula for activities that must occur in any given session because it depends on the youths' goals, needs, and resources. Depending on their unique strengths and weaknesses, youth may require more or less focus on certain areas such a finding a job or obtaining health care. For example, someone with little employment experience may need many sessions focused on finding work and creating a resume, while youth with more experience may need few sessions on these topics.

First advocacy meeting

1. Discuss the intervention, including how long it will last and the advocate's role. Youth may not understand the role of the advocate or the nature of the intervention, so this should be clearly explained.
2. Assess the youth's needs using the Youth Goals for Advocacy form (Appendix).
3. Assess the youth's strengths as they relate to the youth's needs. As an example, under employment assistance on the advocacy form, the advocate should determine the youth's job skills and employment history when specifying these goals.
4. Identify the youth's priorities and develop a plan of action. Clearly identify tasks (e.g., pick up a job application), as well as short-term (e.g., housing) and long-term goals (e.g., obtain high school equivalency certificate). Housing will likely be the highest priority goal. However, securing housing encompasses several tasks that can be broken down with the youth (e.g., finding employment or other income sources, deciding on subsidized or fair market housing, sorting out unpaid utility bills, deciding on location and manageable rent, obtaining identification).
5. When you and the youth have developed an advocacy plan for addressing a specific goal, discuss the obstacles to and resources available for meeting that goal. For example, if one goal is to identify three job openings and complete applications before

the next meeting, the advocate can help the youth think through potential obstacles so the youth will be better prepared to address the obstacle if it occurs.

6. In future sessions, when reviewing the advocacy plans and goals, discuss what worked and what did not. This evaluation can highlight areas in which the youth may need more support from the advocate, and areas in which the youth can function more independently. For example, the discussion can inform the advocate that the youth's anxiety associated with failure may be blocking progress.

Future advocacy meetings

1. Evaluate progress at the beginning of each advocacy meeting. Determine how closely the goals were achieved and identify activities still required to achieve the youth's stated goals.

2. For each future task, clarify what the youth is expected to complete, the timeline for completion, and the advocate's role (such as providing transportation). This division of labour may need to be adjusted if the youth fails to accomplish the task after several attempts.

Independence in achieving tasks might require small steps and a process in which the advocate provides more support, at least initially. Over time, the youth is encouraged to engage in tasks independently and should be reinforced for each success. Reinforcement can be highlighted by the advocate: "You called and checked on the status of your application on your own. Remember how hard that was for you to do even a few weeks ago? This is real progress!" As youth begin to experience more successes, their confidence and self-efficacy will increase. As their self-efficacy increases, they will be more willing to approach new situations with confidence and will experience more success.

IMPLEMENTATION CONSIDERATIONS

Some youth require more support from the advocate in order to accomplish agreed upon tasks. Some advocates might interpret perceived lack of follow-through on tasks (e.g., making calls, picking up applications) as lack of motivation or laziness. However, according to the strengths-based philosophy, no matter the motivation level or reason for lack of follow-through, the therapeutic goal is for youth to experience success. In many cases, this may require that the advocate participate in the task with the youth. For example, an advocate who learns that the youth did not make the necessary calls to turn on

the electricity in a newly obtained apartment will dial the phone and pass it to the youth, offering to talk only if the youth becomes emotionally overwhelmed during the call. Some service providers disagree with the approach of meeting youth where they are at because they think youth should be able to accomplish things on their own, and that they cannot learn to do that if others do it for them. However, mental health issues, prior negative experiences (punishment), and emotional barriers may underlie the lack of follow-through, and without assistance, youth may not be able to overcome these barriers. Advocates should withhold judgement and focus instead on the behavioural activity, seeking to increase the young person's confidence and self-efficacy through the accomplishment of very small tasks, so the person ultimately achieves independence across tasks and domains.

Recurring themes arise in the experience of advocates who work with youth who are homeless. The following sections discuss these themes.

MANAGING CHAOS & CRISIS

Youth may need housing, transportation, or medical care; they may have pending court appearances; or they may experience crippling depression. The advocate can support youth in managing these many needs by helping them focus on one or two tasks. Each task can be broken down into manageable component parts. The initial focus should be to obtain identification because this is required for nearly every other task. The steps for obtaining a birth certificate or a government-issued identification card should be explained. The advocate and the youth can negotiate which steps the youth will complete and by what date. Assistance from the advocate should be discussed, as well as potential barriers to success. Progress toward goals can be derailed by crisis. Youth who are not connected with services are focused on survival, and are therefore in a constant state of crisis. In addition to the crisis of homelessness, they often experience continuing crises associated with street life. These crises can include arrest, physical attack or robbery, illness, or conflict with a friend or romantic partner. They can be overwhelming and require that the advocate give the youth emotional or practical support. Linkage to other services can create a circle of care. It is also important that the advocate maintain future-oriented optimism, for example, by assuring the youth, "We will get through this, you will see."

MATCHING THE GOALS OF ADVOCATES & YOUTH

An essential component of strengths-based outreach and advocacy is helping youth meet their goals. When service providers press their goals onto youth, rather than helping youth set their own goals, advocacy will fail. The low level of service engagement in one demonstration project about treatment for people with mental illness experiencing homelessness (27% of 5,450 people contacted during outreach) was likely due to the fact that client and service provider perceptions of service needs differed significantly (Johnsen et al., 1999; Rosenheck & Lam, 1997). Therefore, it is essential that advocates support youth around their own goals and do not insist on goals the youth do not share. For example, it can be difficult for an advocate to assist someone who uses intravenous heroin and trades sex for drugs and money. It is difficult because the advocate is witnessing self-destruction, and desperately wants the youth to be healthy and safe. The advocate may ask whether the youth wants to discuss detoxification from heroin or seek other employment. If the youth is unmotivated, the advocate needs to refocus attention on those activities the youth is interested in, which can include basic needs such as medical care, access to food/clothing, a place to clean up, and harm reduction strategies. If the advocate continues to push for goals that are not shared, the youth will avoid the advocate, and any opportunity for assistance will end. As the relationship progresses and hope builds, the youth is likely to become more open to change.

REFRAMING FAILURE

Advocates can spend a significant amount of time and effort helping youth reach their goals, only to have progress appear to end abruptly. A newly obtained birth certificate and identification card might be lost within days of receiving it. Securing employment following weeks of assistance with employment applications and transportation arrangements, and of role-playing, ends with the youth oversleeping or yelling at the supervisor. Or the young person emphatically states wanting employment but does not follow through on necessary tasks. In these situations, advocates can experience frustration, perhaps feeling that nothing they do matters, or that the youth does not care about succeeding. This sense of frustration can be exacerbated when the youth screams at and blames the advocate for the failures.

Unconditional positive regard is at the core of strengths-based outreach and advocacy.

It is the experience of acceptance no matter what a person says or does (Rogers, 1957). Many youth expect failure and perceive success as the exception. Failure reinforces more failure and seeds hopelessness. Furthermore, youth often expect others to give up on them, criticize, and judge them. The advocate can reframe perceived failure. Success is a process with many expected bumps along the road. Further, perceived failures often result from forces outside the person's control. An advocate who notices a pattern can make the process of expecting failure explicit to the youth in order to frame future conversations around it and help the youth recognize the pattern. The advocate can never give up, even if the youth appears to do so. It may be one of the first times that someone maintained a steadfast belief in the youth's ability to succeed, even when the belief was not shared. The relationship between the advocate and the youth is itself at the core of success, repairing toxic beliefs and experiences that often hinder progress.

SETTING BOUNDARIES & PREVENTING BURNOUT

Some advocates develop intense caretaking feelings toward certain youth and want to solve their problems. In these cases, advocates may help with activities that are not directly related to the client's goals (e.g., driving the youth to a friend's house) or they make special arrangements for some youth and not others. It might not be possible for advocates to change how they feel toward particular youth; however, it is important that advocates acknowledge their feelings and discuss them with their supervisor. It is important that their behaviours and intervention remain professional and consistent for each youth. In addition, because strengths-based outreach and advocacy requires significant investment on the advocate's part, one goal of supervision is to provide support to advocates to prevent burnout (see chapter 3.1).

CONCLUSION

Strengths-based outreach and advocacy is an effective strategy for finding and engaging the most vulnerable, non–service-connected youth who are homeless into services. The relationship between advocate and youth is key to success and is itself an important focus. That is, regardless of the youths' motivation for assistance or follow-through, engagement with a caring, non-judgemental other is essential for setting the stage for reintegration. Engagement with a supportive advocate can help youth overcome past negative experiences with others, and can plant the seed for hope, self-efficacy, and future orientation. As the relationship

develops, most youth will become willing and able to engage with various service programs. The intervention is flexibly determined depending on the young person's strengths and needs, and can be easily integrated into the programming of services for youth who are homeless.

Acknowledgement

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APPENDIX

Youth goals for advocacy

Name: _____

Date: _____

SHORT-TERM GOALS	LONG-TERM GOALS

I need the following services (Check all that apply):

- Housing
  - Apartment
  - Furniture
  - Bedding

- Alcohol/other substance use
  - Detox
  - Antabuse medication
  - Intensive outpatient treatment

- Mental health (psychiatric care)
  - Personal
  - Kids

- Employment
  - Finding job prospects
  - Job applications
  - Job interview
  - Resume
  - Maintaining a job

- Education
  - GED training
  - High school diploma
  - Vocational training
  - College
  - Financial aid

- Personal finances
  - Cash assistance
  - Food stamps
  - Utility assistance
  - SSI/disability

- Medical treatment
- HIV/STI testing
- Dental treatment
- Child care
- Legal issues

- Personal identification (self)
  - Birth certificate
  - Social security card
  - State ID

- Driver's licence
- Personal hygiene/clothing
- Other: _____

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3.4

THE INDIVIDUAL PLACEMENT & SUPPORT MODEL OF SUPPORTED EMPLOYMENT FOR STREET-INVOLVED YOUTH WITH MENTAL ILLNESS

Kristin M. Ferguson

INTRODUCTION

More than two million youth in the United States are homeless at some time each year (Whitbeck, 2009). They often have histories of depression, complex trauma, substance abuse, and physical and sexual abuse—all of which make obtaining and maintaining competitive employment difficult. Epidemiologic data indicate that 26% meet the clinical criteria for major depression, 35% have attempted suicide, and 72% use illegal substances to cope (Rotheram-Borus & Milburn, 2004). Their connection to school is also irregular or non-existent, which contributes to low educational levels and limited employment skills. Several studies suggest that over one-third of youth who are homeless have dropped out of school, do not attend school regularly, or fail to earn a high-school diploma by age 18 (Thompson, Pollio, & Constantine, 2002; Whitbeck, 2009). These mental health and behavioural health challenges, combined with low educational and employment skills, contribute to high unemployment rates among youth who are homeless compared with their housed peers. Housed youth in the general population (aged 16–24) have unemployment rates ranging between 8% and 17% (U.S. Department of Labor, Bureau of Labor Statistics, 2016), whereas unemployment rates for youth who are homeless range from 39% to 71% across various samples of youth living on the street or in shelters (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Ferguson & Xie, 2008; Lenz-Rashid, 2006; Whitbeck, 2009).

Unemployment among youth who are homeless can be chronic, with many averaging more than eight months without work in any given year (Baron & Hartnagel, 1997). These young people may be unemployed according to the federal government's official definition: being jobless, having actively looked for work in the past four weeks, and currently being available for work (U.S. Department of Labor, Bureau of Labor Statistics, 2015). However, many rely on informal sources of income, both legal (e.g., selling recycled material, self-made items, blood/plasma) and illegal or legally regulated (e.g., prostitution, selling drugs, panhandling, asking people for money in public spaces). These income sources may be in addition to or a substitute for income from formal employment (Ferguson, Bender,

Thompson, Xie, & Pollio, 2011; Gaetz & O'Grady, 2002). Unemployment and illegal informal employment among young people who are homeless is associated with various antisocial outcomes, including increased substance use and criminal activity (Baron, 1999), which can lead to further societal estrangement (Johnson, Whitbeck, & Hoyt, 2005; Thompson, Rew, Barczyk, McCoy, & Mi-Sedhi, 2009).

Employment nonetheless is particularly important to young people who are homeless because it contributes to identity formation, links them to conventional institutions, and provides income that facilitates economic self-sufficiency (Gaetz & O'Grady, 2002). Through employment, these young people benefit from developing skills related to time structure, social contact, social context, and social identity (Harnois & Gabriel, 2000), which many have not had the opportunity to learn within home environments characterized by abuse and dysfunction (Tyler, Cauce, & Whitbeck, 2004). Further, since many of these youth have emancipated from the child welfare system and their biological families, they need to achieve economic self-sufficiency to survive (Mallon, 1999). Without employment opportunities combined with clinical and case management supports, youth who are homeless are at a disadvantage in achieving economic self-sufficiency and independent living in their transition to adulthood. This transition thus requires customized, long-term, and integrated employment, clinical, and case management services. Without these targeted supports, this population remains at risk for economic hardship, labour exclusion, exacerbation of mental illness, and chronic adult homelessness (Tyler & Johnson, 2006).

INDIVIDUAL PLACEMENT & SUPPORT MODEL PRINCIPLES

The individual placement and support (IPS) model is one example of a customized, long-term, and integrated model of supported employment. It is an evidence-based vocational intervention that targets individuals who have severe mental illness with customized, long-term, and integrated vocational and clinical services to help them gain and maintain competitive employment (Drake, Bond, & Becker, 2012). Originally designed for adults with severe mental illness (Drake et al., 2012), the IPS model has been implemented and adapted with multiple populations, including adult veterans with psychiatric or addiction disorders who are homeless (Rosenheck & Mares, 2007), housed young adults with first-episode psychosis (Nuechterlein et al., 2008; Rinaldi et al., 2004), and young adults with mental illness who are homeless (Ferguson, Xie, & Glynn, 2012).

The IPS model follows eight supported-employment principles, as described by Drake et al. (2012):

- Zero exclusion: all clients who want to participate are eligible.
- Integration of vocational and mental health treatment services: vocational and mental health treatment staff members are co-located and frequent communication between team members is essential.
- Competitive employment: clients get help obtaining community-based jobs at competitive wages.
- Benefits counselling: people who receive government benefits need personalized benefit planning when considering employment.
- Rapid job search: the job search process begins within one month of the client meeting with an employment specialist and beginning a career profile or vocational assessment.
- Follow-along supports: individualized assistance to working clients is available for as long as they need it.
- Preferences: client preferences influence the type of job sought and the nature and type of support offered.
- Systematic job development: employment specialists build an employer network based on clients' interests, developing relationships with local employers by making systematic contacts.

Table 3.4-1 on the next page elaborates on these eight points.

TABLE 3.4-1: PRINCIPLES OF THE INDIVIDUAL PLACEMENT & SUPPORT (IPS) MODEL

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Zero exclusion		
All individuals who want to work (or look for work) are eligible to participate. No job skills or educational level screening assessments are used.		
Four grant-required screening criteria identified homeless status and mental illness. Participants were recruited from an agency for youth who are homeless. They had to meet four criteria: ■ be 18 to 24 years old ■ speak English ■ have a past-year primary clinical diagnosis of generalized anxiety, posttraumatic stress disorder, major depressive episode, mania/hypomania, antisocial personality disorder, or alcohol or other substance use disorders) ■ express a desire to work or look for work	Inclusion Focus on self-acceptance of one's job skills and experiences Strengths-based program	IPS staff makes employment accessible to all youth. IPS staff validates the diversity of youths' job skills and experiences.
Integration of vocational and mental health treatment services		
Vocational and mental health treatment staff is co-located. Frequent communication among team members is essential.		
Host agency employment specialist, case managers, clinicians, and supervisor (i.e., IPS staff) met weekly with the principal investigator using a case conference format to discuss cases. IPS staff used a spreadsheet of case notes hosted on the agency's shared server to make regular updates on client meetings and progress. Staff held biweekly telephone consultations with the principle investigator and IPS trainer to review cases and address implementation issues.	Ongoing collaboration across IPS staff with IPS participants Capacity development of IPS staff Supportive supervision of IPS staff	Host agency establishes case conferencing format. IPS staff enhances collaboration around IPS participants' work preferences and goals. IPS staff builds IPS capacity. IPS staff receives mentoring and supervision.
Competitive employment		
Clients are assisted in obtaining community-based jobs at competitive wages.		
IPS employment specialist worked with participants to obtain community-based jobs at competitive wages. The employment specialist and participants met at least weekly to identify potential places of employment, complete job applications, and prepare for interviews (or do informational interviews or mock interviews). Supported education and employment models were combined to assist participants who wanted to complete degree programs or training certificates before working or for those who wanted to work and study.	Supportive staff (access to IPS employment specialist at least weekly) Modelling job search and interviewing skills	Youth develop effective job search and interviewing skills. Youth develop trust in IPS employment specialist. Youth obtain competitive employment.

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Benefits Counselling		
Participants who receive government benefits need personalized benefit planning when considering employment.		
IPS case managers worked with staff from the Department of Public Social Services and the Department of Rehabilitation to educate participants on the impact of paid employment on government assistance, including Social Security Disability Insurance, Supplemental Security Income, Supplemental Nutrition Assistance Program, and General Relief.	Service connection Financial literacy Supportive staff (access to IPS case managers at least weekly)	Youth develop skills for interacting with governmental institutions. Youth develop trust in IPS case manager. Youth receive governmental benefits when eligible.
Rapid job search		
Job search process begins within one month of the client meeting with an employment specialist and beginning a career profile or vocational assessment.		
IPS employment specialist worked with participants to begin their job search within one month of completing an IPS career profile (see IPS Employment Center: www.ipsworks.org).	Supportive staff (access to IPS employment specialist at least weekly) Strengths-based career assessment	Youth develop self-awareness of strengths and areas of growth through IPS career profile. Youth practise job search and interviewing skills. Youth obtain competitive employment.
Follow-along supports		
Individualized assistance to working clients is available for as long as needed.		
IPS staff continued to provide individualized assistance to participants who were working for as long as they wanted follow-up support. Once the young person was working, follow-along supports included weekly check-ins in person or via telephone or text message with the employment specialist, clinician, and case manager.	Supportive staff (access to IPS staff at least weekly) Modelling time management, financial literacy, independent-living, coping, and interpersonal skills	Youth continue developing trust in IPS staff. Youth learn skills to help them thrive in work and home settings.
Preferences		
Client preferences influence the type of job sought and the nature and type of support offered.		
IPS employment specialist used participants' IPS career profile to guide the job search and determine the support needed. IPS employment specialist, clinician, and case manager used a strengths-based approach by helping participants with limited employment experience and skills identify transferable "street-survival" skills that could be applied in competitive employment settings.	Strengths-based career assessment Power balance between IPS staff and participants Autonomy of decision making among IPS participants	Youth develop self-awareness of personal preferences. Youth strengthen autonomy and decision-making skills. Youth gain personal power in voicing and acting on employment preferences.

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Systematic job development		
Employment specialists build an employer network based on clients' interests by making systematic contacts and developing relationships with local employers.		
IPS employment specialist spent 40% of time each week in the community developing relationships with employers and connecting young people to them based on preferences. The employment specialist introduced the IPS employment program to potential employers, shared strengths-based information with them about the client population, and learned more about available positions and job duties.	Building community relationships with employers

Promoting strengths of IPS participants

Identifying job openings throughout the community | Host agency builds sustainable relationships with local employers.

Host agency enhances reputation in local community.

IPS staff increases knowledge of available positions in community and job duties.

IPS employment specialist connects youth with employment based on preferences. |
| **Clinical and case management services** | | |
| Clinical and case management services are not formally a part of the IPS model. | | |
| Participants met with IPS clinician and case manager to identify, assess, prioritize, and treat target areas of need. Clinician and case manager used motivational interviewing, cognitive-behavioural therapy, harm reduction strategies, and referrals to psychiatrists as determined from baseline assessment and IPS career profile. | Clinical services (weekly meetings or check-ins)

Case management services (weekly meetings or check-ins)

Harm reduction

Service connection | Clinician and youth identify clinical needs and goals.

Clinician assesses and treats mental health issues.

Case manager and youth identify independent living goals.

Case manager and youth work toward accomplishing goals.

Clinician and case manager track youths' progress. |

Collectively, the eight IPS principles draw from theories of psychiatric rehabilitation and recovery with individuals who have severe mental illness (Drake et al., 2012). The theory of psychiatric rehabilitation using supported employment posits that a person's functional adjustment can be improved by creating a supportive environment and enhancing the person's skills or abilities (Anthony, Cohen, & Farkas, 1990). Likewise, the theory of recovery states that individuals can get better from their illness and pursue meaningful life goals, such as employment (Deegan, 1988). Rehabilitation and recovery are important for people with mental illness and can be supported by both mental health systems and communities. For example, mental health systems can support rehabilitation and recovery by offering services in familiar, community-based settings. Similarly, local communities can facilitate rehabilitation and recovery by developing opportunities for employment, education, housing, and social support.

Additionally, the IPS principles are consistent with the internal developmental assets identified by the Search Institute (n.d.), and include social competencies, positive values, and positive identity. The developmental assets framework is comprised of empirically grounded internal and external assets in youth that help improve positive outcomes and protect them from high-risk behaviours (Benson, 1999). The IPS components collectively aim to strengthen the internal developmental assets of youth who are homeless to enhance positive outcomes and reduce high-risk behaviours. The IPS model is designed to promote social competencies, particularly planning and decision making, by incorporating youth in the decision-making aspects of their job search and mental health treatment. For example, youth involved in IPS establish goals with the employment specialist, case managers, and clinicians related to their employment search and mental health treatment.

Further, through the IPS mental health component, clinicians work with youth on exercising positive values, such as responsibility and restraint. They work with the young people on prioritizing areas of need and taking personal responsibility for their actions. Similarly, through learning to use harm reduction strategies, youth practise the positive value of restraint. As part of the IPS model, clinicians meet weekly with the youth to identify, assess, prioritize, and treat the target areas of need. They tailor the intensity and focus of the services to the severity of the young person's presenting issues.

Finally, the IPS model is designed to promote positive identity in youth who are homeless by affirming their capacity to obtain and maintain competitive employment, which in turn strengthens their personal power. Through employment, youth identify and develop

their vocational expertise, thus enhancing their sense of purpose. Further, by combining employment and clinical services, the IPS model supports youth who are homeless in developing motivation to change in order to make better-informed life and employment choices, also enhancing their personal power.

To date, there is strong research evidence for using supported employment models, such as the IPS model, with adults who have severe mental illness (Drake et al., 2012). Four initial trials evaluating IPS effectiveness with young adults with early psychosis also show promising results (Bond, Drake, & Campbell, 2012). One key feature of programs with demonstrated efficacy in establishing competitive employment is the integration of clinical and vocational services (Cook et al., 2005). Evidence indicates that clients who participate in vocational rehabilitation with integrated and coordinated clinical services report improvements in relationships, self-esteem, hope, and life satisfaction, in addition to gains in employability, work functioning, work hours, and income (Drake et al., 2012; Mueser et al., 2004; Salyers et al., 2004). Findings also reveal that clients who receive more employment-specific vocational services and who remain for longer durations in vocational programs achieve significantly better outcomes than those who receive fewer vocational services for shorter durations (Cook, 2006). Additionally, using more vocational services has been found to have a positive impact on employment outcomes, whereas using more clinical services is associated with poorer employment outcomes (Cook, 2006). These findings suggest that enhancing the amount of vocational services to clients with mental illness to complement or exceed their existing levels of clinical services may benefit them in obtaining and maintaining competitive employment.

IPS ADAPTATION & PILOT STUDY

Despite the origins of the IPS intervention with housed adults with severe mental illness, the eight IPS supported-employment principles have been adapted to work with young adults (aged 18–24) with mental illness who were receiving services from a non-profit youth homelessness agency (Ferguson et al., 2012). In this 10-month adaptation study, researchers recruited 20 young adults with mental illness who were homeless from a host agency. A control group consisted of 16 young adults with mental illness who were homeless and who attended services at another agency. Researchers relied on host-agency staff members, who were already known and trusted by the study participants, to implement the IPS model. One host-agency employment specialist, three case managers,

and two clinicians were assigned 20 cases among them for the pilot study. The Supported Employment Fidelity Scale suggests a maximum caseload of 20 clients per employment specialist to achieve high fidelity (Swanson, Becker, Drake, & Merrens, 2008). Case managers and clinicians had smaller caseloads given the mental health and other life challenges common among young people who are homeless (Whitbeck, 2009). All IPS participants met individually with the employment specialist, one case manager, and one clinician at least weekly. The IPS clinicians and case managers held their meetings within the host agency, whereas the employment specialist held agency- and community-based meetings. Regarding job development in the community, the IPS employment specialist also spent about 40% of each week out in the community, building relationships with new and existing employers. IPS studies with adults, which have high reported fidelity, indicate that employment specialists should spend 60%–70% of their time in job development in the community (Swanson et al., 2008).

IPS principles

The following section outlines how the eight IPS principles were adapted in this pilot study to work with young people with mental illness who are homeless and how such adaptations helped staff overcome common barriers to IPS implementation and sustainability. Table 3.4-1 outlines the eight IPS principles, their characteristics, specific adaptations that were made, mechanisms of influence, and objectives. The implementation and sustainability of the IPS model in a host agency likely will require considerable changes in staff duties and organizational culture and processes. As such, Table 3.4-1 is designed to serve as a guide for administrators and practitioners seeking to implement the IPS intervention in their agency to overcome implementation barriers. For more information on the full adaptation study of the IPS model with young adults with mental illness who are homeless, see Ferguson et al. (2012).

Zero exclusion

All young adults who met the study's screening criteria were eligible. Eligibility criteria were developed because this was the first pilot adaptation study of the IPS model with young adults with mental illness who are homeless and limited grant funding prevented the inclusion of all clients from the host agency. In the adaptation study, participants had to meet four screening criteria:

- Be aged 18–24;
- Speak English;

- Have received a primary clinical diagnosis in the past year for one of six mental illnesses (generalized anxiety, posttraumatic stress disorder, major depressive episode, mania/hypomania, antisocial personality disorder, and alcohol or substance use disorders}; and
- Express a desire to work or to look for work.

When implementing the IPS intervention as an agency-wide program, all staff can be trained in the IPS model to create a culture of supported employment throughout the agency. This allows staff to overcome the challenges related to implementing an evidence-based program with only a small segment of the client population.

Integrated vocational and mental health treatment services

The host agency's employment specialist, case managers, clinicians, and supervisor began meeting weekly with the principal investigator using a case-conference format to openly discuss active client cases. This integrated approach helped IPS staff overcome the barrier of staff from different fields working in a siloed manner. To facilitate more frequent internal communication among agency IPS staff, the employment specialist developed a spreadsheet of IPS client case notes and hosted the document on the agency's shared computer drive. Each staff member who met individually with study participants updated the case notes following the weekly meetings. To further promote collaboration, both the clinical and vocational staff also attended biweekly consultations with an IPS trainer to review cases and problem solve implementation issues.

Competitive employment

The IPS employment specialist worked with study participants to obtain community-based jobs at competitive wages. He met with participants at least weekly to identify potential places of employment, complete job applications, and prepare for interviews (or in some cases, informational interviews). To overcome the barrier of incompatible work and school schedules in participants' lives, supported education and employment models were combined to assist participants who wanted to complete degree programs or training certificates prior to working or for those who wanted to both work and study. Previous studies combining supported education and employment with housed young adults with first-episode psychosis have shown success (Nuechterlein et al., 2008; Rinaldi et al., 2004).

Benefits counselling

IPS case managers worked closely with the Department of Public Social Services and the Department of Rehabilitation to educate IPS participants on the impact of paid employment on their governmental assistance, including Social Security Disability Insurance, Supplemental Security Income, Supplemental Nutrition Assistance Program, and General Relief. By coordinating IPS services with governmental benefits counselling, IPS staff was able to overcome the challenge of encouraging participants to work without fully understanding the impact of employment on benefits. This way, IPS participants were able to make more informed choices about both their employment and public benefits.

Rapid job search

The IPS employment specialist worked with participants to begin their job search within one month of completing an IPS career profile (for the IPS career profile and other IPS-related materials, see the IPS Employment Center at www.ipsworks.org). The IPS model suggests that the best employment training is on-the-job training; as such, the job search process began right away with IPS participants and did not include any pre-employment training or preparation classes (Drake et al., 2012). By focusing on rapid job placement in the community, IPS staff was able to overcome the barrier of operating lengthy and costly job training programs housed within organizations for homeless youth that often fail to result in formal job offers for participants.

Follow-along supports

Host-agency IPS staff continued to provide individualized assistance to participants who were working for as long as they wanted follow-up support. Once the young person was working, follow-along supports generally took the form of weekly check-ins in person or via telephone or text message with the employment specialist, clinician, and case manager. By using varied contact methods, IPS staff was able to overcome the barrier of high drop-out rates from agency services common among youth who are homeless.

Preferences

The IPS employment specialist used participants' IPS career profiles to guide the job search in terms of the type of job sought and the nature of support the youth would need. The profile is a strengths-based vocational assessment that asks participants about their work goals, work experience, educational and vocational training, military experience, physical health, cognitive abilities, substance use, and government benefits. Use of this strengths-based career profile enabled IPS staff to better support and encourage young adults and to overcome the challenge of working with a population with limited employment experience and skills.

Systematic job development

The IPS employment specialist spent 40% of his time each week in the community developing relationships with local employers and connecting young people to employers based on their identified interests. The employment specialist introduced the IPS supported employment program to potential employers, shared strengths-based background information with them about the client population, and learned more about available positions and job duties. By committing regular time each week to developing relationships with employers in the community, IPS staff was able to overcome the barrier of employer stigma toward young adults experiencing homelessness and mental illness.

MENTAL HEALTH TREATMENT COMPONENTS & OUTCOMES

The IPS clinicians and case managers participating on the IPS team developed various mental health treatment components to accompany the employment specialist's work. First, for participants experiencing depression, mania/hypomania, or anxiety disorders, the clinicians on the IPS team used cognitive behavioural therapy, coupled with referrals to collaborating psychiatrists for medication. For those experiencing trauma symptoms, clinicians provided individual and group trauma intervention services (e.g., cognitive behavioural therapy and referrals for medication). To address high-risk sexual and substance use behaviours, clinicians used motivational interviewing to identify high-risk behaviours and to help the young adults move toward change. Clinicians also used various harm-reduction strategies (e.g., safe-sex practices, prevention of sexually transmitted diseases, HIV testing/counselling, substance abuse referrals) to reduce harmful behaviours associated with substance abuse and high-risk sexual activity through small achievable steps. This integrated employment–clinical–case management approach enabled IPS staff to overcome the challenge of working with a population with multiple and complex psychosocial needs.

The study hypothesized that youth in the IPS group would have greater improvement compared with the control group in five areas: (1) ever worked rate, (2) working at follow-up rate, (3) monthly work rate, (4) weekly work hours, and (5) weekly income (Ferguson et al., 2012). The study found that IPS participants were more likely than the control group to have worked at some point during the study (85% vs. 38%). Working at follow-up was reported by 67% of the IPS group and 25% of the control group.

For the monthly work rate, IPS participants worked a significantly greater number of months over the 10-month study (5.2 months vs. 2.2 months). Moreover, 45%–70% of IPS participants and 19%–31% of the control group were working during any one month of the study. There were no significant differences between the IPS and control groups on weekly work hours or weekly income. With respect to type of employment, IPS young adults worked in retail, restaurants, supermarkets, airports, janitorial services, and security services. Control group participants worked in retail, janitorial services, construction, and supermarkets.

IMPLEMENTATION CONSIDERATIONS

There are several important considerations when implementing the IPS model with youth with mental illness who are homeless. First, IPS is an evidence-based intervention that has demonstrated high fidelity and effectiveness with adults with mental illness who are homeless. When implementing IPS with youth and young adults who are homeless, it is important to solicit buy-in from a host agency, where young people who are homeless already congregate and feel safe. It is also important to secure the participation of the necessary IPS staff: employment specialist, clinician, and case manager. The greater the level of rapport and trust between host-agency staff and participating youth, the greater the engagement and retention of youth in the IPS program will be. In addition to implementing the IPS intervention, it is vital to have a host-agency supervisor involved in its implementation and oversight to support and mentor staff alongside the principal investigator and IPS trainer. The IPS Employment Center has IPS trainers and materials for training host-agency staff to ensure fidelity to the IPS model (www.ipsworks.org).

In the adaptation study, the principle investigator and the IPS trainer introduced evidence-based IPS materials to staff during the two-day training held in the host agency. Subsequently, IPS staff held weekly meetings with the principle investigator and biweekly phone calls with the IPS training consultant to discuss specific cases and to troubleshoot issues that arose during the 10-month pilot. Throughout the study, the principal investigator and the IPS trainer observed and provided feedback to staff on inter-staff and staff–client interactions. Integrating IPS experts from around the country in the design, implementation, and evaluation of IPS studies provides needed guidance to researchers and practitioners who are adapting this model to new populations within a host-agency setting.

A second important consideration for implementing IPS involves the host agency's involvement with the intervention. When introducing the IPS program into a host agency that has an existing employment program, it is important to honour the staff's practice wisdom by incorporating them into all levels of the intervention adaptation, implementation, and evaluation. In the IPS adaptation study, we used a seasoned employment specialist with over two years of experience working with youth with mental illness who are homeless. It was necessary for the employment specialist to work at a very basic level with many of the participants, since they had never held a job and had limited educational attainment. Strengths-based tools such as the IPS career profile and career mapping (Shaheen & Rio, 2006) were instrumental in helping participants begin to identify and market their employment interests, skills, and experiences. The employment specialist also found creative ways to stay in contact with a highly transient population; this included using cellphones, texts, emails, and regular visits to the study participants' job sites (when approved by the young adults). Further, the IPS employment specialist understood the common employment preferences in this young adult population and developed strong relationships with local employers in areas including retail, restaurant, and supermarket work, and janitorial and security services. This enabled IPS staff to build a job bank of available positions to match with IPS participants' preferences.

Another consideration for implementing IPS involves integrating educational programming into employment. When working with youth and young adults who have not yet completed their required education and have not been socialized fully to the workforce, it is important to integrate evidence-based educational programming (e.g., supported education) into employment services. It is common for emerging adults to study and work concurrently, as well as to pursue educational degrees or technical certificates prior to entering the workforce (Arnett, 2004). Combining supported employment and supported education thus allows IPS staff to further honour participants' career and academic aspirations and to reinforce that these two can be blended. In the IPS adaptation study, several participants sought technical training offered through local community colleges (e.g., pharmacy technician certificate), Job Corps (e.g., culinary arts' certificate), and Goodwill Industries International (e.g., forklift training program certificate) prior to securing competitive employment. Other participants worked and studied concurrently to finance their education. Service providers working with this population can offer educational scholarships, academic mentoring, and tutoring programs that help support young adults' educational pursuits. Likewise, employment specialists can work with young adults and employers to identify employment options (or tailor existing work schedules) that support young adults' educational goals, since both academic certificates and technical training can enhance their competitiveness and productivity in the workplace.

When working with young people experiencing homelessness and housing instability, it is also important to incorporate housing options into employment services. To date, evidence-based housing approaches include rapid rehousing and permanent supportive housing that emphasizes housing first (Padgett, Henwood, & Tsemberis, 2016). These approaches follow the principle that flexible psychosocial and vocational interventions must accompany housing supports (National Alliance to End Homelessness, 2012). In the adaptation study, the IPS model was implemented in a host agency that had a drop-in centre, an emergency (30-day) shelter, a long-term shelter, and permanent supportive housing (apartments) with an emphasis on housing first. Housing options for IPS participants were varied, as housing stability is often fluid in this population. For example, while only one IPS participant reported living on the streets at baseline, others initially reported precarious housing situations (e.g., living with abusive parents, with a partner's family, with friends). Still others abandoned shelters for the streets during the study or lost their permanent supportive housing due to relapse and lack of commitment to residential drug treatment. Involvement in the IPS intervention (and in competitive employment specifically) for many young people sensitized them to the importance of safe, stable, and supportive housing as a prerequisite to accomplishing their work goals. IPS case managers worked with participants to tailor housing options as part of their IPS case plan. IPS clinicians worked with participants on mental health issues (e.g., depression, substance abuse, posttraumatic stress disorder) that can hinder success in gaining and maintaining both employment and housing (Whitbeck, 2009). The integration of housing, employment, clinical, and case management services not only honours young people's preferences and life goals; it also is consistent with the best evidence for addressing youth homelessness.

CONCLUSION

Despite its origins with adults with severe mental illness, IPS is adaptable to work with youth with mental illness who are homeless or street involved and is associated with successful retention and employment outcomes. The eight IPS principles of supported employment can be adapted to better support these young people in obtaining and maintaining competitive employment. Staff from agencies that serve youth who are homeless can learn more about the IPS model through the IPS Employment Center, as well as obtaining training, implementation, and evaluation materials to administer the IPS program in their agency. To administer an IPS program with high fidelity, at minimum, the host agency should have a supervisor and at least three staff to form an IPS team (i.e., employment specialist, clinician, and case manager) for every 20 youth participants. IPS

staff should make every effort to implement the intervention according to the guidelines outlined in the Supported Employment Fidelity Scale. Through adopting an individualized and long-term approach of integrating employment and clinical services, providing follow-along supports, and honouring client preferences, services for youth who are homeless will have greater success in socializing these young people to the workforce, increasing their access to competitive employment, and improving their employment skills and outcomes.

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3.5 BEAUTIFUL TROUBLE: POSSIBILITIES IN THE ARTS WITH STREET-INVOLVED YOUTH

Phyllis Novak[1]

Beautiful trouble makers who remember, resist and reimagine.
—Min Sook Lee, OCAD University, Art and Social Change

Offering Crys[2] a ride "home" after a jewelry-making workshop led me to a makeshift "shanty town" under the Bathurst Street bridge in Toronto. I was struck by the vivid colour and detail in this woven compilation of blankets, boxes, and condo sales sandwich boards, used to create multi-storey structures, walls, doors, beds, tables, and chairs. It looked like a theatre set. Crys told me that over 20 youth lived there, and it had taken months to construct. Everyone had a role in this "under-the-bridge" community. Someone fed the dogs and another created the schedule for their walks; someone held the alarm clock to wake people for jobs, school, or appointments; others led study and support groups for those in school, and those wanting to "stay clean." And of course, many of them were musicians, poets, and artists who made things to sell instead of panhandling and who entertained each other in the evenings. They shared their earnings and combined costs, especially for meal-making that happened over their custom-made Bunsen burners. They met weekly to make decisions and talk through problems. Crys was pretty proud of that place and it evoked a kind of envy in me for creative, cooperative, and alternative community.

Months later, the City's Public Health department declared the site a health risk, and determined to close it down. They supported youth, who were ready, to find housing. Some didn't leave, however, and the day came when the remaining residents ran into the SKETCH studios, reporting through tears that bulldozers and cement trucks shovelled through their housing project, piling their possessions and constructions in heaps to act as bonding agents for cement that was quickly poured to create a wall preventing further access. We'd often heard of belongings being lit on fire or picked up by garbage trucks, and I expressed to Crys, reporting this fateful day to me, that I felt terrible that her belongings

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[1] I would like to thank Dr. Jeff Karabanow for his support and input in developing this chapter.
[2] Not her real name

were once again taken from her. She looked at me and stated angrily that she didn't care about her stuff. "We made that place. All they could see is how we could get sick. Why couldn't they see what we made and how it was good?" (Novak, in draft).[3]

The arts have many potential benefits, including intrinsic, community, and personal benefits, and ones that relate to entertainment, quality of life, health and well-being, social capital, education, and economy (Hill, 2014). Art as a form of methodology and intervention is now commonplace in different health care and therapeutic settings, particularly mental health services. It is used to promote intrapersonal and interpersonal skills, functional performance, and personal growth (Griffiths & Corr, 2007). In this chapter, art and the arts refer to many artistic forms: music and vocal arts, creative writing, poetry, drama, dance, visual and digital new media arts, video and film, design, sound, recording arts, textiles and fabric arts, ceramic arts, theatre, community-engaged or activist arts, and installation or performance arts.

THE ARTS IN HEALTH & SOCIAL WELL-BEING

A Canadian Institute for Health Information (2009) report identified various factors that promote positive mental health for youth, all of which have the potential to improve through arts engagement. These factors include:

- Ability to enjoy life in the moment and in the long term (happiness, life satisfaction, subjective well-being);
- Ability to deal with life events (coping and management skills to regulate emotions);
- Emotional well-being (understanding, interpreting, expressing emotions);
- Spiritual well-being (sense of purpose and meaning in life); and
- Social connections and respect for culture, equity, social justice, and personal dignity.

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[3] SKETCH (www.sketch.ca) is a community arts enterprise in Toronto that engages young people, aged 16 to 29 years from across Canada, who are navigating poverty, homelessness, or the margins to experience the transformative power of the arts, build leadership and self-sufficiency in the arts, and cultivate environmental and social change through the arts. Since 1996, SKETCH has engaged over 10,000 young people to inform the creation of a placed-based and relational practice rooted in anti-oppression and transformative justice, and a youth co-designed framework of engagement, that sees young people moving from places of creative discovery through focused skills development and finally, to leadership, either in their own lives or to build capacity as innovators in community development, using the arts to address social change.

These factors are particularly relevant for young people who are homeless or who live on the margins, and whose many challenges include mental health issues, past or current trauma, and the significant daily stress that accompanies trying to meet basic needs. These young people often feel a general sense of hopelessness, despair, and isolation, and struggle with perpetual poverty. "Youth homelessness" is a political and economic issue, but it has become a generalized label that obscures the complexity of the experiences of thousands of diverse individuals (Canadian Observatory on Homelessness, 2016). Youth experiencing homelessness are forced to grow up fast, managing the demands of survival in the present, which requires clarity of thought and strategic action while navigating the natural developmental chaos of transitioning to adulthood. This process becomes more complex when the challenges of dealing with past trauma, multiple diagnoses, displacement (newcomer youth), or dispossession (Indigenous youth) are added (Karabanow, Kidd, Fredericks, & Hughes, 2016).

Reversing the effects of stressful early life experiences requires repeated activities over a long period of time in order to form new connections in the brain. Many activities can promote this change; music, for example, is particularly powerful because it is an enjoyable way of learning new skills and behaviours that can engage all youth (Scott, 2011). Spiritual well-bring and social connections, two other factors that promote positive mental health, are critical in helping youth move beyond the constraints of homelessness. They are essential components of youth engagement, treatment, and service delivery. Connecting to others and developing a sense of social purpose in community help youth overcome social isolation, complex trauma symptoms, poor physical health, and other challenges (Kidd & Davidson, 2007).

A large body of literature demonstrates the value of art in achieving both individual and social ends; it provides a sense of achievement, promotes health recovery, and contributes to a sense of social belonging through group participation (Star & Cox, 2008; Tesch & Hansen, 2012; Walsh, 2008; White, 2006; Windsor, 2005). Oesi-Kofi (2013) noted that while arts-based research and interventions are not new, they are increasingly being taken up by researchers and health practitioners because of art's potential to "honor multiple ways of knowing, including sensory knowing" (p. 137). The appeal, methodologically, is the possibility of co-creating knowledge with participants, emphasizing reflexivity in the process, and "embodying great potential for consciousness raising and critical dialogue" (p. 137).

The resilience of youth and their ability to survive receive nods of admiration when we see the fullness of their challenges (Kidd & Davidson, 2007). What we applaud less often is youths' unique creativity and entrepreneurship, and we may fail to understand that their distinct agency, skills, and sometimes seemingly other-worldly knowledge are actually vital to the shaping of livable, sustainable, and inclusive communities and economies. Using the arts for youth engagement, particularly for those living on the margins, can provide a way for young people to not only heal, but also to build skills and capacities to determine and gain control of their own life trajectories and to realize a contributing role in shaping society. The arts can become levers with which young people, who are most often cut off from participating in the broader cultural narrative, can speak out, critique, challenge, and indeed shift institutional and cultural paradigms (Karabanow, Gurman, & Naylor, 2012). Youth experiencing homelessness can use the arts as a tool to amplify their voices in order to help decision makers understand their experiences and invest in youth-centred solutions: "Shifting public discourse and understandings about youth homelessness is crucial in order to promote public and governmental investments in solutions" (Schwan, 2017, para. 4). Hearing this voice from the margins, as bell hooks (1989) states, enables us to see the "profound edge" of marginality as a "site of radical possibility, a space of resistance," and of "creativity and power" (pp. 149, 152).

While the possibilities of arts-based interventions for youth experiencing homelessness are many, it is important to recognize the broad range and severity of mental health issues these youth experience and to understand that the role of the arts in formal treatment must adapt to meet different needs. Arts engagement should not replace formal treatment, especially when severe psychosis is involved, but nor should it be dismissed. The arts can be used in direct therapy and treatment, or they can be used in therapeutic ways to support the bigger strategy of engaging with the person's overall sense of isolation and hopelessness. Ideally, formal treatment would include the arts both as a direct intervention and as a way to support change.

THE ARTS AS METHOD

Research shows the significance during youth development of connecting with peers, discovering what youth are good at, and being engaged in things that matter to them (Government of Ontario, 2012). Services for youth sometimes are too generalized and do not consider significant issues young people face around race, gender, and identity. These

are areas in which the arts as method allow for individuation and for young people to "re-author" or reintroduce themselves into situations or circumstances in their own ways and on their own terms (Karabanow et al., 2012). The arts welcome diverse culture, identities, and expressions; they are not only celebrated, but necessary. Diverse perspectives promote accessibility, enrich experiences for everyone, and fuel the kind of inclusive innovation society needs to make change. This openness makes a difference in acknowledging and affirming multiple, layered, and complex (as well as changing) youth identities. This is perhaps the most crucial benefit of integrating the arts into mental health treatment, services, and engagement strategies for youth who are homeless or marginalized—igniting individual creativity to explore or "rewrite" one's own story and find one's voice and skills, and developing capacity to assert one's self into society through creative acts.

THE ARTS FOR LEARNING

Skills learned in arts engagement can be transferred to other life domains and offer new directions that traditional treatment or service modalities may not reveal. Reframing arts engagement to develop leadership in youth hones various skills (Goodman, 2015), including:

- Creative problem solving, inventing and experimenting with new ideas;
- Risk-taking and building confidence;
- Ability to go against the mainstream and develop alternative solutions: this is part of the appeal of the arts for youth on the margins, particularly those who are racialized and suffer stigma attached to discrimination, because they have already experienced the challenge of being rejected or shunned;
- Learning to be yourself: discovering unique potential and opportunities;
- Understanding the power of myth, metaphor, and symbol to shape understanding of complexities and connecting cognitive, emotional, physical, and spiritual capacities;
- Observational skills to be aware of others and the situation in which one finds oneself;
- Project planning using design, goal setting, production, finishing and presentation, and constructive critique; and
- Collaboration and appropriation: building empathy, cooperation, and accountability for actions in response to the impacts actions have on others.

Phillips (2012) has identified additional skills that are developed through engagement in the arts:

- Focus and concentration;
- Non-verbal and verbal communication;
- Perseverance, motivation, commitment, and sense of accomplishment;
- Time management;
- Personal discipline and initiative;
- Adaptability and reflexivity;
- Ability to work under pressure; and
- Ability to integrate values, beliefs, and cultural expression into the production of original artwork.

Training youth who are homeless in artistic skills can prepare them for careers in the arts and other creative industries—one of the fastest growing contributors to the economy (City of Toronto, n.d). There are some great programs across Canada—for example, SKETCH, the Remix Project, and VIBE Arts—that integrate arts and community development with career training and paid work experiences to marginalized youth and that prepare them to enter industry or further their education (Schwan, 2017).

THE ARTS FOR DEVELOPING AGENCY

Agency is an essential ingredient in the human experience. The arts stimulate the imagination so we see ourselves bigger than we are. Imagination is necessary to enable youth to try on identities and experiment with new realities beyond confined circumstances and imposed stigmas. The whole trajectory offered to youth through engagement in the arts—discovering, experimenting, and developing capacity to reintroduce themselves as "makers" and "co-creators," rather than as youth with complex challenges—is critical to realizing themselves beyond living as "service users." The process moves youth into civic engagement and active pursuit of new futures beyond the limitations of poverty or homelessness, integrating their experiences and multiple challenges. Karabanow and Naylor (2015) highlight similar findings in their analysis of an art camp for young people experiencing housing instability. The camp gave youth space to provide feedback and build leadership skills with which to confront dominant narratives and create new ways of being. Such a space is critical for young people who feel the restrictions, real or imposed, of mental health challenges. It enables them to transform from stigmatized and powerless individuals into hopeful, resilient, powerful, and active agents in their own personal wellness and in the wellness of broader society.

THE POSSIBILITIES OF ART IN HEALTH CARE

Youth can become co-builders of new service, treatment, and engagement paradigms. What would happen if mental health services for young people who navigate complexities of poverty, homelessness, and marginalization could include medical prescriptions to engage in arts-based activities—not art therapy per se, but simply arts activities in multiple forms? What if court orders mandated participation in arts-based projects to address community issues? What if youth in long-term care facilities or in detention were invited to co-design their treatment and were given tools to make films, songs, or art pieces about their experiences? What if centres for youth engagement in the arts worked alongside hospitals, schools, detention, health, social services, and employment centres to coordinate youth services? What if we viewed an invigorated imagination in youth development as a critical resource in mental health treatment or in wrap-around support to navigate the challenges of homelessness or poverty? And what if the arts could be used as a training method and mental health support for front-line workers and case managers to prevent burnout and connect them as partners with youth in creative activity?

INTERVENTION COMPONENTS

AESTHETIC CONSIDERATIONS FOR ARTS-BASED INTERVENTIONS

This section discusses changing the look and feel of youth engagement and service delivery to embrace the arts. It also highlights past projects to illustrate the possibilities of arts-based interventions for mental health.

Maximizing youth engagement

Engagement that centres on young people's creative capacity and focuses on drawing out their creative contributions means interactions, activities, and supports that immediately activate their imagination. Viewing and engaging youth as community developers, rather than clients or patients, and seeking their creative input in solving individual, community, and global challenges, is empowering and strategic, and can even be fun. Further, if the engagement itself is less about addressing individual experiences and invites youth to consider broader issues, youth can experience a self-constructed, or in the case of groups a co-constructed, context within which to address their own issues, in their own time, and in their own way.

> Six young women explored gender identity and the impacts of drug overuse through making life-size sculptures out of recycled materials. They shared ideas and exchanged found objects, told stories inspired by the rusted metals and discards, and contributed to each other's sculptures over eight weeks of engagement. Together they confronted issues of gender-based violence and addiction, and collaborated on messaging through a public exhibition of their six sculptures that were set up along an open area by the railroad tracks in Toronto. Thousands of GO train commuters were powerfully affected by this group of incredible art pieces that, standing alone, would have been invisible. The process and the product were possible because youth were engaged not as "victims" or "addicts," but as sculptors engaging in critical topics that deeply affected them and because they made public statements in solidarity with their distinct art pieces. The experience catapulted these formerly isolated young people into a new sense of identity as individuals and as a group involved in civic engagement. Through the process, each participant made advances in personal care and coping with addiction and violence.

Creating engaging spaces

The spaces in which services engage young people need physical makeovers to represent the look and feel of health, of aliveness, of invitation to create and collaborate, where youth themselves are primary designers in how the space works. Increasingly more health and youth centres are being designed that consider the effects of colour, shape, structure, and relationship to space. When youth walk into an arts studio rather than into a waiting room, they see raw art materials and equipment, and pieces in various unfinished and finished states. These are powerful metaphors that have a visceral effect and can set the tone for how youth will participate in processes that will benefit them. The energy of "making" is all around them, and their sense of possibility is stimulated because they have access to all kinds of tools with which to "re-create" themselves.

Youth engagement and service delivery spaces (temporary or permanent) could be set up as art studios or "maker labs" in various disciplines. Entering a ceramic arts studio, youth see clay in rough form, carving tools, and pottery wheels. In a music studio they find various instruments and hear original sounds that were recorded with software on laptops. The messages communicated are, first, that they are creators; second, that they

are humans with experiences, ideas, and skills that can help solve problems; and third, that they can make choices about working in a domain of learning they choose. This goes beyond whether a young person has artistic skill or interest. It is about setting up a space that catalyzes a different kind of engagement and honours creative capacity.

Artistic tools themselves (with applied safety-first considerations) can offer messages to young people about their role in treatment. For example, a young person receives a sketchbook or journal and a black fine-line marker. This sends a message that their ideas matter and that their creative process is honoured. The exposure to tools and potential work spaces creates a less institutional feel and even invites youth to help break rigid systems or forms. This means moving beyond having Plasticine or crayons and paper on tables, although that's a start.

> At a mental health conference, a poet's corner was set up in a quiet part of the conference hall. In this simple, calm space, notebooks and fine-tip markers, self-care books, pieces of creative writing, poetry, nature magazines, and quieting objects sat on a coffee table between comfortable chairs, and paneless window frames hung from the ceiling, carving out a calm space in the midst of a talk-heavy and crowded gathering. The space sent a subtle but powerful message to youth to take time apart and be still, and that their reflections, their meaning-making, were a critical part of the conference.

PEOPLE & PARTNERSHIPS IN ARTS-BASED INTERVENTIONS

This section discusses how health and social services providers can work with professional artists and youth leaders to facilitate arts engagement among youth who are homeless.

Working with community-engaged artists and arts educators

Community-engaged artists and arts educators can be partners in health or social services for youth. These professionals develop their art practices in communities, with community members, where process and product are equally valued. Too often, arts engagement is limited to art therapy in clinical practice or to arts activities led by recreation workers, social workers, or at best, child and youth care workers. These activities offer value, but valuable opportunities are missed if established artists, creative entrepreneurs, or arts

educators are not engaged in leadership roles. These partners to young people (and to health practitioners) offer new perspectives, design exercises, activities, and skills development that create access for diverse young people to move into challenging moments, cope with hard feelings, deal with experiences, solve problems, and make new declarations that maintain the focus on issues rather than treatment. Artists ask questions differently. It's just part of being an art maker. Community-engaged artists are specifically trained to animate and engage with community members around their self-declared issues. Realizing the full potential of this work requires hiring professional community-engaged artists.

At a Disable the Label youth gathering,[4] we created a huge archway made of ramshackle wood pieces that symbolized the movement beyond stigma and into health. In creating the archway, nothing was measured; all the pieces were different lengths. It was lopsided and hodgepodge, but had a strong wooden base so it could stand on its own and people could pass through it. Designing together with youth and service providers, we first listed on paper the names, labels, and diagnoses youth wanted to leave behind (e.g., fag, stupid, over-emotional, fat, psychotic, suicidal, bipolar, burden). We later burned the lists in a campfire. Etched into the wood and attached to it for the duration of the gathering were messages and names youth preferred (e.g., fun, inspirational, alternative thinker, adventurer, musician, poet, good friend). All week, youth talked about the power of leaving stereotypical labels behind, burning them in a fire, and entering the gathering space where they referred to each other using chosen, new, hopeful, and artistic terms. It was empowering and beautiful. Artists worked with the organizers to design the concept, and youth were engaged in giving life and meaning to it with their contributions of text. This is an example of the kind of partnership that is possible.

Similar examples resulted from the Ontario Arts Council Arts and Health Residency pilot program in 2010. Artists were placed in long-term health settings in Toronto and North Bay, where they explored the connections between wellness and creativity. The pilot led to numerous partnerships between artists and health centres that focused on health promotion and alternative treatments (Health Nexus, 2010).

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[4] Disable the Label is a summer training retreat for young community leaders and their adult allies in the mental health system. For more about the program, visit www.thenewmentality.ca/disablethelabel/.

Engaging youth peer leaders

The mere presence of peers to move alongside youth participating in processes that are challenging or to model those processes is essential to making things more accessible and effective for young people. Arts approaches work best if peer leaders are part of arts engagement from beginning to end: from needs assessment, to project design, implementation, and evaluation. Sharing the experience with someone who understands offers youth participants a reflection of what could be if they followed a similar path. It is critical to budget for the engagement of young people as leaders to advise project development, co-facilitate, and participate in evaluation. Too often, budgeting for this important role means minimum wage short-term positions, where young people can be exploited for the investment of their time and unique contributions, which can often lead to commitment well beyond paid hours. Preparing youth for peer leadership involves training, supervision, and clarifying roles, as well as developing strategies to deal with triggers. Peers, no matter how far along they may be in their journeys, can be challenged by instability when they work on a project with other youth whose experience resembles their own. Budget considerations for livable wages, training, and ongoing support need to be integrated for successful engagement.

Partnering with front-line workers

The arts can be used to build capacity of those involved in front-line service coordination and delivery. It can also offer skills and renewal to prevent burnout and ensure relevant youth engagement. Commitment to annual training or professional development in the arts can offer new perspectives, and can re-position the caseworker as co-creator with youth, which enables young people to take ownership in their journeys and see the worker as a partner in that journey.

> SKETCH hosts a partners art playground four times a year, where service providers and youth come together for a collaborative art-making experience. In our impact evaluations, service providers report feeling refreshed. They also describe their interactions with youth as feeling different and having a deeper quality that did not tax their energy. SKETCH also conducts a three-day training program three times a year to help service providers and artist facilitators prepare for seasonal projects and activities. The program has become very popular; it now requires registration and has a waiting list of practitioners interested in learning how to use the arts to engage youth.

DYNAMICS & MECHANICS OF ARTS-BASED INTERVENTIONS

This section describes foundational elements in designing arts-engaged programs for youth who are homeless.

Shifting the practice from therapy to creativity

It is important that arts-engaged programs keep things in the realm of creative discovery, skill building, and community engagement, and that they recognize therapeutic impacts as secondary. Art therapy is a distinct clinical practice requiring specific conditions. Creative discovery is different. It focuses on creating ideas, experimenting, making mistakes, and learning skills. The artwork created doesn't need interpretation. Instead, it can be "critiqued" around the use of lines, shapes, colours, composition, and so on as ways for youth to reflect on the choices they make and what they want to articulate, rather than as a way for the viewer to "get inside of the young person's head." Sometimes it may mean supporting youth to shift the direction of their work or asking them questions about composition if they appear lost in a deep, expressive process that may need support. This encourages youth to become more objective viewers of their own production and puts them at less risk of needing more protective conditions. It takes nimbleness and courage on the part of the facilitator to interrupt in these sensitive moments. The engagement is around generating creative ideas, analyzing, and interacting. It is important to support the development of private spaces for those who want to create independently, where possible, but the practice is engagement for their benefit and their safety.

Designing an arts learning framework

Developing an arts learning framework or a working theory of change can guide activities and desired outcome in arts engagement. It takes youth through a process of discovery and development into leadership capacity. This is best done with youth to recognize the learning arc they experience as their engagement deepens over time. Designing programs that allow for incremental and progressive accomplishments for youth that build on one another reinforces immediate positive benefits and points youth toward potential benefits if they invest more time and energy in learning through the arts. Engaging youth to track and recognize their own milestones and learning can offer them increased ownership of their developmental process. This can be as simple as engaging them to photograph the work they create and compile it into a digital portfolio, or it can involve creating a longer-term skills inventory that gives them a sense of accomplishment as they see their skills improve over time.

Anti-oppression and transformative/restorative justice

Critical to working in creative engagement with young people is anti-oppressive practice. This involves a willingness to address the impacts of power and a commitment to equity and restorative justice. The role of art is to make meaning, question assumptions, provoke emotion, and stimulate divergent thinking. This is part of the appeal for youth on the margins to engage in arts processes. For them to invest in the process, they need to know they can question systems and structures, and address barriers or canonized ideas they perceive or have experienced, to limit their freedoms. Setting a context that explicitly declares intentions to break down and reduce barriers to youth caused by systemic oppressions such as racism, gender-based violence, colonialism, ableism, and homophobia or transphobia is necessary for diverse youth to be affirmed in their multiple identities and to freely engage in the process. Encouraging youth to question power dynamics and systems is essential to the realization of agency. Working together in arts processes neutralizes power dynamics that set one person apart from the other as "expert." The "adults" or "service providers" should engage together with young people in art making, rather than sit apart watching the action so youth feel like they are in a fishbowl. Co-creation sends the message that all contributions are equal in value and recognizes the vulnerability of being in a creative process (Neighbourhood Arts Network, 2014).

Investing in an infrastructure for arts engagement

Investing in infrastructure is important. Spaces and tools for arts engagement must be available. Art making (in its various forms) requires more than point-in-time multi-use spaces if we are to realize the full potential of the arts with young people. Just as gymnasiums and outdoor basketball courts are critical to neighbourhoods, arts engagement spaces need to become central in urban planning. If arts engagement is recognized as critical to health promotion and health services, then having accessible youth arts centres near or within health service facilities themselves can offer greater connection to achieving mutual outcomes. Financial investment in hiring and training facilitators, artists, and front-line workers, and in contracting youth themselves to lead, is part of the infrastructure needed for successful arts programming and projects. Art materials and equipment can be expensive, much like sports training equipment for gyms or computers for libraries. But youth living on the margins deserve high-quality tools that demonstrate investment in their creative development, rather than the usual second-hand items that may come with huge service costs.

Long-term financial investment in infrastructures for arts and creativity by governments is critical to develop engagement strategies with youth that support their mental health and leadership development. This includes assistance with training and ongoing support and professional development in the field; resources to hire arts workers and youth peer leaders to work with primary care services; and funds for research around alignment of the arts with learning, technology, and sciences. Post-secondary institutions have developed formal curricula around arts engagement to begin to train practitioners to lead the integration of arts into various sectors and communities. Examples include the Community Engaged Arts Certificate program at York University in Toronto and the Art and Social Change minor degree program at OCAD University in Toronto. Investment and infrastructure to support these efforts and make them accessible represent numerous possibilities in innovations in youth services, treatment, and engagement.

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3.6 PEER SUPPORT WORK TO ENHANCE SERVICES FOR YOUTH EXPERIENCING HOMELESSNESS

Tyler Frederick, Mardi Daley, & Will Zahn

INTRODUCTION

Across contexts, peer workers and peer mentors are becoming an increasingly important resource in delivering youth-focused programming for young people who are homeless or street involved. Peer work has been established across a number of practice areas, including public health, addictions, education, and community-based research. The most considerable development in the role has been within the mental health sector, where peer work is gaining increasing visibility and legitimacy as a central component of a recovery-based approach that is demonstrating positive outcomes (Nesta, 2015). While the incorporation of adult peers is relatively well established in many service sectors, youth and young adult involvement is still developing.

Peer work can encompass a number of activities, and although the role lacks a clear definition, a defining feature is the use of lived experience as a support to individuals in similar circumstances (Vandewalle et al., 2016). Within this broad conceptualization, various authors (Ansell & Insley, 2013; Ontario Centre of Excellence for Child and Youth Mental Health, 2016; Paradis, Bardy, Cummings, Athumani, & Pereira, 2012) have identified the common peer worker roles. These roles include:

- Peer mentor: partners with a client or participant and offers support and encouragement regarding program-specific goals and broader life goals;
- Peer educator: helps develop educational materials and leads educational presentations and workshops;
- Peer navigator: provides help with systems navigation (e.g., accompanying people to appointments, connecting to services, helping to fill out paperwork);
- Peer specialist: a broader role that encompasses some of the above activities and might include some case management, advocacy, and group facilitation; and
- Self-help and mutual aid group: this includes peer support groups and peer knowledge exchanges.

This chapter frames and conceptualizes the peer role and offers practical, evidence-based recommendations for incorporating peer workers into mental health–related programming and service delivery settings. It draws from the research on peer workers and peer mentoring across sectors, but also incorporates the insights of an experienced peer worker (Daley). The primary focus of this chapter is on peer work in mainstream agencies in a more formalized peer worker role. It does not include youth-led organizations or self-help and mutual aid groups.

HOMELESSNESS & THE COMPLEX INFLUENCE OF STREET-ORIENTED PEERS

As anyone working in the youth homelessness sector knows, street-oriented peers (friends and acquaintances of similar age and similar housing situation) play an important and complex role in the lives of youth who are homeless, street involved, or marginally housed. Research shows that on the street, peers are an important source of support. This support is shown to be primarily emotional, but street peers can also be a source of instrumental support in terms of offering protection and sharing resources and information about how to access services (Stablein, 2011). Street peers can also provide an important sense of belonging for a group that faces stigma, discrimination, and mistreatment. Although these peers can be a positive resource, peer relationships on the street can be plagued by mistrust and exploitation (Barker, 2014). Furthermore, some street-oriented peers facilitate substance use and involvement in risky subsistence strategies (Baron, 2013; Tompsett, Domoff, & Toro, 2013).

Connections with street-oriented peers can also play a complicated role in the process of transitioning away from homelessness. In a recent study of the exiting process, many young people felt they had to cut themselves off from their old street-based social networks because they worried about getting drawn back into past behaviours or having friends misbehave at their home, resulting in eviction. However, the choice to cut ties often resulted in feelings of loneliness, social isolation, and exclusion—feelings that can threaten housing and stability in their own right (Kidd et al., 2016).

These complex dynamics suggest that peer mentors and peer workers can play an important role in navigating some of the unique interpersonal and support needs of youth as they experience and transition away from homelessness. Various authors (Barman-

Adhikari & Rice, 2014; Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; David, Rowe, Staeheli, & Ponce, 2015; Stewart, Reutter, Letourneau, & Makwarimba, 2009) have described how peer workers can support young people who are homeless or street involved. Peer workers can:

- Improve access to emotional support by being a source of empathy and understanding;
- Help young people imagine a place for themselves in the mainstream by acting as a bridge between the two worlds and by modelling a future away from homelessness;
- Help rebuild trust with social service agencies and mainstream institutions;
- Be a source of knowledge and practical support around particular challenges, such as exiting homelessness or maintaining good mental health; and
- Be a positive social influence and role model.

IMPLEMENTATION CONSIDERATIONS

VALUE OF THE PEER ROLE FOR ORGANIZATIONS

Research on the work of peer workers across sectors shows that peer workers have a unique and positive impact on organizations and programming. In particular, research (Cyr, Mckee, O'Hagan, & Priest, 2016; David et al., 2015; Nesta, 2015) highlights the following contributions peer workers can make:

- Forge quick connections with clients, which program staff without lived experience might have difficulty making, particularly among hard-to-serve individuals;
- Enhance the credibility of programing among a population that can be mistrustful of service providers and programming interventions;
- Help create a non-judgemental space within agencies and programming;
- Serve as a crucial resource in designing and delivering programs based on their lived experience;
- Help clients imagine new roles for themselves and develop new goals through a positive feedback process. For example, having a good relationship with a peer mentor may inspire a client to pursue peer work, and in pursuit of that goal, the client may engage more with recovery;
- Support specific populations with unique experiences or that are particularly marginalized (e.g., LGBTQ2S, mothers, people who use substances);
- Offer a non-judgemental and safe ear;

- Promote hope and recovery;
- Provide information and insight based on their own experiences with navigating program goals or in their own progress through recovery;
- Facilitate improved interpersonal and communication skills;
- Support the creation of community within the organization or program, and reduce social isolation;
- Improve clients' self-confidence;
- Help shape organizations by informing and influencing funding decisions and the direction of services;
- Improve coping skills and quality of life, and reduce crises and hospitalization; and
- Improve clients' knowledge about services.

VALUE OF THE PEER ROLE FOR THE WORKER

Another important way to think of the peer worker role is as a means through which peer workers support themselves in their own recovery process and goals. Research with adult peer workers finds that this work can lead to improvements in self-confidence, self-esteem, confidence in employability, improvements in self-advocacy, and reduced stigmatization (Ansell & Insley, 2013; Cyr et al., 2016; Nesta, 2015). There is little comparable research with youth peer workers, but similar benefits could be anticipated.

Peer workers can also be motivated by knowledge transfer and the opportunity to gain transferable skills. Further, their involvement can help them regain trust in social service staff and the larger system; they benefit directly from employment, but also feel empowered by having a say in programming. Inclusion in decision making can help restore or boost peer workers' confidence in themselves because they feel valued and are encouraged to engage with the program even more.

This positive cycle of involvement can also encourage peer workers to further invest in their own recovery and goal attainment. In addition to being there to support others, they are continuing their own learning process.

Involvement with the programming team can also help peer workers build key employment skills:

- They learn and develop skills around workplace culture and professionalism, but in a more supportive and understanding environment.
- They learn about and practise how to establish a healthy work–life balance and to effectively self-advocate within an employment context.
- They gain confidence around personal challenges (e.g., panic attacks, learning disabilities, social phobias) that may be interfering with the pursuit of broader employment opportunities. For example, in a supportive environment, the challenge or condition becomes secondary to employment and the peer worker is more likely to build confidence.
- A supportive environment and relationships within the peer worker team and other staff help limit negative ruminations and encourage open communication of issues. The nature of the work gives peers the opportunity to step back when personal setbacks are an issue.

RECOMMENDATIONS FOR PEER WORK

PRINCIPLES OF THE PEER WORKER ROLE

Since the nature and form of peer work varies, so does the tone and philosophy supporting the work. However, there have been attempts within the mental health sector to distill core principles integral to peer work. MacNeil and Mead's (2005) research on adult peer workers in a mental health context is widely cited. Below we provide an adapted version of the seven principles they identify:

- Peer work has a critical orientation that helps clients and participants see their situation from a different perspective and rename and reframe their experience (e.g., identifying structural issues, recognizing a common experience, creating self-awareness around personal patterns and choices).
- Peer work focuses on creating a sense of community and belonging (e.g., building relationships; promoting mutual respect, acceptance, and support; being open to diversity; incorporating elements of anti-oppressive practice).

- Peer work is more flexible than other clinical, youth worker, or social worker roles and is open to being defined by peer workers and participants themselves around their interests, orientations, and needs.
- Peer work is instructive and aims to educate, examine, explore, and discuss.
- Peer work involves mutual responsibility (e.g., a flattened hierarchy between peer workers and participants; a more mutual and less top-down approach to establishing group activities and approaches; a voluntary and shared commitment to working together).
- Peer work takes a sophisticated approach to establishing and maintaining safety (e.g., time is spent developing group rules and strategies for maintaining safety and confidentiality; an effort is made to create spaces that feel safe and non-oppressive to all participants).
- Peer work involves ongoing reflection on and attention to interpersonal boundaries because it is not structured by the same formal rules and professional identities that regulate other clinical and service agency roles (e.g., clear and ongoing discussion of when and how peer workers can be contacted; rules and processes for maintaining confidentiality; actively reflecting on how much of their personal story to share; self-care as a clear component of peer work).

BEST PRACTICE RECOMMENDATIONS

In line with the principles outlined above, the research and practice literature identify best practice recommendations for realizing the full benefits and opportunities of the peer worker role (David et al., 2015; Ontario Centre of Excellence for Child and Youth Mental Health, 2016; Petosa & Smith, 2014; Salzer, 2002; Vandewalle et al., 2016). The following section outlines best practice recommendations.

Make an organizational commitment to the peer worker role. There needs to be knowledge, understanding, and appreciation of the peer role across all levels of an organization. This involves training other staff on the nature and values of the peer role and providing opportunities for the group as a whole to get to know one another. Furthermore, staff in senior positions must model respect for the peer role. This will be a particular challenge in larger organizations, where special attention needs to be given to how the peer role will be integrated and acknowledged within the organization.

Use good communication and a flattened hierarchy. Peer work benefits from good communication and a flattened hierarchy among clinical staff and peer workers. This means fully including peer workers and mentors within the organization and at the decision-making table.

Provide tangible benefits and incentives. Organizations should attach clear and tangible benefits to the peer worker role for both paid and volunteer positions. These benefits and incentives should be as concrete and specific as possible (e.g., training opportunities, transit passes, employment references, free activities; avoid vague offerings like "work experience"). The tension between volunteer and paid positions is discussed in a later section.

Provide ongoing and dedicated supervision. Peer workers need a dedicated supervisor who can provide ongoing supervision and support. This supervisor can also help peers with their own pathways and goals by supporting them and connecting them to opportunities outside of the organization.

Focus on diversity and implement a team approach. Peer workers in the field recommend more than one peer within a program to ensure opportunities for mutual support within the peer worker role. Also, research shows that when the peer worker role involves one-on-one mentorship, pairings are most effective when participants and peers are matched on shared backgrounds and interests. For these reasons (and others), organizations should aim for diversity in their peer workers; this diversity should reflect the full diversity of the clientele.

Understand and support the needs of peer workers. Given that peer workers are often still on their own path toward stability and recovery, organizations need to understand their needs and how best to support them (e.g., transportation, challenges in their own lives, accessibility, contingency plans if a peer worker needs to step back from the role). This consideration also extends to hiring practices and the barrier that policies like mandatory criminal record checks might pose for some peer workers.

Allow for leeway in how peer workers occupy the role. Being flexible means tailoring roles and responsibilities to where the peer worker is at and allowing some autonomy and flexibility in how the role gets carried out.

Consider different types of peer positions. Organizations should consider different levels of peer work to incorporate individuals with different skill and commitment levels. This also allows for upward mobility and a scaffolding of responsibilities and skills.

Offer a seat at the table. Organizations should provide ongoing opportunities for peer workers to be involved in program design and to provide meaningful input on the direction and structure of programming.

Promote autonomy and opportunities for leadership. The peer role should be structured to provide autonomy and opportunities for leadership, and to allow peers to shape how their role is carried out and defined. A peer position is meant to honour and recognize the value of lived experience; micro-management and lack of autonomy work against this value.

Promote self-care. Self-care plans are a good way to support peers in their role. These plans allow peer workers to identify their needs and develop strategies (with support of their supervisor) that help them care for their own needs and stay well.

Adequate training is a key aspect of supporting peer workers and ensuring their successful integration into an organization and its programming. This training should be structured to provide maximum benefit to youth peer workers, and the tone of delivery should value and respect the peer worker. One way to provide maximum benefit is to arrange for peer workers to access formalized and credentialed training outside the organization that will assist with future opportunities. Suggested training topics include:

- Role overview and orientation to the organization;
- Anti-oppression;
- Mental health, including the social determinants of mental health;
- Details of the specific program the peer worker is part of and program-specific training (e.g., community arts, advocacy, counselling);
- Building rapport;
- Maintaining boundaries and establishing rules for contact and use of social media;
- Privacy and confidentiality;
- Providing positive reinforcement and constructive criticism; and
- Planning for the end of the client's time in the program.

CAUTIONS & ETHICAL CONSIDERATIONS FOR PEER WORK

The peer role is complex because the relationship with the client is somewhere between friend and service provider. Much of the value and impact of peer work can be attributed to this unique position, but there are also risks that organizations need to consider. Many tensions and concerns have been raised by peer workers themselves and by those within the consumer/survivor and Mad-identified[1] communities (Paradis et al., 2012; Vandewalle et al., 2016; Voronka, 2016, 2017). These complex issues do not necessarily have straightforward answers. This section identifies some of these tensions and concerns and encourages agencies and peer workers to engage in open dialogue to address them.

CO-OPTATION & THE SILENCING OF CRITICAL VOICES

One tension at the heart of the peer role is the peer worker's ability to speak honestly and critically about the role. Some peer workers have felt silenced in their work— that they are being asked to modify their own narrative to fit with the perspective of the agency with which they are working. A related issue involves the tension around ownership. If peer workers are being asked to share their stories on behalf of an agency, who owns that story and how much control does the agency have over the telling of that story? Also, more practically, if peer workers use their experience and insight to generate educational or supporting materials, who owns those materials and who has the right to change or modify them?

There are no easy answers. The best approach to addressing these issues of voice and ownership is to have open discussions with peer workers. In thinking about the issues, it is useful to reflect on the core principles discussed at the beginning of this chapter, which emphasize the valuing of the peer worker role and the need for peer workers to have some autonomy in occupying and defining their role. These values suggest that organizations that want to leverage personal experiences to improve programming are responsible for ensuring that peers retain control over how that experience is used and shared.

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[1] Mad-identified refers to individuals aligned with the Mad Pride movement, which is a political movement of service users and survivors of the mental health system and their allies. The movement is focused on challenging the stigmatization, medicalization, and criminalization of madness.

EMOTIONAL LABOUR, TRIGGERING, & MAINTAINING BOUNDARIES

Another tension at the centre of the peer worker role is the emotional labour that comes with regularly supporting others and sharing one's personal (often traumatic) experiences. This feature of the work requires unique consideration and support. In particular, it requires opportunities for peer workers to debrief and discuss the role's challenges as they emerge. It also requires clear discussions about maintaining boundaries and self-care.

CONFLICTING LOYALTIES

Another issue that some peer workers have described arises through the inevitable association between peers and the agencies with which they work. This association can alienate peer workers from their existing social networks or can complicate these relationships because they are perceived to have become "part of the system," rather than being an independent voice in the system.

REMUNERATION

Agencies often operate on a limited budget, which makes volunteer peer work seem like a good solution for low-cost programming support. The consensus in the literature, however, is that every effort should be made to pay peer workers. This compensation should reflect the value of the role and the duties involved (i.e., equal pay for equal work). When there is no budget to pay peer workers, volunteer positions may be an option. Built into these positions should be as many benefits and perks as possible (e.g., free meals, transit passes, access to training, reference letters, mentorship, free event tickets). The position should never cost volunteers anything, particularly when they themselves are marginalized individuals.

Organizations should also consider how remuneration might affect financial support peer workers currently receive from government because this assistance may depend on income. Moreover, some peers might not have a bank account. In these situations, gift cards or honoraria may be a good option. Whatever the case, compensation should be clearly discussed and documented alongside expectations for the peer role.

A final caution: agencies should be careful that a peer worker position does not trap individuals in precarious, low-paid work. They should make every effort to hire peer workers into full-time, permanent positions. This might mean modifying hiring practices to reflect that lived experience is as valuable as educational credentials.

TOKENISM & SECOND-CLASS STATUS

A common concern that peer workers raise is being hired in a token role and having second-class status within the organization. Peer workers have reported not being allowed to use the staff washroom or not being invited to staff parties. The peer worker role must be valued across all levels of the organization. Peer workers may also experience lack of respect and challenges to their legitimacy when carrying out their duties outside of their organization. They should discuss these issues with their supervisor, and agencies should be prepared to advocate on behalf of their peer workers.

CONCLUSION

This chapter has described the value of peer work, summarized best practice recommendations for the peer worker role, and highlighted cautions related to this role. The research and practice literature show that peer workers have the potential to make significant contributions to organizations and programming, but that the uniqueness of the role requires special consideration and support.

RESOURCES

Youth helping youth: Fostering peer support as part of the youth mental health service continuum (Canadian Mental Health Association, B.C. Division, 2007)
www.cmha.bc.ca/wp-content/uploads/2016/07/YouthHelpingYouth.pdf

Youth peer support in a mental health context (Ontario Centre of Excellence for Child and Youth Mental Health, 2016)
www.excellenceforchildandyouth.ca/sites/default/files/eib_attach/Youth_Peer_Support_FINAL_June2016.pdf

Youth peer-to-peer support: A review of the literature (Report prepared for Youth MOVE National, 2013)

www.youthmovenational.org/images/downloads/YouthPeertoPeerLiteratureReviewFINAL.pdf

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3.7 THE DIGITAL LIVES OF YOUTH WHO ARE HOMELESS: IMPLICATIONS FOR INTERVENTION, POLICY, & SERVICES

Anamika Barman-Adhikari, Eric Rice, Laura Onasch-Vera, & Mary Hemler

INTRODUCTION

Each year, 1.5 million to 3 million youth in the United States experience homelessness[1] (Toro, Lesperance, & Braciszewski, 2011). They are considered to be one of the most marginalized groups in the country. Among the many challenges they face are acquiring health care, employment, and stable housing. It is becoming increasingly important to consider how to use information and communication technologies (ICT) to increase service engagement and outreach and improve health outcomes and quality of life among youth who are homeless.

ICT encompasses a range of interactive tools and platforms; these include social networking sites such as Facebook and Twitter, where people create profiles and share them with network contacts; content-sharing sites such as YouTube and Flickr, which are used to share, rate, and discuss videos and photographs (Adewuyi & Adefemi, 2016); and mobile phones and mobile phone–based applications, which have become a popular alternative to traditional websites for delivering information.

This chapter discusses recent research on ICT use among youth who are homeless. It also describes interventions in the United States that have used these technologies to engage this population, and explains how what we have learned can be translated into service and policy initiatives that reduce disparities in accessing information and other resources in this vulnerable group.

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[1] We use the definition of homelessness developed by Tsemberis, McHugo, Williams, Hanrahan, and Stefancic (2004), which acknowledges that homelessness can involve a broad range of situations. The definition includes not only people who live on the streets (defined as literal homelessness), but also people who have some stable housing (e.g., transitional housing, couch surfing with family/friends) but who still are precariously housed.

YOUTH WHO ARE HOMELESS AS DIGITAL NATIVES

According to the Pew Research Center (2014), 89% of people aged 18–29 report using social networking sites, and 67% access them on their cellphones. In fact, young adults (aged 18–25) spend more time every day with media and technology than on any other activity, earning them the designation "digital natives" (Coyne, Padilla-Walker, & Howard, 2013). Digital natives were born or raised during the age of digital technology and therefore have been familiar with these technologies from an early age (Prensky, 2001).

Since young people who are homeless are resource poor, it is often assumed they are isolated from the digital world. However, recent research shows that up to 90% have a profile on a social networking site and over 50% use social media, either several times a day (19%), once a day (16%), or every couple of days (15%) (Barman-Adhikari et al., 2016). These unstably housed young people access the Internet and social media in various places: 47% through a public library and 40% through a youth service agency (Rice & Barman-Adhikari, 2013).

Research also shows that 40%–60% of youth who are homeless own a cellphone (Harpin, Davis, Low, & Gilroy, 2016; Rice, Lee, & Taitt, 2011). Of those, 17% used their cellphone to call a case manager, 36% to call a potential or current employer, 51% to connect with home-based peers, and 41% to connect with parents. Given this relatively high rate of phone ownership, mobile health applications might be a way to reach and engage this otherwise hard-to-reach population.

UNDERSTANDING YOUTH WHO ARE HOMELESS THROUGH THEIR DIGITAL FOOTPRINT

Youth who are homeless may be similar to housed youth when it comes to using ICT, but access to these technologies may be even more important for youth who are homeless because it can be a significant resource for a population that traditionally lacks resources (Jones & Fox, 2009). For example, research has found that youth who are homeless use the Internet for instrumental purposes—28% to locate housing and 13% to look for jobs (Rice & Barman-Adhikari, 2013). These youth also report relying on the Internet and social networking sites for informational purposes: one study found that 47% sought information about HIV or other sexually transmitted infections online, 40% sought information about sex or sexuality online, and 23% went online to find HIV testing services (Barman-Adhikari & Rice, 2011).

Youth who are homeless also use ICT for socializing and communicating. More importantly, they use them to facilitate inclusion in social worlds beyond their street environments (Barman-Adhikari & Rice, 2011; Rice, 2010; Rice & Barman-Adhikari, 2013; Roberson & Nardi, 2010). Studies have found that these youth use social media and cellphones to connect with family, friends from home, and caseworkers, allowing them to maintain ties not connected with street life (Barman-Adhikari et al., 2016; Rice & Barman-Adhikari, 2013).

Youth who are homeless report using social media to discuss a wide range of issues. In their survey of 1,046 youth experiencing homelessness, Barman-Adhikari et al. (2016) found that youth used social media to talk about school or work (26%), family issues (24%), being homeless (24%), safe sex (7%), and goals (5%). It is clear that youth are leveraging the interactive aspects of ICT to discuss sensitive issues and find support in dealing with them, which is important for a population that often has difficulty accessing services or does not trust formal service providers (Hudson et al., 2010; Lindsey, Kurtz, Jarvis, Williams, & Nackerud, 2000). Studies have also found that youth who are homeless who connect with home-based, positive role-modelling peers, family, and case managers through the Internet and social media are more likely to use condoms (Rice, 2010), less likely to use drugs and alcohol (Rice, Milburn, & Monro, 2011), and less likely to experience depression (Rice, Ray, & Kurzban, 2012).

Although using technology has benefits for youth who are homeless, it can also expose them to risky situations. The Internet and social media have made it easier for youth to look for and meet sex partners. For example, Rice, Monro, Barman-Adhikari, and Young (2010) found that about 25% of youth they surveyed reported looking for a sex partner online, a rate similar to that reported by college-going housed youth and young adults (McFarlane, Bull, & Rietmeijer, 2000). What is different, however, is that youth who are homeless who reported meeting a sex partner online were 18 times more likely to engage in exchange sex or survival sex (i.e., trading sex for money, a place to stay, or other material things) (Rice et al., 2010). Across studies, 11%–41% of youth who experience homelessness report engaging in survival sex (Walls & Bell, 2011). Youth who engage in these practices report higher rates of HIV and sexually transmitted infections (McFarlane et al., 2000).

The open forum that social media creates for positive engagement around various topics can also promote engagement in risky behaviours. For example, Barman-Adhikari et al. (2016) found that almost one-third of youth reported talking about drugs on social media and those who talked about drugs were more likely to engage in sex with multiple partners. Therefore, social networking sites may present an important data source for understanding the social context of youth health behaviours, including attitudes and social norms regarding substance use and sexual risk behaviours.

INTERVENTIONS & SERVICES THAT USE INFORMATION & COMMUNICATION TECHNOLOGIES

Youth who are homeless are transient and often difficult to engage in place-based services, making interventions that use social media or other communications technology an innovative and accessible approach to engaging this hard-to-reach population. We know of only three empirically evaluated interventions or methods in the United States (Bender et al., 2015; Rice, Tulbert, Cederbaum, Adhikari, & Milburn, 2012; Sheoran et al., 2016). The following sections summarize the key findings of these studies. We focus on how communication technology was used with this hard-to-reach population, what lessons were learned, and how ICT can be adapted for social service settings.

AN ONLINE SOCIAL NETWORK–BASED HIV PREVENTION PROGRAM

Rice, Tulbert, et al. (2012) developed a youth-led, hybrid face-to-face and online social networking HIV prevention program for youth who are homeless called Have You Heard? The program used Facebook and Myspace. The researchers trained seven peer leaders to engage face to face with 53 youth who were homeless (F2F) in creating digital videos and comic book illustrations (via content-creation and sharing websites such as YouTube) that promoted safe sex or HIV testing. These seven peer leaders and 53 F2Fs then recruited 103 online youth without any face-to-face contact. These youth were part of either the Facebook or Myspace groups. Peer leaders participated in one week of leadership training, one week of website development training, and nine weeks of training in peer engagement and disseminating prevention messages. The peer leaders were trained in the following topics:

- Assertive communication skills;
- HIV prevention;
- crafting persuasive messages;
- Outreach techniques;
- Delivering engaging messages online;
- Brainstorming about online media to engage peers in discussions about HIV prevention and testing; and
- Creating an online presence and potential ramifications of that web presence and online activities (e.g., for employment).

Since this was a feasibility study, it did not report on actual outcomes (i.e., how many youth actually changed their engagement in risk behaviours as a result of participation in the intervention). Instead, the study provided guidance on issues of recruitment, assessment, and participation. It found that recruitment via online social networks is faster and much more efficient than traditional face-to-face methods. Participant retention was also very successful. Youth overall felt they were able to keep their presence in the program and feel connected because they could access the intervention at their own convenience and complete the intervention at their own pace. However, the authors note one caveat: although the intervention demonstrated the capacity of online social network technology to recruit and retain youth in the intervention, it did not succeed in getting youth to complete the post-intervention assessment. Of the online youth, 98% failed to complete the final assessment, and of the F2F youth, 51% failed to do so. The authors suggest that it might be important to compensate youth in order to get more complete data.

SOCIAL SERVICE APPS

In the past few years, several communities have designed smartphone apps specifically for youth who are homeless. One example is YTH StreetConnect, the only app to have been featured in the academic literature (Sheoran et al., 2016). This app connects youth who are homeless with social service and health providers and other critical resources in Santa Clara County, California. The app has one interface for youth and another, StreetConnect PRO, for service providers. The apps works via Android and IOS operating systems, as well as Wi-Fi.

The app developers (Sheoran et al., 2016) initially conducted a literature review to understand patterns of Internet and cellphone use among youth who are homeless. They then conducted interviews with service providers who worked with this population about how the app should be designed and what information it should provide. Once the prototype was developed, the researchers conducted usability testing via the live app. Two key considerations were addressed during this testing: the user experience and feasibility. Several focus groups were held to get more in-depth feedback from youth about their experience using the app.

Significant changes were made to the app based on the youth and provider feedback. The final youth version of the app (see Figure 3.7-1) has an easy-to-use interface that allows youth to search for services by zip code, current location, and all resources, or by type of service. It also provides information on the eligibility requirements of the agency, and youth can leave their own reviews and ratings of the agency. Youth said the app was intuitive and fun, and allowed them to easily connect with services by being able to call and locate them with the map provided. Youth also reported that the functionality of the app made it seem like "Google and Yelp combined." They enjoyed the accessibility it provided, as well as being able to decide which service agency to visit based on other user ratings.

FIGURE 3.7-1: STREETCONNECT APP FOR YOUTH WHO ARE HOMELESS

From "YTH StreetConnect: Development and usability of a mobile app for homeless and unstably housed youth," by B. Sheoran, C. L. Silva, J. E. Lykens, L. Gamedze, S. Williams, J. V. Ford, & M. A. Habel, 2016, JMIR mHealth and uHealth, 4(3), e82. Reproduced with permission.

StreetConnect (youth version) has the following features:

- Location-based database of services;
- Interactive mapping;
- User-submitted ratings and comments;
- Emergency hotlines;
- Access to sexual health information;
- Weekly text message health tips; and
- Accessibility via Wi-Fi.

StreetConnect PRO, the tablet app for healthcare providers, has the following features:

- Location-based database of services;
- Interactive mapping;
- Referral function;
- Emergency hotlines;
- Access to best practices;
- Medical questionnaire for clients (assesses homelessness vulnerability and sexual risk);
- Accessibility via Wi-Fi.

Although they have not been empirically reviewed, two other excellent examples of social service apps are Los Angeles' WIN app (www.ourchildrenla.org/win-app/) and Pittsburgh's Big Burgh app (www.bigburgh.com).

ELECTRONIC CASE MANAGEMENT

Bender et al. (2015) assessed the feasibility and acceptability of electronic case management (ECM) with youth who are homeless, using cellphones, texts, email, and Facebook. For this study, 48 youth aged 18–21 were recruited from a shelter in Denver, Colorado, and assigned to electronic case management services. Youth in the ECM group received pre-paid cellphones with unlimited talk and text for three months, and their email and Facebook information was collected.

Youth were offered four ECM sessions, which were provided every two to three weeks over a three-month period. A graduate student was trained to be the electronic case manager. Sessions focused on four aspects: check-in, assessment, goal identification, and problem solving. The study used a multi-modal way of using technology to contact

participants. Youth were contacted by case managers and could contact them in a variety of ways, but contact always followed a particular sequence. Case managers first contacted youth by calling their cellphones. If youth did not respond to this initial contact, they were then contacted by both a call and a text message. If there was no response to this second contact, the case managers would call, text and email or contact participants via Facebook. The study found that almost 90% of youth participated in at least one ECM session. Youth also preferred cellphones (especially texting) over email and Facebook for responding to their case manager. Moreover, 70% reported that they preferred texting over any other method because it enabled them to communicate even when school and work obligations prevented them from speaking to the case manager (Bender et al., 2015). The study revealed that ECM was highly acceptable to this group of youth: 80% indicated that connecting with their case manager electronically was a positive experience and that it was convenient and accessible.

IMPLEMENTATION CONSIDERATIONS

Our review of the literature revealed that ICT use among youth who are homeless is pervasive and has both positive and negative consequences. We found that existing technology-based interventions for these youth have taken three approaches to date: using existing platforms such as Facebook or Myspace to disseminate interventions; developing standalone apps that connect youth to services; and using email, online social networks, or texting (via cellphones) to provide case management services for youth. All of the reviewed interventions were part of feasibility studies, which do not provide robust evidence that these interventions have actually been able to change behaviours. However, the studies do provide preliminary evidence that youth who are homeless are active users of these digital technologies, that youth find it easy to connect via these new technologies, and that these technologies can expand reach, foster engagement, and increase access to services for this otherwise hard-to-reach population.

Organizations and service providers thinking about adopting ICT-based tools and interventions should consider the issues discussed in the following sections.

RECOGNIZING THE COST, TIME, EXPERTISE, & EFFORT NEEDED

A range of tools, such as social media and mobile apps, can be used as part of an ICT-based platform to engage youth. It is important for organizations and service providers to assess the amount of time, effort, and expertise needed to design and implement ICT-based programs. It is generally recommended that organizations with no experience using ICT-based techniques for engagement or service provision start with low-resource tools and then progress to tools that require more resources and support (Centers for Disease Control and Prevention, 2011). For example, existing online social networks such as Facebook require no technological expertise beyond knowing how to set up an organizational page and organize content. Moreover, commercial social network platforms are free and can reach many participants simultaneously without any geographic barriers, making them cost-effective and potentially increasing scalability in the future. However, a standalone mobile app such as YTP StreetConnect that is designed to deliver unique and tailored content requires significant technological and domain-related expertise, costs thousands of dollars, and needs to be maintained and updated on a regular basis. Additionally, it is easier to create content for existing online social network platforms. For example, downloading videos and podcasts from partner websites and posting them on the organization's online social network platform is straightforward. On the other hand, an app like YTP StreetConnect, which has a database of organizations, will need frequent updates because of the fluid nature of service systems.

Regardless of the preferred platform, developing and implementing the ICT-based intervention requires some amount of time, effort, and money. For example, the Have You Heard? campaign had to train and compensate peer leaders to deliver the intervention and recruit participants. In their electronic case management initiative, Bender et al. (2015) trained and retained a graduate student to conduct the ICT-based outreach, and gave participants prepaid cellphones. Organizations that operate on skeletal budgets may not be able to afford these costs.

ADDRESSING LIABILITY ISSUES

Many service providers have told us they are concerned about liability and confidentiality issues around using ICT-based interventions. Some tell us they would not know how to handle disclosure of suicidal or homicidal ideation on online social network platforms or even via phone calls or text messages. We recommend that if someone expresses

suicidal or homicidal ideation online, the service provider should first contact that person through the online site or another form of contact. As a first step, service providers who think there is a risk should give the person information about crisis hotlines and local sources of support. They should advise those in imminent or severe crisis to go to their nearest emergency room for a psychiatric evaluation. If the person provides consent, service providers themselves can request a welfare check for these youth (if their contact information is available). Information about crisis hotlines and local supports can also be posted online or through a mobile app so youth can access it even if service providers cannot reach them.

UNDERSTANDING YOUTH PREFERENCES

We cannot stress enough how important it is to gauge youth preferences when deciding what platform to use and what the content of the messages should look like. The research (Barman-Adhikari et al., 2016) discussed earlier found Facebook to be the most popular online social network platform among youth who are homeless, but it might eventually lose popularity because technology changes very fast. For example, when Have You Heard? was developed (Rice et al., 2012), Myspace was very popular with youth, but it has since fallen out of use. The constantly evolving technological environment means that organizations must keep up with youth preferences. Additionally, ICT-based interventions can be delivered through multiple message modalities (i.e., using audio, video, images, badges, GIFs, and maps) and tailored and interactive in nature. The use of these different message modalities is appealing to youth because it aligns well with broader youth culture and is critical to getting and sustaining their attention. Understanding which formats are most engaging for this population is important in designing an effective ICT-based intervention.

DEFINING PRECISE GOALS & OBJECTIVES

Another important decision for agencies to make early on is what the objective of the campaign is. Very often, different objectives require different communication channels (Centers for Disease Control and Prevention, 2011). For example, Bender et al. (2015) found that youth preferred cellphones as a mode of contact around case management, but that texting and online social networks were more effective when the objective of the agency was to reach a wider audience to disseminate information.

Gonzales, Douglas Anglin, & Glik (2014) explored youth opinions about using text messages to support substance use recovery after initial treatment. The study found that 70% of youth endorsed texting as a feasible medium for maintaining recovery. In terms of the types of messages they preferred to help them prevent relapse, most youth were looking for emotional support; this included positive appraisal (90%), lifestyle change tips (85%), motivational reinforcement (80%), and coping advice (75%). Youth also sought instrumental support, with 50% wanting access to information resources and appointment reminders. Youth also gave feedback about logistical features of text messaging. Most preferred to receive one message a day, sent during the day (preferably afternoons). They indicated that the relevance they attach to the message depends on who sent it: peer leaders were considered to be most credible and influential in increasing the salience of the message.

ENGAGING NATURALLY OCCURRING NETWORKS

Our review of the literature reveals an important finding about the role of ICT in the lives of youth who are homeless: these young people often use ICT to connect to people outside of their street environment. Yet none of the interventions we reviewed has used ICT tools such as social media or Facebook to connect youth to sources of support outside of their street networks. This potential function of ICT needs some attention. Agencies serving youth who are homeless could begin to explore this possibility. For example, caseworkers could ask youth to create ecomaps (diagrams that visualize the social relationships of people) of non-street relationships they consider supportive, and then brainstorm with them how they could remain in touch with these supports, focusing on how youth could use ICT to maintain contact. For this sort of approach to be effective, however, broader structural policy–related changes might need to occur. Internet and cellphones would need to be more widely accessible to these youth. This is more important for youth who live on the streets and have to rely on public places such as libraries and youth-service agencies for Internet access. More government resources to agencies that serve youth who are homeless would increase access among this population to the Internet and cellphones.

BUILDING DIGITAL LITERACY & SAFETY PROGRAMS

Our literature review suggests that youth who are homeless are increasingly using ICT tools for instrumental purposes, such as finding jobs, or health information. Agencies can support youth in these efforts by providing resources for developing computer and digital literacy skills. Caseworkers could help youth locate job opportunities, create resumes, and develop job etiquette skills, such as crafting an email inquiring about a job opportunity.

One area of concern that our review reveals involves digital safety for these youth. Research suggests that youth are increasingly using social media to meet sex partners or to exchange sex. Therefore, it is a good idea for service providers to educate youth who are homeless about the risks of meeting sex partners on the Internet and about navigating risky topics online.

CONCLUSION

ICT will not solve the problems of youth homelessness, but thoughtful engagement with youth through ICT can help these young people live healthier, more productive, and stable lives. These digital natives are already using ICT to access information, jobs, and social services. Service providers can build upon these ongoing activities. Social media platforms such as Facebook and Twitter could be useful tools for agencies doing outreach or conducting intervention programs with youth who are homeless. New smartphone apps may be a critical part of a successful engagement strategy for many communities, although such strategies require a greater commitment to creating and maintaining the technologies. Finally, ICT, especially smartphones, can be used to enhance traditional social work case management.

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3.8

PARTNERSHIPS THAT SUPPORT MENTAL HEALTH INTERVENTION FOR STREET-INVOLVED YOUTH

David O'Brien[1]

INTRODUCTION

After decades of fragmentation within the community-based child and youth mental health sector, there is an emerging trend and understanding of how cross-sectoral partnerships and integration between organizations can improve mental health outcomes for children, youth, and young adults. This chapter describes the benefits of these partnerships and key considerations in developing them. It also presents a case study of a successful partnership that is helping to address mental health issues among youth in the shelter system.

CONTEXT

In 2011, the Ontario government developed the "Moving on Mental Health" strategy to improve access to high-quality mental health and addiction services. One of the deliverables was clear pathways between child and youth mental health organizations and out-of-sector stakeholders such as health care, youth justice, child welfare, education, and the youth shelter system. As of 2017, there are now 33 child and youth organizations across Ontario responsible for service alignment, integration with out-of-sector stakeholders, and service mapping across assigned regions. The objective will be to have a more responsive system where children and youth receive the right services, at the right time, at the right place.

Several factors are driving this "working together approach," which is a shift from the usual situation where organizations work in silos. First, service users in the child and youth mental health system have become frustrated with poor communication between service providers, the absence of pathways between them, and the lack of infrastructure connecting community-based child and youth mental health with health care, youth justice, and the youth shelter system. The result of this fragmented system is that children, youth, young adults, and their families are often reassessed over and over without getting

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[1] Thank you to Stephen Gaetz for his contribution in developing this chapter.

any actual treatment and most get lost in the transition when multiple supports through several sectors might be required. Many children and youth, along with their families, lose hope and become frustrated with the system; in extreme circumstances, their mental health deteriorates, resulting in a complete breakdown of their natural supports, which often leads to homelessness.

This gap between sectors is also perpetuated by funding formulas that stop child and youth mental health services when the person reaches age 18. Youth living in shelters are usually aged 16–24. The adult mental health system has very few community-based options in Ontario. This situation raises questions about which sector is responsible for treating youth who live in the shelter system and what community-based supports they receive after they leave the shelter system. While we struggle to provide answers, youth and young adults who are the most vulnerable, who have the highest rates of mental health impairment, are not receiving the supports they require. In Canada, homeless youth are 2.5 to five times more likely to struggle with a mental health issue (Atzema, C. et al., 2012). These youth face many barriers to treatment, including long wait times for service, lack of a formal diagnosis, and unstable housing.

We are seeing some movement toward addressing these issues through the Moving on Mental Health strategy in Ontario and developments across the country that are focusing on integrated care, cross-sectoral models. In British Columbia, Foundry is a province-wide network of integrated health and social service centres for young people aged 12–24. Foundry centres provide a one-stop-shop for young people to access mental health care, substance use services, primary care, social services, and youth and family peer support. Similar integrated service approaches have opened in Chatham-Kent, Ontario, and in Edmonton through a youth hub initiative called ACCESS Open Minds. In Toronto, 'what's up' Walk In and YouthCan Impact use an integrated care approach. Each hub involves cross-sectoral partners integrated with one another in a co-location and offers barrier-free service. These emerging models across the country have the potential to engage youth who are homeless or at risk of being homeless because potential service users can simply drop in. No appointment or identification is necessary and each hub has a simple registration process.

PARTNERSHIP CASE STUDY

In February 2015, East Metro Youth Services (EMYS), a community-based child and youth mental health centre, and Eva's Initiatives, a youth shelter, developed and implemented a partnership that would allow a child and youth mental health therapist to work onsite at Eva's twice per month. The idea was to allow youth living in the shelter to access onsite therapy rather than be referred to a location outside of the shelter. In previous years, youth who were referred to community-based mental health treatment would not make the connection or would not show up to appointments. Through the partnership, however, over 60 youth had onsite counselling from the EMYS therapist within a 24-month period. Having a therapist on location provides quick access, helps build trust, and creates an opportunity to make a warm transition to other community resources. Furthermore, partnering with a therapist from an outside organization gives youth the opportunity to separate their clinical treatment from their living environment and supports a wraparound service approach if youth feel comfortable with this. The EMYS therapist and Eva's case managers co-developed several coordinated treatment plans that addressed mental health needs, employment and school connections, and housing options through a wraparound approach. Perhaps the greatest strength of having a community-based organization send a therapist to Eva's was that the relationship built with the youth could be fostered within their living environment and then continue in the community over the longer term once the youth had transitioned out of Eva's.

The partnership with EMYS offers the chance to fill a much-needed gap within Eva's and the youth shelter system; that is, access to mental health therapy for the most vulnerable young adults. Given budget constraints within the youth shelter system and the barriers that youth who are homeless face in accessing community-based mental health services, both Eva's and EMYS felt it was essential to work together and share resources in the best interest of these youth. Not only has the partnership supported youth who are homeless; it has also provided a knowledge exchange opportunity between the organizations on topics such as mental health awareness for Eva's and building stronger capacity at EMYS to serve youth who require harm reduction supports.

The partnership between EMYS and Eva's is built on a collective impact approach. Collective impact is a partnership framework that is used to address complex social problems. Through innovation and a highly structured approach, the objective is to develop, implement, and sustain partnerships across various sectors to accomplish sustained social

change. The assumption of a collective impact approach is that no one organization or policy alone can resolve a complex social issue; rather, it is through partnership in which all parties have the same goal that goals can be achieved (Kania & Kramer, 2011). In the case in the relationship between Eva's and EMYS, providing rapid and barrier-free access to mental health services is the primary objective.

The partnership between EMYS and Eva's is an individual and localized project, but the objective over time is to link with other similar initiatives. Such partnerships would develop a greater presence and awareness of need and create potential solutions to improving access to community-based mental health services for youth living in shelters.

BENEFITS OF PARTNERSHIP

Partnerships have numerous intrinsic and extrinsic benefits for organizations. These benefits include:

- Sharing resources (space, staffing, expertise, funding);
- Sharing knowledge and developing new ways of working within partnership agreements;
- Developing and delivering comprehensive programming that is holistic in nature;
- Increasing organizational capacity to provide additional services to the community;
- Enhancing community input into programmatic decision making;
- Positioning organizations for new sources of funding;
- Preventing duplication in services; and
- Creating an opportunity to provide aligned, standardized, evidence-based, and evidence-informed services at local, regional, or national levels.

CHARACTERISTICS OF SUCCESSFUL PARTNERSHIPS

ORGANIZATIONAL READINESS

Over the last five years, partnerships between non-profit organizations have become a significant trend. Before jumping into a partnership, each organization should consider the following issues:

- Vision and purpose: does your organization have a clear understanding of why a partnership is required? What do the organization, community, and staff get out of the partnership? What can the organization contribute to the partnership? Is there a clear role?
- Commitment: is there a strong commitment at all levels of the organization? Are all levels within the organization willing to contribute to the partnership's success?
- Time: does your organization have the time for commitment? Partnerships can take several months and even years to develop.
- Capacity: does the organization have the capacity over the long term to sustain the partnership? How will positions be shifted to accommodate a new work assignment?
- Compromise: what will you give up? What is the organization willing to compromise on? What are the risks of compromising?
- Organizational culture: is the organization able to support and welcome new people, ideas, and innovations? Does your organization operate from a collective perspective? Do the organizational mission, values, and strategic objectives support a partnership culture? If so, does understanding of the organization's mission, values, and strategic objectives that support partnership development transfer to all levels?

FIGURE 3.8-1: PARTNERSHIP DEVELOPMENT

Assess   Commit   Partnership

Explore   Initiate
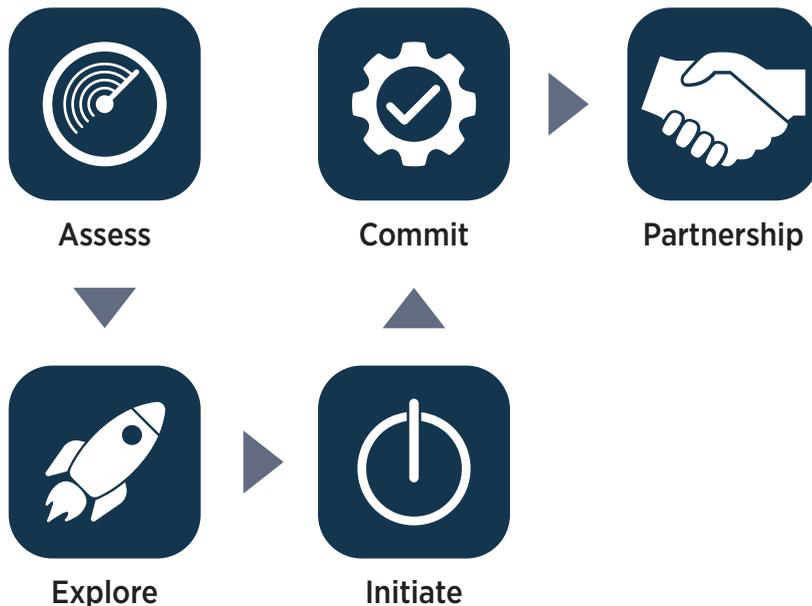
RELATIONSHIPS

The key ingredient for any successful union is the quality of relationship between the leaders within the partnership. Even with all we have learned about partnerships through the theoretical research, if there isn't a strong relationship between the parties involved along with drive toward a common goal, the partnership can stagnate, fragment, or collapse altogether.

Building trust between individuals and organizations is the primary characteristic in laying the foundation for a healthy and productive relationship. Like any type of relationship, trust is built on authenticity, mutual respect, and vulnerability. Building trust can start by structuring in social activities such as going to lunch, planning community events, attending retreats, and participating in brainstorming opportunities. By engaging in less formal activities, people can get to know one another outside of the project. Trust is also built through small-step projects that lead to larger-scale initiatives. Small-step successes can measure commitment level within the organizations and follow-through of objectives. They test the waters around how the relationship handles stress, disappointments, sudden changes of plans, and barriers that all projects face.

COMMON GOALS & OBJECTIVES

Every partnership needs a clear direction. This means that participating organizations must agree on common goals. Goals need to be understood, accepted, and equally valued by each partner.

In the case of EMYS and Eva's, the overarching goal is to create access to mental health counselling services. Both EMYS and Eva's understood that having onsite access to counselling was the best way for youth living in the shelter to connect with this service. Previous attempts to send youth from Eva's to any of the six 'what's up' Walk In locations failed due to barriers that youth living in the shelter faced. The secondary objective of the partnership is to have the EMYS therapist continue to follow the youth once they have secured housing in the community. This warm transition was equally critical, although both organizations continue to face resource issues around maintaining support once youth leave the shelter. As a longer-term goal, both organizations have committed to developing a strategy and plan to seek funding sources for aftercare expansion of the project.

COMMUNICATION

Once a clear direction is established, a communication infrastructure should be established. Successful communication requires the following components:

- Point people chosen from each organization who will develop a leadership team. They should have decision-making authority and hold a senior management position within their respectful organizations;
- Weekly partnership development and implementation meetings involving all parties in the partnership;
- Monthly meetings with all parties involved to review goals and troubleshoot issues that might develop once the partnership project has been implemented;
- Sharing and accessing youth information and knowledge on an ongoing basis between the organizations. This involves regular check-in by phone or through emails;
- Clear decision-making processes that are in place before the project is implemented; and
- Documentation of meetings and the decision-making process to create a spirit of transparency and accountability.

SUSTAINABILITY & MANAGEMENT

Most partnerships are developed and implemented, but very few are sustained throughout the project life cycle. Often organizations become overwhelmed, work beyond their means, and do not have effective evaluation methods for revealing how the partnership is impacting the intended goals. Ongoing evaluation of impact provides an understanding of successes, which motivates the partners to continue, identify gaps, and review at what stage of the project the life cycle sits.

Partnerships and their projects need ongoing management. There is a myth within the non-profit sector that once a partnership project is developed and implemented, it will sustain itself. For partnerships to endure the project life cycle, they need to be managed. Communication infrastructure, strong leadership, outcome evaluation, trust, and transparency are as important in week 1 of a partnership as in year 3. Nuances from the original agreements may change to reflect a current state, but the overarching structures and principles should remain intact and need to be managed.

AGREEMENTS

Each partnership agreement should have six clauses that cover the following areas:

- Decision making: how are decisions made? Who makes decisions? What is the protocol if decisions can't be made? Is there a hierarchy in terms of decision making?
- Capital contribution (including in-kind): this includes staff time, managers' and directors' time, space, rent, administrative costs.
- Indemnification: often partners in the non-profit sector will agree not to compensate each other for damages, losses, or expenses; not to guard or secure against anticipated loss; and not to give security against future damage or liability.
- Liability: each organization will be responsible for its own liability insurance.
- Conflict resolution: the agreement outlines the steps that will be taken between the partners to resolve conflict.
- Dissolution: the agreement outlines the steps a partner will take to withdraw from the agreement. A partner is usually required to give 60 days' notice to withdraw.

CONCLUSION

The complexity of challenges that street-involved youth face requires an interdisciplinary and inter-organizational approach that is barrier free and prioritizes access. No one organization alone has the resources to provide the services these young people need. A multi-organizational integrated care model creates a platform from which street-involved youth can reach their full potential. Formal collaboration that is standardized between organizations brings together expertise and creates seamless access for youth to receive services at the right place, at the right time, and at the right level of need.

RESOURCES

Collective impact (Stanford Social Innovation Review, 2011)

https://ssir.org/articles/entry/collective_impact

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3.9 RESILIENCE-BASED MENTAL HEALTH INTERVENTION FOR STREET CHILDREN IN DEVELOPING COUNTRIES

Hasan Reza

INTRODUCTION

"Street children" are an underprivileged group that is visible in public places of urban areas in developing countries. These children engage in informal economic activities to make a living for themselves and their families. They are found in every corner of the globe, but are more visible in developing countries in Africa, South Asia, and parts of Latin America (Thomas de Benítez, 2011). There is debate about the size of this population, with estimates ranging anywhere between several million and 100 million. Part of the difficulty in determining the exact number is the lack of a universally accepted definition of street children[1] (Thomas de Benítez, 2011).

These challenges aside, the question remains: Why do these children leave their homes for the complex hardships of street life? Research from developing countries tends to view children's movement to the street through two lenses: poverty and family dysfunction. Chronic poverty often creates unbearable conditions at home for young children and exerts pressure on family members to find economic means for survival (Ballet, Bhukuth, & Radja, 2013). In this situation, children migrate to the streets voluntarily or involuntarily to support their families. From the family dysfunction perspective, family environments that feature conflict, violence, abandonment, and authoritarian behaviour weaken or disintegrate ties among family members, prompting the child's eventual departure from the home (Ballet et al., 2013). Moreover, population growth, urbanization, war, and HIV epidemics affect the stability of economic and social institutions in developing countries; when these institutions are unstable, families and individuals migrate to urban centres that are themselves economically depressed and thus offer limited opportunities. Some families disintegrate under these conditions and children are forced to take to the streets for survival (Kombarakaran, 2004).

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[1] UNICEF and other organizations identify two types of street children: Children on the street are those who use the street for economic activities and return to their family home. Children of the street, on the other hand, are homeless and live and sleep on the streets. This pair of definitions excludes many of the children who do not fit either category. There are children who use the streets as a transitional habitat that allows them to move between a state of independent living on the street and their family home. These children are both "of" and "on" the street. Since we haven't agreed how we define this population, it is difficult to determine how many street children there are globally.

While the reasons for street migration vary, one thing is clear: these children struggle against insurmountable odds. Literature from developing countries paints a grim picture of the fight to survive and of victimhood and lost childhood (Aptekar & Stoecklin, 2014). The most common experience among these children is systematic exclusion. They are excluded from basic rights to food, shelter, school, health care, and sanitation, and are denied the social and physical protection that most people enjoy. In addition, structural barriers block them from social and political participation and the pathways to becoming productive citizens (United Nations Children's Fund, 2006).

Given this chronic deprivation and multiple stressors, street children are at particularly high risk of physical and mental health problems in countries where the health needs of the general child population already receive little attention. The World Health Organization (2017) has estimated that 20% of children and adolescents worldwide experience mental health problems. Many factors contribute to poor child mental health in developing countries. For example, in 2015, about 174 million children in Africa and Asia were at risk of stunting due to malnutrition, which hinders cognitive and social-emotional development and educational performance, and increases the risk of mental illness and chronic physical disease (Lu, Black, & Richter, 2016).

Limited research exists on child and adolescent mental health in developing countries (Patel, Fisher, Nikapota, & Malhotra, 2008).The absence of any large-scale global studies makes it difficult to determine the worldwide prevalence of mental health problems among street children. What studies are available are country specific and based mostly on non-standardized protocols and convenience samples, using diagnostic tools that have not been validated (Cumber & Tsoka-Gwegweni, 2016). Despite the scarcity of research, there is consensus among researchers and practitioners that street children experience much higher rates of mental health disorders compared with children in the general population.

This chapter reviews research on the mental health of street children in developing countries. It proposes a model of mental health intervention that fits with programming being delivered by agencies that serve developing countries, and describes organizational and programmatic considerations in implementing this model.

MENTAL HEALTH & SUBSTANCE USE AMONG STREET CHILDREN IN DEVELOPING COUNTRIES

Studies from developing countries reveal a high incidence of mental health problems among street children. These issues include anxiety, depression, low self-esteem, posttraumatic stress disorder (PTSD), and suicidal ideation. A study in Ghana found that 87% of street children exhibited moderate to severe psychological symptoms such as self-stigma, violent behaviour, and suicidal ideation (Asante, Myer-Weitz, & Petersen, 2015). Similarly, in a Brazilian study, 89% of street children were diagnosed with a psychiatric disorder, and 40% with a substance abuse disorder (Scivoletto, da Silva, & Rosenheck, 2011).

HOPELESSNESS, SELF-HARM, & SUICIDE

A sense of hopelessness is common among children who are homeless. Woan, Lin, and Auerswald (2012) found high levels of hopelessness, social alienation, and depression among street children in Asia and Latin America. Hopelessness stems from an insecure life, abuse, and cultural and social exclusion, which many of these children face every day. Those who have lived on the streets for a long time and have few ties with family members and other street children are more likely to experience hopelessness and low self-esteem. Being physically abused or learning that their peers experience such abuse also contributes to a sense of hopelessness. A Turkish study found that abuse in a police station significantly increased the sense of hopelessness (Duyan, 2005).

Studies have found a link between hopelessness and suicidal ideation and self-harm. For example, a study of 150 street youth in India aged 10–16 found that 13% had seriously contemplated suicide and 3% had attempted it at least once since they began living on the street (Khurana, Sharma, Jena, Saha, & Ingle, 2004). There is also evidence that poor psychological functioning (e.g., emotional problems, peer relationships problems) is directly linked to suicidal ideation (Asante et. al., 2015). Suicidal ideation is more common among females than males, perhaps because girls' street life is more stigmatized and involves more sexual violence than that of boys (Cumber & Tsoka-Gwegweni, 2016). A study in Pakistan found that about 40% of street youth inflicted self-injury by cutting themselves, with a median of 10 times. This self-injury was most prevalent among current drug users (Sherman, Plitt, ul Hassan, Cheng, & Zafar, 2005).

TRAUMA & ABUSE

Street children experience high rates of trauma and abuse prior to their street migration. In fact, abuse in the family is a critical catalyst for children's movement to the street (Conticini, 2005; Reza, 2016). Once they are on the street, children encounter multiple forms of abuse, including physical, emotional, and sexual. This abuse comes mostly from people in their social surroundings (e.g., employers, service clientele, police, older youth). A randomized study in Egypt found that 93% of street youth had experienced some form of violence or abuse. Physical abuse was reported by 45% and sexual abuse by 12% (Nada & Suliman el., 2010). Similarly high rates of physical and emotional abuse have been reported among street children in India (Mathur, Rathore, & Mathur, 2009). The pattern of abuse tends to be gendered, with girls more likely to experience sexual abuse and boys more likely to experience physical abuse. Studies in Africa and Latin America have consistently found that sexual violence among street children is more common among girls than boys (Lalor, 2000). In a Nigerian study of girls engaged in street vending, 70% had been sexually abused, with 17% having had penetrative sexual intercourse (Lalor, 2000). This gender difference, however, does not mean that males do not experience sexual abuse. A study in Ethiopia reported that 29% of male street children were victims of some form of sexual abuse (Tadele, 2009). Children in this study also ranked sexual abuse as the most frightening threat of street life. Having a physical disability also increases the risk of abuse. A study from Bangladesh found that in addition to experiencing physical, emotional, and sexual abuses, street children with disabilities are exploited for economic reasons. Some are sent by their families to beg on the streets, and others are rented or even sold to organized rings that force them to beg on the streets and in public places (Sayem, 2011).

Violent victimization in childhood and adolescence has far-reaching implications for short- and long-term psychological functioning and overall social development. In the short term, victims of physical and sexual abuse have an increased prevalence of post-victimization stress, hopelessness, and anxiety. Victims of non-familial violence tend to have a higher risk of PTSD and are more likely to report feelings of sadness (Boney-McCoy & Finkelhor, 1995; Macmillan, 2001). In the long term, victims of sexual abuse are much more likely to suffer from depression, drug dependence, or phobic disorders. Physical abuse in childhood dramatically increases the risk of later experiencing a depressive episode or PTSD (Macmillan, 2001). Given the high prevalence of histories of physical and sexual abuse among youth living on the street, these youth are at higher risk of developing depression, PTSD, and drug dependence. Nanda and Mondal (2012) found

that sexually abused street children in India had higher rates of anxiety and depression than street children who had not been abused. A study in Iran found that more than half of street children, of whom a large portion was sexually abused, met criteria for depression (Ahmadkhaniha, Shariat, Torkaman-nejad, & Moghadam, 2007). Similar findings were reported in Ecuador and Brazil, where street children had higher rates of PTSD and depression compared with the general child population (Pluck, Banda-Cruz, Andrade-Guimaraes, Ricaurte-Diaz, & Borja-Alvarez, 2015; Silva, Cunha, & Scivoletto, 2010). The Brazilian study reported that the rate of depression was more than 30 times higher than that found among children living with their families (Silva et al., 2010).

However, not all studies of this population have reported similarly high rates of depression and PTSD. In India, Khurana et al. (2004) found that only 8% of children in their study met criteria for depression, even though many of them were physically and sexually abused. An Iraqi study found that 10% of this population had depression but also found a higher prevalence of anxiety disorders (57%) (Taib & Ahmad, 2014). In a separate study from the same region, Taib and Ahmad (2015) found that male street children had significantly higher rates of anxiety and depression than did school children (59% and 21% vs. 26% and 5%). They also found that street children had higher rates of other mental health issues, including disruptive disorders such as attention-deficit/hyperactivity disorder, conduct disorder, and tics, although the differences were not statistically significant. The authors caution that the lack of significant differences in disruptive disorders does not mean street children are not at risk of developing them; rather, genetic and environmental factors play an important role, and research has found that latent genetic factors can interact with environmental risk factors to trigger symptoms later in life (Taib & Ahmed, 2015; Thapter, Lagley, Asherson, & Gill, 2006). This may explain why children who stay longer on the street are more likely to develop mental illness (Taib & Ahmad, 2014).

SUBSTANCE USE PROBLEMS

Substance use among street children is widespread, and many studies from developing countries have examined this issue (Kudrat, Plummer, & Yousif, 2008; Mahmud, Ahsan, & Claeson, 2011; Sardana, 2015; Sherman et al., 2005). A literature review by Woan et al. (2012) found varying rates of substance use across countries, ranging from 35% to 100%. It also found that some street children begin substance use at a relatively young age (as young as 10), and that rates of use are higher among boys than girls. This gender

difference may reflect cultural practices and norms in some countries (e.g., Bangladesh, India, Pakistan) and the greater difficulties girls may have accessing drugs (Mahmud et al., 2011). The nature of substance use varies, depending on availability and location, but children generally use substances that are cheap and widely available, such as alcohol, cigarettes, inhalants, paint thinner, heroin, and marijuana.

Substance use has proven to be detrimental to children's physical and psychological functioning. In addition to experiencing immediate health risks (e.g., cardiotoxicity, DNA damage, pathological changes in the liver), street children who use substances are more likely to have mental health issues such as depression, stress, and anxiety (Edidin et al., 2012; Nyamathi et al., 2010). A study from Ghana (Asante et al., 2015) reported that substance use correlated with children's heightened anxiety and other emotional problems. In a Pakistani study, Sherman et al. (2005) found a relationship between drug use and self-inflicted wounds. However, the relationships between substance use and mental health problems could be bidirectional. Anxiety, depression, and hopelessness make children vulnerable and street children may use substances to medicate these conditions and counter life stressors. Sardana (2015) found that mental health is a significant predictor of substance use and that degrees of substance abuse can be predicted by the state of mental health. Conversely, substance use can worsen psychological functioning, thus increasing vulnerability to substance abuse (Elkoussi & Bakheet, 2011).

A RESILIENCE-FOCUSED MENTAL HEALTH MODEL FOR STREET CHILDREN

The dismal mental health conditions of street children in developing countries has led to calls for immediate policy and program intervention by governments, service providers, and international agencies. The national governments of these countries face serious challenges to creating effective practice models or policies. They lack infrastructure and resources, as well as a basic understanding of the mental health needs of street children (Earls, Raviola, & Carlson, 2008). In the absence of government policies and services, it is imperative that non-governmental organizations doing work with street populations promote mental health by developing policies and programs that address individual and group needs.

RISK & PROTECTIVE FACTORS

Building mental health interventions within a resilience framework is a promising approach to working with street children. Resilience refers to "the capacity, processes, or outcomes of successful adaptation in the context of significant threats to function or development" (Masten, Best, & Garmezy, 1990, p. 426). It involves two core assumptions: that individuals and groups are prone to risk or adversity, and that protective factors help individuals and groups deal with such threats (Harvey & Delfabbro, 2004). Risk processes involve an episode or a series of environmental conditions or circumstances that challenge the normal functioning of individuals and groups. For street children, these domains of risk are economic, social, and environmental, and are manifested through poverty, hunger, lack of shelter, physical and mental health problems, and traumatic life experiences. Each of these risk factors alone increases the risk of negative outcomes and any combination of these factors increases the risk even more. This cumulative risk has profound effects on mental health (Monn et al., 2013).

Protective processes involve assets or resources that help modify or minimize the effects of risk factors. Protective factors may neutralize the effects of the risk, or they may activate other protective factors to enhance positive outcomes (Fleming & Ledogar, 2008). For street children, protective processes can emerge from three domains: the individual, the family, and the external environment. Individual factors include social competence, problem-solving skills, intelligence, and sociability (Garmezy & Rutter, 1983). Street children demonstrate these strengths through everyday survival activities. Family factors include socio-economic resources, child–parent relationships, and parental harmony. Children on the street who have family connections may activate these protective factors. Protective factors in the external environment also include resources available in the larger community, such as services from an agency or informal support networks (Smith & Carlson, 1997).

DEVELOPING RESILIENCE-FOCUSED INTERVENTIONS

Resilience-focused interventions that recognize risk and protective factors among street children can improve mental health outcomes. Interventions should conceptualize mental health in positive terms and emphasize health-promoting and preventative objectives. Health-promoting activities aim to enhance mental health, whereas prevention-focused activities aim to reduce the incidence, prevalence, or seriousness of mental health problems

(Barry, 2001; Patel et al., 2008). An Iranian study found evidence for the effectiveness of resilience-focused mental health interventions for street children. Children received 15 sessions of resilience training that covered topics such as stress, negative thoughts, positive social relationships, self-confidence, and positive inner speech. At the end of the program, children showed improvements in self-acceptance, relationships, environmental mastery, sense of purpose in life, and personal growth (Dousti, Pourmohamadreza-Tajrishi, & Ghobari bonab, 2014).

Because mental health does not exist in isolation, mental health programs for street children must consider the synergy of environmental, physical, and psychological factors. Agencies should embrace both promotional and preventative objectives and introduce holistic interventions that address basic physical needs and promote physical and mental health.

Two kinds of interventions have the potential to foster resilience among street children: those that focus on reducing risk factors and those that focus on boosting protective factors.

INTERVENTIONS THAT FOCUS ON RISK FACTORS

Central to interventions that focus on reducing risk factors inherent in the situation of street children is meeting physical needs. Many service agencies in developing countries offer services through centres that provide food, space for recreation, help with personal hygiene, and other essential services. Research has shown that subsistence services that provide food, shelter, clothing, and other basic necessities are most in demand among street children and the continuation of these services comes from integration with other types of services (Thompson, McManus, Lantry, Windsor, & Flynn, 2006). In some instances, agencies work with communities to reduce stressors from the environment. Some agencies in Bangladesh, for example, work with community members, including law enforcement agencies, business groups, and government officials, to create a safe community environment for street children (Aparajeyo-Bangladesh, n.d.). This form of intervention helps reduce rates of harassment and abuse among street children.

INTERVENTIONS THAT FOCUS ON PROTECTIVE FACTORS

A second kind of resilience-based intervention focuses on enhancing protective factors for street children. This can be achieved in two ways: first, by providing mental health services to help manage mental health issues; and second, by strengthening children's individual and group resources to prevent mental health crises.

Enhancing protective factors through mental health services

Interventions that focus on providing mental health services can be delivered on a residential or outpatient basis, or through community outreach. Residential programs are generally very narrowly focused and only people who are living in a shelter or receiving other forms of support are eligible for residential mental health care. Counselling services for shelter residents in developing countries are an example of such an intervention. This model of mental health services in which children are provided services in shelter has some potential. Research in developing and developed countries has found that counselling in residential settings reduces psychological distress and substance use and improves sleep. Key to the success of such interventions is participant interest and trusting therapeutic relationships (Altena, Brilleslijper-Kater, & Wolf, 2010). Drop-in centres may be a useful resource for street children who do not want or trust residential services. They can be particularly appropriate for this population, whose families often depend on their child's economic contribution, making it difficult for these youth to commit to their own mental health needs. Drop-in services could be tailored to meet the unique needs of these youth. Mental health services can also be delivered through community outreach. This allows agencies to extend mental health services to the broader community of street children.

Agencies may adopt a hybrid model that incorporates any combination of inpatient, outpatient, and community outreach services. For example, Salaam Baalak Trust (n.d.), an Indian agency serving street children, runs a mental health program that includes community outreach and inpatient care. A team of mental health outreach workers does informal mental health screening among youth on the street. A child identified as having a possible mental health disorder is referred to the mental health team for formal screening and treatment. This type of hybrid model allows agencies to expand their mental health services. For example, agencies can reach out to children who would not otherwise access their services and bring them into a program that focuses on building resilience and promoting mental health, such as an open air school.[2]

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[2] Open air or mobile schools are programs for street children set up in public areas such as train stations or marketplaces where street children gather. In this informal, interactive setting, outreach workers teach various topics, including life skills, health and hygiene, safety, and resolving conflict.

Enhancing protective factors by leveraging existing resources

Street children may have individual and group resources, such as positive social relationships, that can mediate the negative effects of street stressors. Research shows that positive social relationships promote the development of psychosocial processes needed to cope with life's stressors and protect against ill health (House, 1981). Social support networks have been shown to be critical to street children's physical and emotional well-being (Davies, 2008). Through these networks, children gain knowledge and skills that help them access crucial resources such as food and shelter and that promote a sense of security (Aptekar, 1988; Felsman, 1989; Mizen & Ofosu-Kusi, 2010; Reza, 2014). Friendships on the street are a source of practical and emotional support. Friends can offer sympathy, solidarity, practical assistance, and protection to peers in crisis or facing abuse. Sometimes, youth also mobilize group members to protest in public against abuse and exploitation (Reza, 2014). Most importantly, street children indicate that love, sympathy, and cooperation are the most important assets in street life. Peer groups are central to improving the quality of their individual and collective survival on the streets (Conticini, 2005).

IMPLEMENTATION CONSIDERATIONS

Implementing a resilience-focused intervention for street children requires an agency culture that emphasizes resilience. This might require change in how agencies develop and implement interventions. Building a resilience framework begins with acknowledging, understanding, and defining mental health needs. This might be explored with simple questions: What are the mental health needs in the organization's catchment area? What services are required to address these needs?

Needs assessment surveys and consultation with outreach workers can help to answer these questions. Identifying demographic factors such as age, gender, and length of time on the street is important in order to tailor interventions to the unique needs of various groups. For example, gender might be an important consideration in developing a mental health intervention because girls are more likely to experience sexual abuse and to internalize the trauma, whereas boys are more likely to experience physical abuse and to externalize symptoms (Aptekar & Stoeklin, 2014). Cultural and religious factors are also important considerations in developing and providing mental health interventions. In some cultures, behavioural manifestations of a mental health disorder may not correspond to standard Westernized diagnostic categories. For example, in some Islamic countries,

signs of spirit possession are not considered to be symptoms of mental illness; rather, they are considered to be a genuine religious phenomenon in which an alien spirit enters the body to alter the person's identity and actions and cause harm (Khalifa & Hardie, 2005). This type of belief runs deep among Bangladeshi street children. Awareness of such culture-bound syndromes is important for proper diagnosis and treatment.

Agencies should select interventions that best fit their needs and abilities, considering factors such as available resources, service infrastructure, service delivery system, and, above all, program scope. In a resilience-focused mental health intervention, the scope could be promotional or preventative. Interventions that provide both require more logistics. Agencies that decide to focus on prevention need to determine what approach is most appropriate and effective. There is no universally appropriate intervention. For example, pharmacological interventions to treat severe psychiatric illness may be more accessible in resource-rich countries, and some interventions, such as brief motivational therapy, cognitive-behavioural therapy, peer-based intervention, and harm reduction interventions, have been evaluated mostly in resource-rich countries (Altena et al., 2010). Agencies in developing countries can adapt these interventions to make them more accessible and appropriate for the people they serve. For example, one Egyptian agency implemented an environmental behavioural modification intervention that used entertainment, role play, theatre, and other positive activities to improve self-esteem and social skills among street children (Hosny, Moloukhia, Abd Elsalam, & Abd Elatif, 2007). An evaluation of the program found a significant improvement in some aspects of behaviour. It is such innovation in developing culturally appropriate interventions that best addresses local needs.

Collaboration with other service agencies, government, and academic centres can reduce program overlap and costs, extend the reach of programs, and improve the quality of services. For example, the Equilibrium Project was developed by the Institute of Psychiatry at the University of Sao Paulo in Brazil in partnership with services for street children run by the city and other agencies. The collaboration involved determining clinical needs as perceived by street children and led to the development of services to meet those needs (Scivoletto et al., 2011).

Careful planning allows for more strategic street outreach. It improves access to services and helps agencies continually assess whether needs are being adequately addressed. Planning can also lead to necessary modification in service options (e.g., adding evidenced-

based interventions) and service delivery systems. Agencies should carefully evaluate their service delivery strategies. Research reveals that low service use is an issue, and that barriers stem from individual and structural issues. Individual-level barriers include lack of awareness of services, poor communication skills, fear, and mental and emotional stability. Structural barriers include program structure, availability, social stigma, and communication skills of program staff (Kurtz, Surratt, Kiley, & Inciardi, 2005). Program success requires removing these barriers and creating a positive service use environment. Although many agencies in developing countries offer basic services for survival on the streets, many children remain beyond their reach. Relying on traditional models of service delivery, in which clients initiate contact, is unlikely to succeed with this population because many street children do not recognize they have mental health issues that can be treated and mistrust of institutions is common (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). This means that service agencies must find innovative ways to reach out to children, build trust, and encourage them to access services. One innovative approach to outreach is to recruit boys and girls form peer groups of street children and train them to connect peers who need help with services.

CONCLUSION

Poverty, abuse, and family dysfunction are some of the many factors that precipitate children's perilous journey to the streets in developing countries. In an environment that features chronic multiple stressors, the chances of leading a healthy life dwindle. Some children demonstrate resilience in the face of these challenges, but the vast majority become victims of systemic deprivation, abuse, and exclusion. Research provides overwhelming evidence that most street children experience mental health disorders. Thus, the need for mental health services is great. Yet developing countries often struggle to meet this need, given the lack of government support. Non-profit agencies assume most of the responsibility, but have scarce resources. A resilience-based mental health model is a good starting point for these agencies. By focusing on preventative and promotional aspects of mental health, it harnesses children's own resources while providing external support. Moreover, a resilience-based model can be integrated into existing programs. Finally, by collaborating with international development agencies, local agencies can expand the reach of resilience-based interventions to improve health outcomes among street children in developing countries.

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PART 4

ASSESSMENT & EVALUATION

4.1 ASSESSMENT TOOLS FOR PRIORITIZING HOUSING RESOURCES FOR YOUTH WHO ARE HOMELESS

Eric Rice

CONTEXT & EVIDENCE

In almost all communities in North America, the number of youth experiencing homelessness exceeds the capacity of the housing resources available to them. This situation leaves communities with the predicament of trying to decide who to prioritize for the precious few spots available in housing programs. For adults, this same dynamic exists and many communities have turned to vulnerability assessment tools to help them make these difficult decisions. Most communities have moved to a coordinated entry system. In such systems, most agencies within a community pool their housing resources in a centralized system. People seeking housing are first assessed for eligibility. Criteria usually include being chronically homeless, in addition to veteran status and vulnerability (U.S. Department of Housing and Urban Development, 2015, 2016). Based on these assessments, individuals are prioritized for housing and placed on waiting lists until appropriate housing becomes available in the community.

In the context of adult homelessness, tools for assessing vulnerability have focused on assessing factors associated with premature mortality (Hwang, Lebow, Bierer et al., 1998; Juneau Economic Development Council, 2009; Swanborough, 2011) or with greatest system costs (Economic Roundtable, 2011). However, since youth under age 24 are unlikely to experience health-related premature mortality or to have created enormous system costs, new assessment tools have been developed in recent years that reflect the needs and realities of youth who are homeless. Most widely used are the TAY Triage Tool (Rice, 2013), developed by the Corporation for Supportive Housing (CSH) and myself, and the Next Step Tool for Homeless Youth,[1] which was developed by Orgcode Consulting (2015) with CSH and myself.

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[1] The full name of the tool is Transition Age Youth – Vulnerability Index – Service Prioritization Decision Assistance Tool (TAY-VI-SPDAT).

TAY TRIAGE TOOL

The TAY Triage Tool (see below) is a seven-item (six-point) index based on extensive research conducted by myself in conjunction with CSH. Unlike the adult tools, which are based on developing predictors of system cost or premature mortality, the TAY Triage Tool is anchored in assessing which youth are most likely to experience long-term homelessness. The tool defines long-term homelessness as five or more years of housing instability. We arrived at this definition in consultation with key stakeholders from the systems of care that serve youth in Los Angeles who are homeless. These stakeholders included permanent supportive housing providers and representatives from foster care, juvenile justice, housing, and mental health who met with us to discuss what issues were most salient for youth (Rice, 2013).

TAY Triage Tool Questions

1. Have you ever become homeless because: There was violence at home between family members? (1 point if yes)

2. Have you ever become homeless because: I had differences in religious beliefs with parents/guardians/caregivers? (1 point if yes)

3a. Have you ever become homeless because: I ran away from my family home?

3b. Have you ever become homeless because: I ran away from a group home or foster home? (1 point if yes to 3a and/or 3b)

4. If you have ever tried marijuana, how old were you the first time you ever tried it? (1 point if youth was age 12 or younger)

5. Before your 18th birthday, did you spend any time in jail or detention? (1 point if yes)

6. Have you ever been pregnant or got someone else pregnant? (1 point if yes)

From TAY Triage Tool Pilots Report (p. 7), by E. Rice and A. Rosales, 2015, New York: Corporation for Supportive Housing. Copyright 2015. Reprinted with permission.

Based on the literature on vulnerability and risk-taking among youth who are homeless (e.g., Milburn et al., 2009; Toro, 2011), we assessed a large number of possible variables to include in the triage tool. Whenever it was possible, we tried to focus on specifications of variables that were likely to precede long-term homelessness in order to avoid complex issues of causality. For example, rather than assessing current levels of alcohol use, we assessed whether the youth had consumed alcohol at age 12 or younger. We chose this specific variable because high levels of alcohol use could lead to long-term homelessness, but long-term homelessness could just as easily lead to high levels of alcohol use, whereas using alcohol before age 12 is unlikely to be a result of long-term homelessness among youth.

In the process of arriving at the final items included in the TAY Triage Tool, we examined approximately 50 possible associations, including 19 different reasons for becoming homeless (e.g., "I experienced sexual abuse," "my desire for adventure"). Other possible associations included alcohol and marijuana use; first sexual experience at age 12 or younger; foster care involvement; incarceration before age 18; eight different traumatic experiences (e.g., "being hit, punched, or kicked very hard at home"); symptoms of posttraumatic stress disorder; employment; dropping out of high school; being HIV-positive; testing positive for other sexually transmitted infections; currently sleeping on the streets; having children; being pregnant (or impregnating someone); trading sex for money, food, drugs, housing, or other resources; sexual orientation and gender; and race/ethnicity. Details about the modelling strategy that resulted in the final scale can be found in the summary report available online (Rice, 2013).

This work was followed by two years of extensive research in various cities that tested the tool's generalizability and validity. Five additional communities pilot tested the implementation of the tool. Its generalizability was supported by data we collected in Clark County, Nevada, and in Connecticut. The data showed that scores were associated with longer term homelessness in those communities. We used focus groups to assess the face validity of the tool, and in Nevada and Connecticut, we were able to assess construct validity as well. Details of this testing are presented in a report that is available online (Rice & Rosales, 2015).

NEXT STEP TOOL FOR HOMELESS YOUTH

Another targeted assessment tool is the Next Step Tool for Homeless Youth developed by Orgcode Consulting (2015). The development process of this evidence-informed tool involved an extensive review of the scientific literature on vulnerability factors for youth who are homeless and then creating assessment items that capture factors identified in the review. In consultation with CSH and myself, Orgcode incorporated items from the TAY Triage Tool into its larger assessment tool. It is worth noting that some items in the Next Step Tool we eliminated from the TAY Triage Tool because the item did not differentiate between shorter- and longer-term homelessness. An example of this is: "Have you been attacked or beaten up since you've become homeless?" Conversely, there are items the Next Step Tool incorporates that were not considered in the development of the TAY Triage Tool, such as "Does anybody force or trick you to do things that you do not want to do?" Neither tool is perfect. Both, however, strive to identify vulnerable youth in order to help communities prioritize housing for youth based on objective criteria known to assess vulnerability.

USING ASSESSMENT TOOLS TO INFORM INTERVENTIONS

Using either or both of these assessment tools to inform an intervention requires several steps:

1. The community decides whether to adopt a coordinated entry system that will screen and assess the vulnerability of youth who are accessing services and who need housing, or whether a single housing agency will use the tool.
2. The tools are then used as part of a coordinated entry system or by a particular housing agency if a coordinated entry system is not in place.
3. Based on the scores, the community decides which youth to prioritize for housing.
4. The community matches youth to particular housing options available in the community.
5. The community assesses the outcomes of youth placed into housing with the tool and in an iterative fashion adjusts steps 3 and 4 to best assist the greatest number of youth.

Because these tools are very new and coordinated entry systems for youth are just now being implemented in many communities, there is still much debate about prioritizing youth and matching them to housing options. These issues and the five steps are discussed in the following sections.

USING A COORDINATED ENTRY SYSTEM

The TAY Triage and Next Step tools can help communities and individual agencies prioritize youth for housing and even match youth to housing resources. Many communities, particularly in the United States, have attempted to create coordinated entry systems for youth and have incorporated these tools into them. These systems usually cut across a continuum of care, in some instances, a single city, county, or even state. Most coordinated entry system efforts involve the majority of providers of basic care to youth who are homeless (e.g., drop-in centres, emergency shelters), as well as housing providers (including permanent supportive housing and transitional-living programs). While I do not have information about every community in the country, I have been on the steering committee of a nine-community collaborative called the Coordinated Entry Learning Collaborative. The group is led by Megan Blondin of MANY, a U.S. network that engages stakeholders across sectors to support vulnerable youth and young adults. The nine communities are Los Angeles and Sacramento, California; the State of Connecticut; King County, Washington; Colorado Springs, Colorado; Minneapolis, Minnesota; Washington, DC; Clark County, Nevada; and St. Louis, Missouri. All of these communities are implementing the Next Step Tool and simultaneously collecting information on the specific items that make up the TAY Triage Tool. The plan is to evaluate both tools as the data are collected simultaneously.

ASSESSING VULNERABILITY

Both the TAY Triage and Next Step tools are quick ways to assess vulnerability. The 28-item Next Step Tool can be delivered as is and is available for free from the Orgcode Consulting website (www.orgcoge.com). Because the TAY Triage Tool is even briefer, it is recommended that communities embed it within a larger (but still short) assessment. Most communities have a brief screening tool that collects basic demographic and contact information, and that determines program eligibility. This would be an ideal instrument in which to embed the TAY Triage Tool. CSH and I have also posted online an example questionnaire that can be used as is and can be downloaded for free (www.csh.org/TAYTriageTool). Neither tool requires extensive training. The CSH link includes a presentation of the TAY Triage Tool that explains how to implement the tool in a community context. An online video about the Next Step Tool is available at www.vimeo.com/iaindejong.

In my work with the Coordinated Entry Learning Collaborative, one complication has emerged around assessing youth. Not all communities assess the same youth. In some communities, workers are taking the tool with them when they do street outreach, and in other communities, youth are being assessed in drop-in centres. This means that many youth who do not access social or housing services are being reached, but that youth who are entirely resistant to services are not. Other communities are using the tools only when youth present at housing agencies looking for specific assistance with housing. This approach reaches an even smaller number of more highly service-engaged youth. How and where the tools are being used affects the distribution of scores. Communities that use street outreach are seeing more high-scoring youth than those that use drop-in services as assessment points, which in turn see more high-scoring youth than those who use the tools in the context of housing agencies. It is not clear what approach is best; the approach should be determined by the specific needs and resources of a given community.

Based on the research that went into the creation of the TAY Triage Tool, we know that youth who score higher are more vulnerable to long-term homelessness (Rice, 2013; Rice & Rosales, 2015). In the case of the Next Step Tool, this is a general vulnerability, not tied to a particular outcome, and no research has been conducted to date that links this tool to particular outcomes, such as long-term homelessness, substance abuse, or mental health issues. We also know that youth who scored higher on the TAY Triage Tool had higher rates of depression and reported more traumatic experiences and problems with drugs and alcohol (Rice, 2013). An added benefit of the Next Step Tool is that it is based on a scoring system that has been calibrated to match the scoring systems of Orgcode Consulting's tools for single adults and families. This means that in communities where there is no separate coordinated entry system for youth, but where youth are competing for "adult" resources, their vulnerability can be assessed with a youth-appropriate tool that uses the same overall scoring system as the adult tools. The TAY Triage Tool, on the other hand, is a standalone instrument that is not easily comparable to other assessment tools for other populations.

PRIORITIZING YOUTH

Communities or particular housing organizations must decide how to use assessment scores to prioritize youth. The action taken in this step depends largely on the housing resources available to the community. If there is enough housing for every youth who needs it, then a reasonable use of the prioritization tool may be simply as a queueing mechanism for who gets served first, but all youth will get placed. On the other hand, if there is an enormous gap between housing need and available housing, as is the case in Los Angeles, then communities can use these tools to prioritize youth for housing. This process is often painful for many service providers and communities because they want to help everyone.

Determining priority based on vulnerability raises the issue of early intervention. Youth who quickly exit homelessness to more stable housing are less likely to experience mental health and substance use problems (Milburn et al., 2009; Toro, 2011). This finding suggests the importance of intervening early—reaching youth when they first hit the streets, before they begin to accumulate negative street experiences and feel their many effects. Moreover, youth who score high on vulnerability (at least on the TAY Triage Tool) are more likely to have substance use and mental health issues that need more intensive services (Rice, 2013). The benefit of the TAY Triage Tool in this context is that all the items are related to early life experiences that can pre-date the first episode of homelessness and thus can be used to identify youth who are likely to experience many problems later in life, even if those problems have not yet emerged. Helping youth early in their homelessness experiences is important for long-term positive outcomes. How this may complicate the prioritization process is not entirely clear.

MATCHING YOUTH TO HOUSING

Once youth have been prioritized, communities and housing organizations need to determine how to use the vulnerability scores to decide what specific program is most appropriate for each youth. Currently, there is no research to validate the specific cut scores on the TAY Triage or New Step tools. Moreover, there is no research evidence to suggest that cut scores from either tool successfully place youth in particular housing situations. My feeling is that youth who score higher on either tool will likely have the most difficulty successfully transitioning into housing and remaining stably housed. However, both tools make recommendations for housing that are intended to ensure that

highly vulnerable youth are prioritized for intensive housing resources. With the TAY Triage Tool, we suggest that youth who score 4 or higher be prioritized for high-intensity housing services, such as permanent supportive housing, but that may also include high-support or high-intensity transitional living programs. This recommendation was based on our research which found that youth who score 4 or higher have many co-occurring issues, such as mental health and substance use problems and traumatic experiences. These youth are more likely not only to spend longer on the streets without intervention, but also to have various complex issues that require intensive case management in conjunction with housing resources. Orgcode Consulting recommends that youth who score 8 or higher on the Next Step Tool be assessed for long-term housing with high-intensity services (Orgcode Consulting, 2015). This score was decided on to calibrate the youth tool to an equivalent scoring scale in the single adult and family tools.

The assumption behind the TAY Triage and Next Step tools is that youth who are more vulnerable are in greater need of more intensive services, likely permanent supportive housing, whereas youth who score lower need less intensive services or may benefit from non-housing support services. In theory, these assumptions seem reasonable, but there is limited evidence to date to support them. A score of 4 or higher on the TAY Triage Tool does differentiate between youth who have many co-occurring issues and those who have few, and it seems reasonable to assume that those higher-scoring youth will need high-intensity services. But no evaluation research exists to demonstrate that these cut scores are the most accurate reflections of vulnerability and need. Therefore, communities should use these scores with caution, thoughtfully and iteratively, to determine how and when to use them.

EVALUATING OUTCOMES & REFINING THE PROCESS

I cannot stress enough the importance of evaluation, the final step in the intervention process. At the time of writing this chapter, very few communities, even within the Coordinated Entry Learning Collaborative, have placed enough youth into housing with the assistance of these assessment tools to be able to evaluate placement outcomes. Thus, we are in the uncomfortable position of not yet knowing exactly how well this process works. Communities need to conduct extensive qualitative and quantitative evaluations of the assessment, prioritization, and matching processes so they can refine them. The lives of thousands of youth depend on a thoughtful and rigorous implementation of housing interventions.

In the context of outcome evaluations, communities should assess whether the tools are appropriately assessing, prioritizing, and placing all youth. Some high-scoring youth may need only time-limited supports of moderate intensity because they have personal resilience factors that outweigh their vulnerability. For some youth, returning to family homes or short-term rental subsidies may be sufficient. Likewise, some youth who score relatively low may actually need high-intensity services. In my work with the Coordinated Entry Learning Collaborative, I have seen this latter situation with youth who have severe cognitive or developmental delays who may not engage in many risky behaviours but who nonetheless need high-intensity services to thrive. Communities should consider such issues as they plan, evaluate, and iteratively adjust their housing systems for youth.

IMPLEMENTATION CONSIDERATIONS

Scores on these tools should not be translated into housing placement decisions without plans to evaluate and adjust score-based decisions over time. We have recommended that youth who score 4 or higher on the TAY Triage Tool be prioritized for housing with high-intensity services. Orgcode Consulting (2015) has recommended that youth who score 8 or higher on the Next Step Tool be prioritized for such services. However, the jury is still out on whether these recommendations actually lead to successful housing placements and positive youth outcomes. There is no evidence yet on what using these cut points will do for communities or for the youth being placed in housing. We need much more evaluation research. Still, communities must start somewhere and these recommendations were developed very carefully. As communities conduct their evaluation work, they should consider how to adjust these score-based placement decisions based on actual outcomes in their specific programs.

Youth who score higher on these tools are likely to have the most difficulty staying in housing and to have relatively poor outcomes. Communities need to remember that high-scoring youth have many co-occurring issues that include mental health and substance use issues and histories of trauma. These youth face many challenges and need intensive services. The challenges may make it more difficult for them to attain employment or exit housing programs to stable, independent housing. Communities should recognize that program outcomes for the most vulnerable youth may not be as "good" as those for youth who are less vulnerable.

Housing programs should not fill an entire housing program, especially congregate living programs, with only high-scoring youth. Decades of research with high-risk youth show that interventions that incorporate only high-risk youth can increase negative outcomes through what is known as "deviancy training" (Dishion & Dodge, 2005). The most effective youth programs have a mix of high-risk and lower-risk youth with active adult mentoring and supervision. This approach effectively downplays the normative importance of high-risk behaviour and augments the normative importance of pro-social behaviour. Thus, communities must think very carefully about how to house the most vulnerable youth.

KEY MESSAGES FOR PRACTITIONERS

- Assessment tools such as the TAY Triage and Next Step tools can help communities prioritize youth in need of housing.
- These tools support housing interventions for youth who are homeless by assessing needs, prioritizing youth, matching youth with appropriate housing, evaluating placement outcomes, and helping to refine the entire process.
- Most communities are early in the process of adopting these tools and more evaluation research is needed to refine the process.
- To date, no research has evaluated the utility or consequences of the specific cut scores recommended by these assessment tools. Communities must conduct rigorous evaluations of how cut scores are used in the allocation of housing resources.
- Implementation challenges should be considered: specific threshold scores should be adjusted based on evaluation work; youth who score high on assessment tools are likely to face more challenges once they are housed; and placing only high-risk youth together in congregate living programs may increase negative outcomes.

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4.2 PRAGMATIC STRATEGIES & CONSIDERATIONS FOR EVALUATING MENTAL HEALTH PROGRAMS

Tyler Frederick

INTRODUCTION

Evaluation research involves gathering a wide variety of indicators in order to better understand how a program is operating, its impact, and what can be done to improve it. The performance indicators that many organizations collect routinely as part of their daily operations can provide important information for a program evaluation (e.g., attendance, client demographics), but are not themselves considered evaluation research. Evaluation involves systematically and intentionally collecting and reviewing information in order to understand and strengthen a program.

This chapter offers service providers guidance around evaluating programming within their organizations, with a particular focus on mental health initiatives. It discusses developing evaluation questions and choosing sources and methods for obtaining information. It also examines ethical considerations in conducting evaluation research.

COLLABORATION VERSUS GOING IT ALONE

Organizations can and should conduct their own evaluation research when possible. However, collaborating with external evaluation professionals can be extremely helpful, particularly if the aim is to conduct a complex evaluation or if there are no internal personnel to take on the task. Additionally, a third-party evaluator can bring a valuable outside perspective to the evaluation and help address ethical issues that can arise when a program asks its own staff and clients to participate in research. The two main options for getting expert guidance are to hire a consulting firm or solicit the help of a local university.

The main advantage to hiring a consulting firm is the quick turnaround time; the main drawback is the cost. Universities, in comparison, are a good low-cost option, but turnaround time can be slower because researchers at a university will have other things competing for their time. For organizations that want to approach a university, a good

first stop is a research partnerships office. Most large universities have a department that facilitates collaborations between the university and outside organizations and companies. If there is no such office, then the best approach is to look at faculty profiles within departments such as social work, psychology, sociology, public health, and medicine. Organizations should look for researchers whose research interests overlap with the population and focus of the initiative.

Simple projects can likely be carried out on a small budget, with student volunteers and the faculty member providing time in-kind. Projects that are more complex might require writing a grant to solicit funds. Organizations working with a university should take the time to draft an agreement to clarify roles and responsibilities and to determine ownership of the data. University researchers are usually motivated to participate in evaluation research so they can use the data for their own research and publishing opportunities. University partnerships offices can be helpful in drafting these types of agreements.

This chapter can inform discussions with a consultant or university researcher, and will also be useful to organizations that want to conduct their own research.

TYPES OF EVALUATION

There are six main types of evaluation research:

- Needs assessment: to understand the characteristics and needs of a client population and to identify current gaps in service for the purposes of designing new programs;
- Monitoring review / compliance with standards: to ensure that a program complies with the requirements of governments or funders and to ensure that a program is showing fidelity with a chosen implementation model;
- Implementation/process evaluation: to understand how a program is operating and to identify issues and challenges with its structure and operation;
- Impact/outcome evaluation: to understand the short-, medium-, and long-term impacts the program is having on those involved and to ensure that it is fulfilling its intended mandate;
- Program review: to update a program and make minor adjustments to ensure it is responsive to shifts in client needs, staffing, and budget priorities; and
- Efficiency assessment: to improve operational efficiency and reduce program costs.

Determining the appropriate type of evaluation is a key part of the process because it shapes the data that will be collected and analyzed. This chapter focuses on needs assessments, process evaluations, and impact evaluations. These are the most common types of evaluation and the steps for conducting them can be easily adapted to other types of evaluation.

LOGIC MODELS & DEVELOPING RESEARCH QUESTIONS

Once the type of evaluation to use has been decided, the next step is to figure out what questions the evaluation needs to answer. Questions developed at this stage are meant to be broad and guiding. Organizations should aim for two or three central questions and make sure they match the type of evaluation.

Logic models can be valuable in identifying these guiding research questions. They involve a process of determining, documenting, reviewing, and modifying the intended structure of a program (W. K. Kellogg Foundation, 2006). The main components of a logic model are:

- Resources/inputs: resources the program will use in fulfilling its goals;
- Activities: the main tools, structures, and processes of the program;
- Outputs: the direct product of the program's activities;
- Outcomes: specific changes the program aims to achieve among program participants. These outcomes are usefully divided into short-term, medium-term, and long-term outcomes; and
- Impact: broader and more fundamental changes that will occur within the organization, community, or relevant system due to the operation of the program.

Combining these components, the typical structure of a logic model looks like this:
Resources/inputs → activities → outputs → outcomes → impacts

Logic models are valuable for research because the different types of evaluation address questions relevant to specific components of the logic model.

NEEDS ASSESSMENTS

Needs assessments address questions at the beginning of a logic model. The goal is to understand the characteristics and needs of the population of interest. This knowledge can then be used to determine intended outcomes and design activities.

Example questions for a needs assessment:
- What are the demographic, social, and background characteristics of the population we serve or want to serve?
- What are the experiences (successes, challenges, barriers) of this population?
- What needs have experts identified among this population?
- What needs does this group identify for itself?

PROCESS EVALUATIONS

Process evaluations review a program's activities and are used to ensure they are operating as intended. They are also useful for identifying gaps and barriers in the processes through which program activities are being delivered.

Example questions for a process evaluation:
- How are participants experiencing the program activities and what is their level of satisfaction?
- How are staff members experiencing the program activities and what is their level of satisfaction?
- How easily are participants navigating their way through the intended structure of the program?
- What are the main barriers participants are experiencing to their full and successful participation in the program activities?
- Are participants progressing through the program in line with the intended time frame?

OUTCOME EVALUATIONS

Outcome evaluations are primarily concerned with determining whether participants are experiencing the intended outcomes and impacts of the program. It is important to decide what level of outcome the evaluation will target (i.e., short-, medium-, or long-term). In deciding this, it is necessary to ensure enough time has lapsed to gauge adequately whether the intended outcome has been achieved. For example, an initiative may need to run for one year or more before any type of long-term outcome can be effectively evaluated.

Example questions for an outcome evaluation:
- Is this program fulfilling its intended short-, medium-, and long-term outcomes?
- What impact is this program having on participants' mental health (short-, medium-, and long-term)?
- Are participants using the skills they learned in their daily lives?
- Do participants feel the program is adequately meeting their needs?

IDENTIFYING DATA SOURCES

Once the guiding research questions have been identified, the next step is to decide from whom and where the information for the evaluation will come. The following section identifies key sources of information and suggests possible methods to use for obtaining information from each type of source.

ACADEMIC EXPERTS

Getting access to the academic research on a particular population can be a valuable first step in understanding the social and demographic characteristics of a population and its needs, and for understanding common problem areas. A recommended way to gain this information is to reach out to a scholar who does research in the particular area of interest. Looking at the profiles of researchers at a local university can be a helpful start. Google Scholar (scholar.google.ca) is a useful tool for identifying people who do research in the area of interest. Email them to ask for help locating key pieces of information on the population of interest.

Organizations can also do their own searching through the Internet, but this can be unreliable because so much information is of unclear quality and providence. If you are conducting your own search, use Google Scholar or a trusted organizational website or clearinghouse (e.g., www.homelesshub.ca). On Google Scholar, include keywords about the population or topic, and use terms like "systematic review," "scoping review," or "meta-analysis," which will identify studies that review a large quantity of information on the subject. The online Cochrane Library can also be a useful place to find systematic reviews on various mental health topics (www.cochranelibrary.com/cochrane-database-of-systematic-reviews/index.html).

Possible methods: literature reviews, expert interviews

STAFF, PARTNERS, & STAKEHOLDERS

Staff can be a valuable source of information for process and outcome evaluations because they can indicate needs they are seeing in the community or challenges they are experiencing with a particular program. The method chosen for obtaining information is important because ethical issues can arise when staff members are asked to provide information and feedback (these considerations are discussed in a later section). Stakeholders, organizational partners, and funders can also be valuable sources of information because they can describe how a particular organization or program is perceived outside the organization. They can also discuss gaps in service, funding priorities, and best practices within a particular service sector.

Possible methods: interviews, focus groups, anonymous surveys, anonymous comment boxes

PERFORMANCE INDICATORS & INTERNAL STATISTICS

The statistics that organizations collect routinely as part of their daily operations can be useful for program evaluations. For example, attendance statistics can provide information on who is being served (and therefore who is not being served), how long clients are accessing services, and repeat clients. In a process evaluation, internal statistics are most informative when they are paired with other methods of obtaining information. For example, internal statistics could help an organization see that younger clients seem to be discharged more frequently than older clients. This finding can then be explored in more detail through surveys or interviews.

Possible methods: data analysis

CLIENTS & RESEARCH PARTICIPANTS

Clients are a key source of information for program evaluations because they are best positioned to understand how well a program or service is meeting their needs, and to identify program strengths and weaknesses. Ethical considerations around asking clients to participate in a program evaluation need to be addressed and are discussed in a later section. *Possible methods*: interviews, focus groups, case studies, anonymous surveys, anonymous comment boxes

CHOOSING AN EVALUATION METHOD

COMMENT BOXES

Comment boxes can be a simple, low-cost way to gather information on how a program is functioning. Furthermore, they are anonymous, which is helpful for soliciting honest feedback. However, where comment boxes are installed is important. For example, having a box at the front reception desk may discourage people from submitting feedback because they do not want to be seen filling out a comment card. Putting the box in a less busy area will address this issue. Another option is to create opportunities where all program participants submit a comment form, whether they complete it or not, so individual responses cannot be identified. It is important that the people being asked for feedback know that someone is reading the comments and taking steps to address them. For example, a newsletter or poster can summarize feedback and action, or anonymous feedback (retyped to protect anonymity) can be posted on a board with an accompanying response.

SURVEYS

Surveys are useful for collecting information on a set of specific questions. The questions are typically close-ended (yes/no or multiple choice). Surveys can include a few short open-ended questions, but they should be used sparingly because they can create survey fatigue.

Surveys can be used in needs assessments to gain a better understanding of the characteristics and needs of a client population (e.g., demographic information, top needs, service use). In process evaluations, surveys are useful for asking about specific qualities or characteristics of a program and for gauging satisfaction with particular components. For outcome evaluations, surveys can elicit information about how clients have been impacted by a particular initiative and can track change over time for key indicators (e.g., mental health, life satisfaction, hope, symptomology).

Constructing survey questions

Surveys should be as short as possible and should include no more than 50 questions. Most surveys include at least a few basic demographic questions (e.g., age, gender, sexuality). These questions make it possible to identify differences across groups. For small surveys (50 or fewer people), keep demographic questions to a minimum to protect anonymity.

For help developing background and demographic questions, consult the questionnaires used by Statistics Canada that are listed in the "Definitions, Data, Sources and Methods" section of its website (www.statcan.gc.ca/eng/concepts/index?HPA=1). It is possible to search by subject and to focus on surveys with youth. The link for each survey contains a PDF file of the survey questionnaire. The questions can be adapted for review purposes.

For outcome surveys, organizations may want to include scales or assessment tools that asses various components of mental health and well-being. Beidas et al. (2015) have put together an excellent list of brief, free, and validated assessment tools. Most of the tools they list are intended for screening purposes only, which means they can identify a potential mental health problem, but not provide a diagnosis. Other free, well-validated scales include the World Health Organization's (1997) Quality of Life scale, which is available through its website (look for the BREF version), and the GAIN set of appraisal tools that assesses mental health and addiction domains (GAIN Coordinating Center, n.d.).

If you are constructing questions from scratch, consider using Likert-style, multiple-choice questions because they provide a continuum of responses and therefore can be more informative than a simple yes/no question. A question can look like this:

How satisfied are you with the mental health group you have been attending?

1. Very satisfied
2. Somewhat satisfied
3. Neutral
4. Somewhat dissatisfied
5. Very dissatisfied
6. Don't know
7. Choose not to answer

When developing questions from scratch, watch for the following common mistakes:

- Double-barrelled questions: questions that actually contain two questions; for example, "How satisfied were you with your caseworker and the amount of time the caseworker spent with you?";
- Response options that are not mutually exclusive: the question might contain more than one response option that might be true; for example, "How old were you when you first felt like you experienced symptoms of mental health problems: 10–12, 12–18, or 18–25?"; and
- Response options that are not exhaustive: the person might have a response that does not match any of the listed response options. A good way to avoid this problem is to include a catchall option like "None of these choices applies to me" (this wording is preferred to "Other" because it carries less negative connotations).

Establishing time points for surveys: Cross-sectional versus longitudinal surveys

Needs assessments and process evaluations usually involve a survey at only one point in time. For a needs assessment, the survey is usually conducted before the program or initiative begins. The survey for a process evaluation usually happens after the program has been running for a sufficient enough amount of time that participants are able to comment on its components.

Outcome evaluations, on the other hand, benefit from a pre-test/post-test design so it is possible to measure change over time. Conducting surveys before and after a program is essential to drawing valid conclusions. For example, in a survey conducted at the end of a six-month mental health group, all participants report good or excellent mental health. Based on these findings, the program developers conclude that the program was a success. The problem, however, is that without knowing each participant's self-reported mental health before the program begins, there is no way to determine whether participants in

fact experienced any change in their mental health as a result of the program. A problem with pre-test/post-test surveys is that participants cannot remain anonymous. Ethical considerations around anonymity are discussed in a later section.

CONTROL GROUPS

For outcome evaluations, the gold standard for assessing impact is to include a control group in the evaluation. Control groups are a sample of people who are similar to the people whose outcomes are being assessed, but who have not completed the program. Comparing the two groups allows evaluators to make sure any changes that were observed between the pre-test and the post-test can be attributed to involvement in the program. If the program group and the control group both change, it suggests that something other than the program caused the change. For example, sometimes people improve on their own over time without an intervention. Adding a control group obviously introduces a level of complexity, but without one, findings about the impact of a program must be interpreted with caution. One good option for establishing a control group is to use individuals on the program's wait list if one exists.

FOCUS GROUPS

Focus groups involve a small group of people (ideally five to eight) who are guided through discussion by a facilitator. A strength of this format is that participants can elaborate on the responses of other participants, which can be useful for establishing a broad understanding of a program or gaining insight into a shared group experience. Focus groups are also cost-effective and can be quicker to conduct than individual interviews. However, they require a moderator who has experience facilitating group discussions, and they are not anonymous. Lack of anonymity means that participants might be reluctant to speak up, particularly if they do not agree with the developing group consensus. Furthermore, sensitive topics should never be discussed in a focus group because confidentiality outside the group cannot be guaranteed and because the discussions might be triggering for some individuals. To get the most of the focus group, facilitators should be experienced in managing group conversations and should be prepared with five or six open-ended questions. Designating someone to take notes is a good way to capture main themes that emerge during the discussion. Audio-recording the session and transcribing the discussion is possible, but the process can be time-consuming.

QUALITATIVE INTERVIEWS

Qualitative interviews involve one-on-one conversations between an evaluator and a participant. They are particularly useful for gaining in-depth information about a person's unique needs or about the person's experiences with a program. They are also an appropriate format for discussing sensitive topics. The trade-off for the depth of the information is that findings may not be generalizable to a broader population. The ability to generalize is particularly limited in interviews (and other methods with small sample sizes) because certain types of clients might be more likely to participate. For example, people who had a bad experience with a program may be more likely to volunteer for an interview than people who had a good experience. The feedback might be useful in highlighting challenges with the program, but it might not provide an accurate overall picture of participants' experience with the program. Conducting 10 to 20 interviews captures a broad range of experiences and opinions and increases generalizability (the more interviews the better, but they are time intensive). An alternative is to conduct a survey to assess the group as a whole and then follow up with a few interviews to explore pertinent themes in more detail. If participants are all very similar to one another and the list of questions is short, then fewer interviews will be needed for common themes to emerge. As the participant sample becomes more diverse and the range of questions becomes broader, more interviews need to be added to compensate for the additional variation and complexity. To get the fullest picture, interviews should continue until the evaluators begin to hear repetition of themes, feelings, and experiences—this point in the data collection process is called saturation.

In-depth interviews can be thought of as guided conversations. Using open-ended questions (5–10 is ideal), these interviews are less structured and tend to follow participants where they want to go (within limits). The list of questions is not intended to be rigidly followed, but reminds the interviewer of key topics as the conversation progresses and flows naturally. The interviewer should probe for details and ask follow-up questions. Interviewers can use various strategies to ensure a successful interview. It is a good practice to ask participants to give examples to help illustrate their points. Beginning the interview with easier and less intrusive questions helps build rapport. Being open, genuine, and empathic, and using active listening skills are important characteristics of a good interviewer. A useful technique that captures a number of these skills is to cast the interviewee as the expert and to conduct the interview with that as the underlying principle.

CASE STUDIES

Case studies are another source of detailed information. They usually involve an in-depth review of three or four clients. Like interviews, they provide rich information but the findings are not easily generalized to other clients. A case study usually involves an interview with a case manager or other staff member, an interview with the client, and a review of internal case files. The idea is to gain as complete a picture of the client's experience as possible, including how the client came into the program and progressed through it, and what outcomes they experienced. It is useful to select case studies along a key dimension or central question. For example, an evaluation can review the case of a person who excelled in the program, another who struggled, and another somewhere in the middle. Case studies are particularly valuable for process evaluations because they provide detailed information on how a person experienced the program, including key points of friction between the person's circumstances and the structure of the program.

ETHICAL CONSIDERATIONS

Research ethics are a central component of high-quality evaluation research. The key components of ethical research are informed consent, voluntary participation, and confidentiality. A key principal cutting across these components is the need to acknowledge power imbalances and to ensure that participants are given an honest opportunity to choose whether and how they participate, that the research respects their safety and comfort, and that participants have an opportunity to share their stories as honestly as possible without being mediated or filtered. It is also important to acknowledge and thank participants for their involvement. This can be a simple thank you or a written note, but we strongly encourage organizations to consider a small honorarium as a token of appreciation and to acknowledge the person's time. Gift cards, food vouchers, and personal products are all good options. An honorarium does not need to be expensive; in fact, organizations should be careful not to use honoraria to convince people to participate because this practice does not reflect the value of voluntary participation (discussed below).

It is also useful to consider having any proposed evaluation project reviewed by an internal ethics committee. Committee members are familiar with the federal Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of

Canada, & Social Sciences and Humanities Research Council of Canada, 2014). An ethics review is not technically required for evaluation research under TCPS2 rules, but it is recommended to help identify unintended ethical issues (we all miss things), as well as to give outside people with research experience a chance to consider the research design and provide input.

INFORMED CONSENT

Research participants have the right to understand exactly what the research involves before agreeing to participate. The process of obtaining informed consent may include giving participants the opportunity to ask questions and get answers. Best practice around informed consent involves giving participants an information sheet that details the research. It should describe the method (interview, focus group, etc.), estimated time required, and risks associated with the research, and explain confidentiality and how personal information will be stored and shared. The evaluator should go through the sheet with the person to address potential literacy issues. Typically, both sign the sheet to indicate the content has been discussed and the participant freely agrees to participate.

VOLUNTARY PARTICIPATION

Participation in research should be voluntary: participants join of their own volition, without any feeling of pressure or coercion. This is a particular concern in evaluation research because participants may feel pressured to participate as a condition of receiving services or as a condition of their employment. Key to the informed consent process is clearly notifying participants that they are under no pressure to participate and that there will be no consequences for not participating. Voluntary involvement also means participants can choose not to answer questions and can withdraw their information from the evaluation even after the information has been collected (usually up until the point when analysis has started).

CONFIDENTIALITY

Participant information should be kept confidential to the fullest extent possible. This means striving to make participant involvement and information anonymous. Anonymous data means that even the researcher does not know who provided a particular response and that no identifying information (like names or birthdates) is collected at any point in the data collection process. This type of research is really only possible through anonymous, self-completed surveys and comment boxes. When the research cannot be anonymous, every effort should be made to keep the information as confidential as possible. In the case of pre-test/post-test surveys, this involves collecting the least amount of information needed to match the two surveys (e.g., initials and day of birth) and storing that information separate from the surveys. This can be accomplished by recording the ID number and the identifying information in a separate password-protected Excel document. A person's survey booklet is then identified with only their ID number. This same ID number is used for the second survey, allowing the evaluators to match the survey booklets.

DATA ANALYSIS

The final step after collecting evaluation data is analyzing the data. When conducting interviews and focus groups, transcripts are best, but detailed notes can also work. The goal of analyzing qualitative information like focus groups, interviews, case studies, and comment boxes is to carefully read through the information and identify themes and trends. It is useful at this stage to reflect on the broad research questions that were established at the beginning of the process and to organize the themes according to those questions. During data analysis, it is important for researchers to be open and self-reflexive to their biases to ensure they are not simply picking out themes that confirm their own understanding and interpretation of things. The goal of qualitative analysis is to really respect and honour the perspective of the interviewees. A helpful strategy for remaining open and self-aware is to pay particular attention to quotes from participants that contradict expectations.

Analyzing the results of quantitative surveys has its own challenges. It may require specialized statistical knowledge about how to assess the relationship between questions or variables. For example, the average score on a set of questions measuring life satisfaction increases by five points from the pre-test to the post-test. Without conducting additional

analyses, it is impossible to know whether this is a real statistical difference or whether a five-point difference is something that could easily happen by chance. It is best to get the help of someone with data analysis experience or to learn how to conduct basic statistical tests before drawing conclusions from the results of a survey. Common techniques to consider include descriptive statistics, which look at characteristics such as the distribution of data (histograms, frequency tables), the central tendency (mean, mode, median), and the dispersion of the data (standard deviation). Analysis can also involve using inferential statistics by analyzing cross-tabulation tables using chi-square tests, correlations using Pearson's r, and paired sample t-tests.

RESOURCES

Canadian Evaluation Society
evaluationcanada.ca

European Monitoring Centre for Drugs and Drug Addiction best practice tools
www.emcdda.europa.eu/themes/best-practice/tools

European Monitoring Centre for Drugs and Drug Addiction evaluation instruments bank
www.emcdda.europa.eu/eib?LanguageISO=EN

Evaluation handbook (W. K. Kellogg Foundation, 2010)
www.wkkf.org/resource-directory/resource/2010/w-k-kellogg-foundation-evaluation-handbook

Program evaluation reference and resource guide (Ontario Treasury Board, 2007)
otf.ca/sites/default/files/274278.pdf

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ABOUT THE AUTHOR

Tyler Frederick, PhD, is a sociologist and an assistant professor at the University of Ontario Institute of Technology. He is a community-based researcher with a focus on marginalized young people. His research focuses on how young people navigate homelessness and how this process shapes their mental health, identity, and well-being.

AFTERWORD

A YOUTH PERSPECTIVE

Being homeless is stressful. It's 24 hours a day. Even if you experience a good week or month, there is always an underlying and pervasive feeling of instability, that everything around you is temporary. Despite the positive things you experience, there is still a strong fear that you will lose everything you have gained or relapse into homelessness. As a young person who has experienced homelessness and a transition back to housing, I have found that homelessness had a large impact on my mental health. I have learned, from myself and others, that the experience of homelessness can easily trigger previous or new mental health symptoms. For example, feelings of loneliness, isolation, and a general lack of family and community support often lead to an overall sense of hopelessness or depression. This depression can then translate into substance use or risky behaviours as youth seek comfort through harmful coping strategies because they lack healthier or more adaptive options. These risky coping measures can then lead to even greater or longer lasting mental health challenges and harm. This is why support for young people who are homeless is essential.

In my own experience, the most helpful services have come from dependable and flexible outreach workers, as well as highly trained and accessible mental health professionals. Outreach workers have been a lifeline for me. They created the feeling that somebody was actively helping me because they would come to wherever it was I needed them to be. Trustworthy, dependable and flexible service was key. However, access to these services is not very easy; wait lists are often over a year long or require specific referrals from physicians to which youth may not have access. These are barriers for youth who live on the street and who are forced to remain homeless longer because services are lacking or because they don't know how to get connected to a professional. Unfortunately, many youth who are homeless experience serious mental health challenges and require intervention, but cannot easily access highly qualified and trained mental health professionals such as psychologists and psychiatrists. I feel that this access is an investment in the well-being of youth that helps prevent further escalation of already stressful experiences.

I had the opportunity to enroll in an integrated program called HOP-C that linked me with a supportive team that stayed connected with me and with each other. I had access to high-quality mental health care, an outreach worker, and peer mentorship in the community. This included the opportunity to attend fun community events. These events helped me and others in the program see past our current circumstances and have fun and let loose. They reminded me that there is more to life than my current situation and that I had the capacity to be happy.

My own improved mental health has increased my capacity for life and my ability to work toward a better future. It enables me to put actions to my words. This change started with attending appointments and making efforts to maintain a healthy balance, and then led to working toward education and employment goals. Improved mental health has shifted my perspective on life: I feel hope, that I can achieve things. The focus of my life is no longer on mere survival, but on seeing and experiencing what life has to offer.

I support resources that assist workers and systems in better addressing the mental health and addiction challenges of youth. These supports help youth who need extra assistance, due to their histories and difficult experiences, to realize their potential and see a better future for themselves. Service providers who have solid training in mental health and addiction make us feel more secure and supported, and help ease the burden of homelessness. For me, they made getting through life just a little bit easier. They instilled hope and reminded me that there is life after homelessness. The best workers were constant sources of motivation, encouraging me to not give up on my life goals. All youth deserve this.

M.H.

ABOUT THE EDITORS

Sean Kidd, PhD, CPRP, is a senior scientist and division chief of psychology at the Centre for Addiction and Mental Health in Toronto. He is also an associate professor in the Department of Psychiatry at the University of Toronto. His career has focused on marginality and service enhancement, specifically among youth experiencing homelessness and people with severe mental illness. He has published landmark papers in qualitative methods in psychology, and is internationally recognized for his research on youth homelessness, including being one of the most published scholars in that area. He has done extensive work in developing and testing psychiatric rehabilitation interventions and in examining social inclusion among marginalized populations.

Natasha Slesnick, PhD, is a licensed clinical psychologist. At Ohio State University, she is associate dean of Research and Administration in the College of Education and Human Ecology, and a professor of couple and family therapy, human development, and family science. Her research focuses on youth and families experiencing homelessness, specifically on developing and evaluating interventions for substance use, HIV risk, mental health, and housing. She has evaluated and refined an ecologically based family systems intervention for shelter-recruited adolescents who have run from home, and for their families. She has also modified and tested individually focused interventions for street-recruited youth and young mothers with children in their care. Dr. Slesnick launched two drop-in centres for youth who are homeless: one in Albuquerque, New Mexico, and another in Columbus, Ohio.

Tyler Frederick, PhD, is a sociologist and an assistant professor at the University of Ontario Institute of Technology in Oshawa. He is a community-based researcher with a focus on marginalized young people. His research focuses on how young people navigate homelessness and how this process shapes their mental health, identity, and well-being.

Jeff Karabanow, PhD, RSW, is a professor of social work at Dalhousie University in Halifax, Nova Scotia. His research focuses on housing stability, service delivery systems, street health, and homeless youth culture. He has completed a documentary about the plight of street youth in Guatemala City and several animated shorts on Canadian street youth culture. Dr. Karabanow is one of the founding members of Halifax's Out of the Cold Emergency Shelter and is co-director of the Dalhousie School of Social Work Community Clinic.

Stephen Gaetz, CM, is a professor in the Faculty of Education at York University in Toronto, and director of the Canadian Observatory on Homelessness/Homeless Hub. His program of research has been defined by his desire to "make research matter" by conducting rigorous scholarly research that contributes to our knowledge base on homelessness, and that at the same time can be mobilized to have a bigger impact on policy, practice, and public opinion. Dr. Gaetz has pioneered efforts to bring together researchers, practitioners, policy makers, and people with lived experience of homelessness to participate in community-engaged scholarship and knowledge creation designed to contribute to solutions to homelessness. As director of the Canadian Observatory on Homelessness, one of his key projects is the Homeless Hub, an innovative web-based research library internationally recognized as a leading example of innovation in knowledge mobilization.
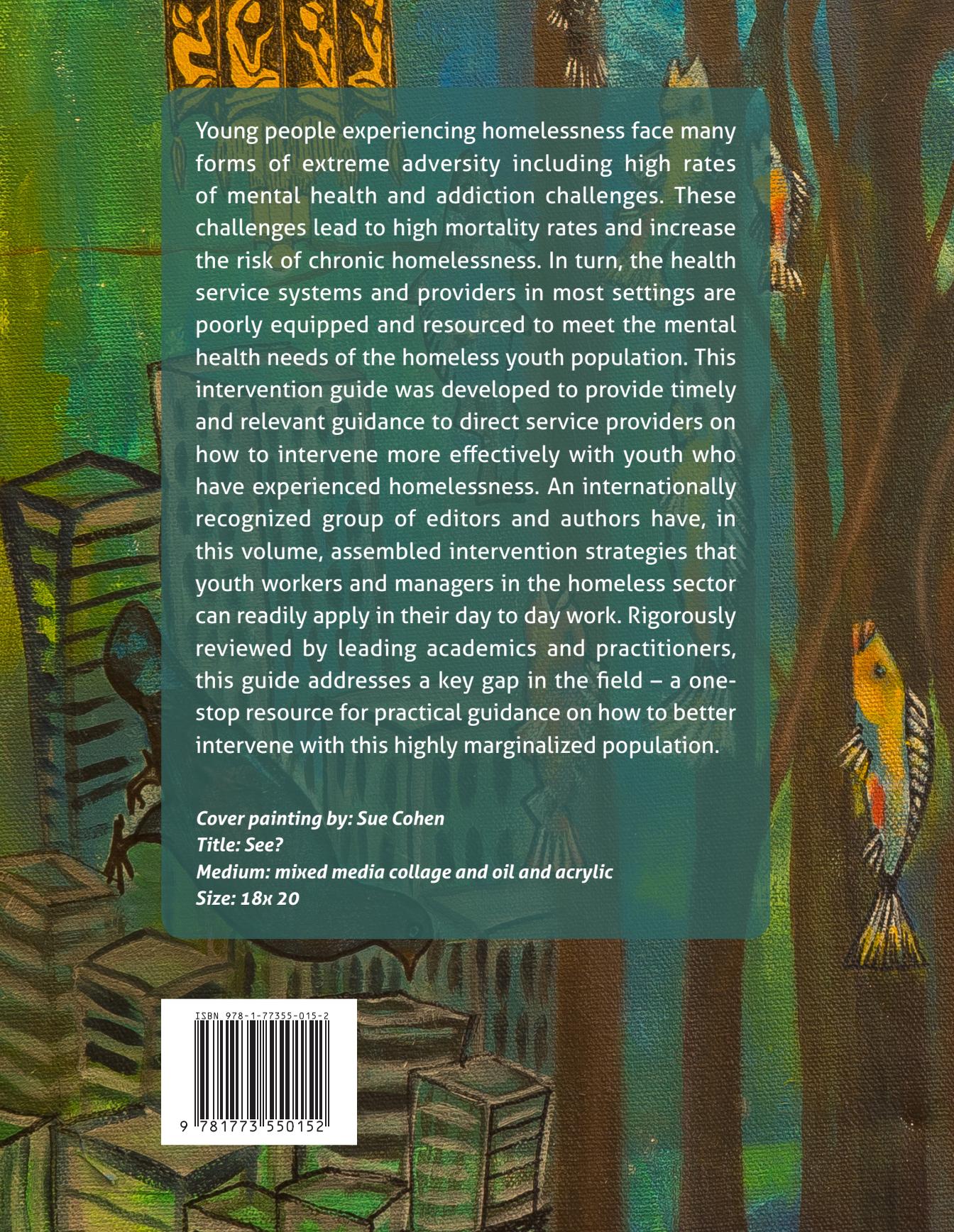
Young people experiencing homelessness face many forms of extreme adversity including high rates of mental health and addiction challenges. These challenges lead to high mortality rates and increase the risk of chronic homelessness. In turn, the health service systems and providers in most settings are poorly equipped and resourced to meet the mental health needs of the homeless youth population. This intervention guide was developed to provide timely and relevant guidance to direct service providers on how to intervene more effectively with youth who have experienced homelessness. An internationally recognized group of editors and authors have, in this volume, assembled intervention strategies that youth workers and managers in the homeless sector can readily apply in their day to day work. Rigorously reviewed by leading academics and practitioners, this guide addresses a key gap in the field – a one-stop resource for practical guidance on how to better intervene with this highly marginalized population.

Cover painting by: Sue Cohen
Title: See?
Medium: mixed media collage and oil and acrylic
Size: 18x 20