Intersection of homelessness and mental health: A mixed methods study of young adults who accessed psychiatric emergency services

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ABSTRACT
Young adults who experience homelessness have high rates of mental disorders, yet low rates of outpatient mental health service use. This mixed methods study examined the intersection of homelessness and mental health in a sample of 54 young adults (ages 18–25) who were hospitalized on a short-term, inpatient psychiatric unit. Nearly half (n = 26) reported being homeless in the prior year and more than a quarter were homeless at the time of admission (n = 15). Qualitative analyses identified key factors that contributed to both mental health problems and homelessness including disrupted support networks, fragile family relationships, foster care involvement, substance use and traumatic events. Homelessness was both a facilitator and a barrier to successfully accessing mental health services to manage mental health symptoms. Findings highlight the interconnection of homelessness and mental health and their common relationship with additional underlying risk factors. Providers across service settings need to recognize the overlap of client populations and provide integrated, trauma informed care to address housing instability, mental health, and substance use together.

1. Introduction

According to the 2016 Annual Homeless Assessment Report, over 30,000 unaccompanied homeless young adults (ages 18 to 24) were identified across the United States in the annual Point-in-Time Count in January 2016 (U.S. Department of Housing and Urban Development, 2016). Prior studies have found that over two thirds of homeless youth and young adults meet criteria for a mental disorder (Cauce et al., 2000; Hodgson, Shelton, & van den Bree, 2013). In a study conducted in Washington State, Cauce et al. (2000) found that two thirds of their sample of homeless youth (ages 13–21; n = 362) met criteria for at least one of six disorders based on DSM-IIIR criteria. Whitbeck et al. (2004) found even higher rates in their study of homeless youth ages 16–19 across eight Midwestern States, where 89% of youth met criteria for one of five mental disorders in the previous year and 67% met criteria for two or more (Whitbeck et al., 2004). In both of these studies, behavioral disorders, including conduct disorder and oppositional defiant disorder, were present in over 50% of the sample, while mood disorders such as major depression and mania were identified in over 20% (Cauce et al., 2000; Whitbeck et al., 2004).

The high rates of psychiatric diagnoses found in homeless youth are influenced by the elevated prevalence of these problems prior to becoming homeless (Craig & Hodson, 1998; Martijn & Sharpe, 2006) and an increase in diagnosable mental health problems associated with becoming homeless (Bender, Ferguson, Thompson, & Langenderfer, 2014; Thompson, Bender, Windsor, Cook, & Williams, 2010; Whitbeck, Hoyt, Johnson, & Chen, 2007). In a study of 161 homeless youth that accessed homeless services in London, Craig and Hodson (1998) found that 70% with diagnosable mental disorders reported onset of these...
disorders prior to homelessness. Another study that explicitly explored pathways to homelessness found that psychological problems (defined as diagnoses of PTSD, Major Depression or Psychotic Symptoms) were a significant contributor to both pathways into homelessness and problem trajectories after homelessness (Martijn & Sharpe, 2006). The authors used qualitative data and a diagnostic interview with 35 young people in Australia to understand the circumstances that led to homelessness and then how problems progressed after homelessness. They identified five different pathways to homelessness composed of family problems, trauma, substance use and psychological problems. Psychological problems played a role in four of the five pathways into homelessness that were identified. After homelessness, several trajectories included psychological problems - one where previously identified psychological problems increased in severity following homeless and another where psychological problems emerged for the first time after the onset of homelessness (Martijn & Sharpe, 2006).

Another critical aspect of understanding mental disorders among homeless youth is the presence of trauma, both before and after homelessness. One study of nearly 400 youth ages 13–24 in Los Angeles found that prior to homelessness, 71% of had come from adverse home environments characterized by domestic violence or substance use, 51% had experienced physical abuse and 33% had experienced sexual abuse (Wong, Clark, & Marlotte, 2016). In their study of homeless youth in London, Craig and Hodson (1998) found that 69% had experienced an adverse childhood event. In the LA study, most had experienced multiple traumatic events with a mean of 3.8 out of 10 traumatic events prior to becoming homeless (Wong et al., 2016). These experiences were directly related to psychological problems assessed in the study including PTSD, depression, and self-injury with sexual trauma and cumulative trauma exposures having particularly significant effects (Wong et al., 2016). In addition, trauma exposure continues once young people become homeless. Studies have found that up to 83% of homeless adolescents on the streets were physically or sexually victimized after becoming homeless (Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004) and many also witness traumatic events (Bender et al., 2014). In an analysis of three latent victimization classes identified based on victimization after becoming homeless, Bender et al. (2014) found that those with high victimization as well as those that had witnessed traumatic events had elevated risk for PTSD and major depressive disorder compared to those with low victimization experiences. Length of time on the streets has also been associated with mental health problems, with those who remain on the streets longer at increased risk for psychological problems (Solorio, Milburn, Andersen, Trifskin, & Rodriguez, 2006), possibly due to the victimization experienced while homeless. The Martijn and Sharpe (2006) study specifically examined the role of trauma and its relationship to psychological problems in pathways to homelessness and identified a specific group representing 25% of the sample in which a traumatic event had preceded a mental health diagnosis of PTSD or Major Depression or both.

1.2. Mental health service use and homelessness

Although mental health need is high among homeless youth, many go without mental health treatment (Hodgson et al., 2014; Hughes et al., 2010). Young adults overall, have low rates of utilization of outpatient treatments, with only 32% of those with a diagnosable mental illness receiving treatment in the past year as measured in the National Survey of Drug Use and Health (Center for Behavioral Health Statistics and Quality, 2016). Research specifically examining the rates of mental health treatment among homeless youth is limited, however, it appears that rates of mental health service utilization among homeless youth are similarly low. One study of 90 young people in the UK found that while 88% met criteria for a current mental disorder, only a third of those had used outpatient mental health services at follow-up eight to 12 months later while 24% had been to an emergency department (Hodgson et al., 2014). Another study of 688 youth in Los Angeles found that 32% of youth had used a mental health service. Among those that did not receive treatment, the most commonly identified barrier was not knowing where to go or how to access treatment (Solorio, Milburn, Andersen, Trifskin, & Rodriguez, 2006). Barriers that prevent homeless youth from using health services have also been identified in several qualitative studies. Three different studies using focus groups in Los Angeles (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008), Santa Monica (Hudson et al., 2010), and Ontario (Kozloff et al., 2013) to explore barriers and facilitators to using health care services generally among homeless youth identified structural barriers, such as costs and wait lists, as well as, personal barriers, such as stigma and fear of discrimination. Christiani et al. (2008) also specifically explored barriers to substance use treatment and found that young people articulated clear connections between mental health, homelessness and using substances to manage. This served as a disincentive for seeking treatment since substance use was perceived as helpful for surviving on the streets and managing mental illness (Christiani et al., 2008).

1.3. Young adulthood

Examining the connection between mental health and homelessness in young adulthood is important since it is a developmental period where the incidence of mental disorders peaks (Kessler et al., 2007), yet the use of mental health services is lowest (Pottick et al., 2008). Young adults are less likely than older age groups to seek treatment and more likely to attempt to manage mental health challenges on their own (Center for Behavioral Health Statistics and Quality, 2015). This likely reflects the fact that for some young people, these disorders are newly emerging, so they are learning to understand and manage them for the first time. Even for those that have received a diagnosis and treatment prior to the transition to adulthood, however, this developmental period is a time in the life course where they are exploring and trying out roles (Arnett, 2006) and tend to resist incorporating mental illness as part of their identity (Biddle, Donovan, Sharp, & Gunnell, 2007). They are also hesitant to identify as homeless and often stay in doubled up situations also known as “couch-surfing” where they are not connected with supportive services (Santa Maria, Narendorf, Bezette-Flores, & Ha, 2015). When they do seek help, it is generally through homeless systems that are designed with the needs of older groups of adults in mind. Research conducted through a housing first program for those with serious mental illness found that young adults differed from older adults in important ways (Kozloff et al., 2016). The young adults had higher rates of substance use disorders, higher rates of recent assaults and lower rates of connection to regular sources of medical care. And notably, 61% of the youth in their sample had used the emergency department in the past six months (Kozloff et al., 2016). Better understanding the experiences of young adults with serious mental illness who have experienced homelessness can provide information to assist both mental health service providers and homeless service providers to better meet the needs of this vulnerable group.

1.4. The current study

While prior research has documented a strong connection between mental disorders and homelessness, this body of research has primarily come from samples recruited from homeless specific settings rather than within a sample recruited in a psychiatric setting. The current study aims to fill this gap by examining homelessness within a broader population of young adults that had recently experienced a psychiatric crisis and received a diagnosis of a serious mental illness that resulted in short term inpatient hospitalization. Examining the narratives of young people that had experienced homelessness and a psychiatric crisis provides an opportunity to understand the factors that led to these situations and to further examine the relationship between the two. The study focused first on examining differences among the overall sample…
of young people interviewed at the psychiatric crisis unit, comparing those who had experienced recent homelessness to those with more stable housing situations. Then, the qualitative narratives of the subgroup that had experienced homelessness were examined to answer three specific research questions: How did they become homeless and did psychiatric symptoms play a role? How do episodes of homelessness contribute to psychiatric symptoms? What is the relationship between homelessness and mental health service use?

2. Methods

Data in this study are from a larger mixed-methods research project that explored the service histories and experiences of young adults who sought psychiatric crisis services (N = 54). The study setting was a public, voluntary, short-term crisis stabilization unit for uninsured patients connected to a large public psychiatric emergency center that was located in an urban area of the Southwest United States. From June 2013–April 2014, young adults were screened for inclusion criteria by the unit psychiatrist at the time of admission and referred for participation in the study. Young adults ages 18–25 with a qualifying diagnosis of a serious mental illness that made them eligible for publicly funded outpatient services – major depression, bipolar disorder, or a psychotic disorder – were eligible to participate in the study if the psychiatrist determined that they were stable enough to provide informed consent. Data gathered on diagnosis in the study only focused on whether respondents met one of these three diagnostic categories and was then classified as a priority population for public outpatient care. Many participants had symptoms that indicated likely comorbidity beyond these categories including ADHD, PTSD, and substance use disorders, however, these were not measured in this study. Participants that met eligibility criteria were interviewed by this author or one of three trained doctoral students, first with a structured survey instrument to gather quantitative data, then using a semi-structured interview with open ended questions to gather qualitative data. The structured interview contained questions on demographics, foster care and juvenile justice history, history of arrest, living situation and detailed questions about prior mental health service use based on the Service Assessment for Children and Adolescents (Stiffman et al., 2000). Substance use questions were based on items from the Monitoring the Future study (Johnston, O’Malley, Bachman, Schulenberg, & Miech, 2015). The qualitative semi-structured interview included open-ended questions examining how the participant came to use crisis services, their understanding of their problems and symptoms, experiences throughout their lives with mental health symptoms and services, social support, and future plans. In this interview, young people talked about their own perceptions of mental health symptoms which were not always specifically related to the identified qualifying diagnosis or to any specific diagnosis at all.

The current study was designed to further explore homelessness among this sample, a prevalent experience that organically emerged as critical in the narratives of a subgroup of participants. Homelessness within the past year was determined by self-report in the structured interview. If the participant reported that they were currently living in a shelter or on the streets, we coded them as homeless. In addition, if the young person answered affirmatively to the question “Have you been homeless in the last 12 months?”, we also considered them to have had a recent experience of homelessness. Based on these criteria, almost half of the overall sample met criteria for recent homelessness (n = 26). We descriptively examined the characteristics of young people who reported experiencing homelessness in the prior year (n = 26) in comparison to those with stable housing (n = 28) to better understand the demographic composition of this subgroup. Chi-square tests were used to examine significant differences between the two groups. Then, qualitative data from the subgroup who had experienced homelessness in the prior year (n = 26) were analyzed with the aim of better understanding the relationship between homeless experiences and psychiatric symptoms. Differences identified in the quantitative analyses were used as sensitizing concepts (Padgett, 2008) which gave the analysis team a construct to be aware of as they read the data. For example, system involvement was significantly higher in those with experiences of homelessness, so the analyst paid specific attention to respondents’ descriptions of interactions with public systems such as foster care and juvenile justice and their potential relationship to homelessness as she read the qualitative interviews.

Qualitative analysis was conducted using an approach informed by grounded theory methods (Corbin & Strauss, 2008) that inductively identified themes across the data and relationships among them. The goal of the analysis was not to generate a theory, so this was not a grounded theory study, but it drew on the inductively driven methods articulated in grounded theory in the analytic approach. Each interview was analyzed with the specific aim of understanding the role of homelessness or housing instability in the broader narratives of mental health symptoms (current and past) and mental health service use. We operationalized homelessness experiences broadly to capture indicators of housing instability such as a parent kicking a child out or a description of loss of housing due to inability to pay the rent. Whether the young person ended up on the streets as a result of these types of experiences, they were viewed as critical to understanding the situations that result in literal homelessness. Codes were assigned to any passages that related to homelessness or housing instability, using the words of the young person to capture the essential meaning whenever possible. After coding 10 interviews, these codes were reviewed and grouped under emerging axial codes. The author used memos to reflect on the overall story of each interview and emerging themes across the interviews and developed diagrams to illustrate the relationships emerging between different codes. A constant comparative approach was used as the remainder of the interviews were coded, noting narratives that presented different aspects of the emerging stories and refining the specific relationships among themes.

3. Results

Details of the sample and the differences between youth that were recently homeless compared to those who were not are presented in Table 1. The sample overall was racially diverse (28% African American, 20% Bi-racial, 26% White, 20% Hispanic and 6% other) and just under half were female (44%, n = 24). Nearly half of the sample (47%, n = 26) indicated that they had been homeless in the past year and 27%, (n = 15) were currently homeless. Participants who reported current or recent homelessness were more likely to be male and to report histories of arrest and involvement in foster care and the juvenile justice system than participants without recent homelessness (see Table 1). While they were no more likely to have used outpatient services than other participants, those who reported current or recent homelessness were more likely to report a history of psychiatric medication use and prior use of inpatient mental health services. Rates of substance use were high for all young adults across the sample and while current or recently homeless participants reported higher rates of marijuana and other substance use, differences were not statistically significant. But, current or recently homeless participants had significantly higher rates of problem drinking with 46% reporting a drinking binge lasting two days or legal trouble due to drinking in the past year.

These differences observed between youth with current or recent homelessness and those without recent homelessness provided guidance for both contextualizing the qualitative findings and as sensitizing concepts in qualitatively analyzing how mental health and homelessness interact among young adults seeking emergency psychiatric care. The qualitative examination of homelessness among the subsample of youth allowed for posing analytic questions that capture the processes of “how” and “why” mental health problems and homelessness occur among certain youth. In the following section, we
address each of the qualitative research questions, first describing historical factors that led to homelessness (research question 1), then exploring the interactive relationship between homelessness and mental health (research question 2), and finally examining the relationship between homelessness and mental health service use (research question 3).

3.1. Becoming homeless

Participants talked about housing instability in ways that illustrated the conditions that led to their homelessness and the role of mental health symptoms in these events. Disrupted support networks, combined with challenging behaviors and fragile family systems, contributed directly to housing instability and homelessness. In addition, the foster care system emerged as a significant contributor to both homelessness and mental health. Substance use was also a prominent feature that contributed to fragile family relationships and exacerbated mental health symptoms.

3.1.1. Challenging behaviors and disrupted social support networks

At the heart of housing instability and homelessness for many young adults were disrupted social support networks. In descriptions of incidents that precipitated homelessness, participants frequently reported getting “kicked out” by families or friends. The incidents that prompted being “kicked out,” however, were often described in conjunction with extreme behavior on the part of the participant, something they readily acknowledged. This behavior generally involved substance use and impulsive behaviors, which were sometimes tied specifically to a diagnosis or stopping medications but other times just as a desire to be independent. One participant described how she ended up on the streets: “One night I decided I just wanted to have sex, drink and do drugs, and be me and I did that and when I came back all my stuff was on the porch.” Another participant described going off of his medications and then “acting up,” which led to getting kicked out of a foster home at age 17. When asked to describe this, he specified: “Acting up, once again, setting fires, getting in fights, punching holes in the wall when I get mad, stuff like that.”

For some participants, the stories included a series of moves, going through temporary arrangements with friends and family until all options were exhausted. One young man described having to leave a living situation with an uncle due to his drinking, then moving in with a friend: “And I lived with my friend for a while, and I was drinking a lot and um, (friend) just had two kids and his wife didn’t even know me, ... like after that I didn’t really have, I burned all my bridges, you know.”

3.1.2. Fragile family relationships

While the behaviors of young people were clearly difficult for families, the context of their stories illustrated that these behaviors were often occurring within a fragile family context. A number of participants described having moved to reunify with family members that they had not lived with in a long time. Others described parents who struggled with their own problems such as substance use and mental illness. Some participants had spent extended time in public systems, living in foster homes or placed out of home through the juvenile justice system so they had no shared history of working through challenges with their families. One young man had spent his entire life in foster care but had re-established relationships with his biological family through Facebook. After he aged out, he moved across the country to live with a father he did not know. He reflected on this decision:

“I decided to move down here...and I think my decision was based on a dream I had....and my Dad tried to warn me, my whole family tried to warn me— "what are you gonna do if you get put out on the streets...?" We don’t want that for you ...and I didn’t listen to them and now actually I’m in a situation where I am homeless.”

Another young person described his living situation after being discharged from drug rehabilitation at age 16. His descriptions suggest that there were foundational difficulties not just in his own relationships with family but in other family relationships as well:

“from [Drug rehab] I went back to the house, to my mother’s house, and got kicked out and went to go stay with my grandfather for a little while. Me and my grandfather, we got along just fine, but he was getting up in age and then it got to the point where he couldn’t have too much going on around him, so I had to come back to my mom’s house. Well, there, my mother and my step-father got into an argument, broke up and we went to stay with some friends of hers ...”

3.1.3. Role of foster care system

Woven into their narratives of recognizing mental health symptoms and seeking treatment were stories of trauma and homelessness...
experienced during childhood that led to involvement in foster care. These stories illustrated that homelessness was a part of the history that led to involvement with the foster care system as well as a current concern in young adulthood. One young woman who had come to the psychiatric crisis unit from a homeless shelter, told a story of homelessness and abandonment as she explained how she came into the foster care system:

“When I turned 13, my mom really just stopped caring about us, she stopped doing cleaning house, she stopped doing pretty much everything to be a mom, she stopped caring, she would act like she was our friend, my mom would drink with us and she would smoke with us…but then when I was 13 she sold the car, and she got really drunk and she took me and my little brothers and sisters to the park and she said she was going to leave and go get some sodas and come right back …so I stayed there by myself with my little brother and my two little sisters, until like 12 o'clock at night and she never came back, so I put them in the stroller and I walked back to the abandoned house that we were staying at, and um, I did that for about 2 months back and forth to the park waiting for my mom to come back, but she never came back…”

This young woman then entered foster care but the system was not able to achieve a stable or permanent placement for her. She eventually left foster care to move into a housing situation with an older man that turned abusive and provided little support. Through reconnecting with her sister after leaving foster care, she got support to leave the relationship and find housing at the young adult homeless shelter where she exhibited suicidal ideation. The shelter then facilitated her hospitalization.

Another young man described how he came into foster care:

“I was 7, when I first went into foster care …cuz they found out that we was living in a stolen van, we didn’t have no food, we didn’t have no shelter, we didn’t have clean clothes or anything, that my parents had to beg for food, and they noticed that my little brother had asthma really bad and he couldn’t breathe when my dad was smoking around him and my dad would never stop smoking around him …”

Unfortunately, systems rarely figured as sources of stability in these narratives but instead contributed to homeless situations in young adulthood either by directly discharging young people to shelters or the streets or by discharging to unstable situations. After spending years moving from placement to placement, including several residential treatment centers, the young man quoted above described how he left the foster care system:

“The foster home dropped my stuff off at the church that I go to on Wednesday nights, and it was a Wednesday night whenever they bought me a hotel room and then they bought me a bus ticket for the next day, and then I got on that, they took me to the bus station, I got on the bus and then I left.”

These stories illustrate that entry into the foster care system was sometimes associated with homelessness which involvement in the system was intended to address. However, at the time of exit out of the system, young people left without stable housing. These housing situations then contributed to mental health symptoms, which eventually led them to use the psychiatric crisis unit.

### 3.2. Homelessness and mental health

While mental health problems contributed to the causes of homelessness, homelessness also contributed to mental health problems. This was talked about directly by some youth but also in relation to shared relationships with substance use and with other adverse events.

#### 3.2.1. Homelessness as cause or contributor

Some participants explicitly described how homelessness itself either led to mental health problems or exacerbated pre-existing symptoms. One young woman described how her symptoms have gotten worse due to her housing situation; “now I live really don’t have anywhere to stay, um, I’m more unstable mentally than I was. …like suicide’s a real option now, and it wasn’t before.”

And, some directly linked the onset of serious mental health struggles with homelessness. One young man who described an onset of mental health problems in young adulthood, attributed his symptoms directly to his homeless situation: “The first time I realized that I was having the symptoms was, I say, about two or three years back when I first got homeless, and I first was like, oh, man, I’m homeless, how is this happening? I’m out in the cold. And the burden hit me hard, like, man it took all the breath from me when that happened, it just, my chest got real heavy, my mind started racing and wandering trying to figure out, man, what I’m going to do...”.

#### 3.2.2. Homelessness, substance use and mental health

A prominent feature that appeared in multiple aspects of the narratives of homeless youth was substance use. Substance use was described as a contributing factor to both homelessness and mental health problems. Substance use fueled family conflict and led to participants being kicked out and it also increased financial problems that led to homelessness. One participant described his struggles: “when I was having my own apartment, I had a job, and I was doing my drugs and I just kept on spending my money on my drugs so I couldn’t pay the rent and couldn’t pay the bills”. It was also seen by some participants as exacerbating mental health problems. One young woman identified that the reason she was seeking psychiatric treatment was to be free of substances “You have to spend a bunch of money on it (drugs), it creates a bunch of problems with your family, you end up having more stress, more anxiety, um it brings upon a whole bunch of different psychiatric problems, people go nuts on it, um, it causes you to lose everything you’ve ever had...”.

Using substances as a way of managing mental health problems instead of medications was common among participants and linked to homelessness in a few ways. Sometimes, young people directly connected stopping their medications and starting substances as a reason for homelessness. One young woman explained: “I stopped taking my medications, I started drinking again, and my sister kicked me out.” In other cases, homelessness made it hard to keep up with prescriptions and illegal drugs were a readily available alternative for managing mental health symptoms. One participant described how he seeks drugs on the streets: “I just go out there and find them, find something to, not even match my (psychiatric) drugs, something that like would help, help me out. But right now what I’ve been doing, like I haven’t been having my medicine so I’ve been taking Xanax, that’s the pills I’ve been taking like just to get through, just to have something in my system to have me low and calm.”

#### 3.2.3. Homelessness, traumatic experiences, and mental health

A number of participants talked about the intersection of homelessness and other types of adversity that then contributed to mental health problems. Examples of adversity across the sample included legal involvement, domestic violence, abuse on the streets, having children taken away by the child welfare system and testing positive for HIV. In some cases, homelessness, was part of a series of events that included traumatic experiences and mental health problems. When asked how she had come to use the emergency services, one young woman described her current symptoms in relation to past trauma that included housing instability: “I wanted to commit suicide, um, cuz of my past, I’ve been molested, I’ve been beaten, I’ve been, had a gun to my head from my mother, my sisters and brothers helped beat me, I ran away from home and now I’m dealing with family issues.”

Another young woman described how homelessness directly led to
victimization, which contributed to current mental health problems:

“I used to live on the streets, my momma used to stay in the old apartment, I ran out the house, middle of the night, didn’t know where to I was going. I had met a pal on the streets, in a cold wet day, that’s when it happened. Got raped and everything, gun pointed to my head, and it’s hurtful.”

Another young man’s story illustrated the connections between adversity, homelessness and mental health. He first described how homelessness had led to survival sex, which eventually led to legal involvement. While in jail, he learned he was HIV positive:

“The second day of being in the jail cell, nurse calls me to her office, and tells me that I’m HIV positive because she gave me an HIV test, like a swab, and she tells me that I’m HIV positive and my whole world just shattered, I didn’t know what to think, I just know that I started bawling... I was already going through a lot of stress and emotional torture and then I had to deal with the fact that I’m, not only am I homeless but I’m HIV positive now, who wants to go through that?”

3.3. Homelessness and mental health services

Homelessness also intersected with the process of seeking help for mental health problems in ways that were described both positively and negatively. In some descriptions, homelessness was a facilitator for mental health service use, particularly the connection to their current hospitalization. In other cases, homelessness was described as a barrier since it was a situation where they had to prioritize survival over less emergent concerns like seeking medications or therapy.

3.3.1. Homelessness as a facilitator to mental health service use

As the young people described how they came to use psychiatric crisis services, homelessness and homeless service providers played several different roles. Many of the young people were experiencing homelessness immediately before entering the crisis stabilization unit so they had come to the psychiatric crisis center directly from the streets or from a shelter. Some described how homelessness escalated their symptoms to the point where others intervened to get them connected to psychiatric care. One young man described how he got connected to the crisis stabilization unit by his father who picked him up after he made a suicidal call:

“I was sleeping under Interstate 59, and I woke up cause of the traffic going on and uh, then the construction. And I woke up and then I started walking down the street and I found a knife and I decided that today was going to be the day I was going to take my life.”

Another young person described escalating symptoms and homelessness that contributed to the crisis that led to his admission:

“Just having fatal thoughts of suicide, when I was homeless, living on the streets and uh, my major depression and my paranoia uh, and just you know, I’m always being down...I didn’t have no choice but to go to [Adult Shelter] they didn’t have what I really wanted there, so I left, and, I was walking down the sidewalk where the train goes ... and I jumped in front of the, the tracks”.

Older young people described coming to the psychiatric emergency center after realizing that they needed to seek help and homelessness was described as part of the motivation. A young man who had been sleeping in the park across the street from the hospital described his reasons for seeking treatment: “I just be getting in a lot of trouble. My mind’s been getting’ to where I can’t control it really, like how I want to control it, so I just came here to check in, get myself checked out.”

Another young man described how the situation of homelessness led him to decide to seek help to improve his situation: “I was homeless, and I’d get mad at everybody else, just cuz my life’s pain, plus my struggling and basically, one day I just hopped up and I prayed, and I’m like, I’m tired of this, I want more out of life, ... and I came here and I signed myself in.”

For some young people, getting into the shelter led to a connection with mental health service providers who identified serious symptoms and facilitated a crisis hospitalization. One young person described how the adult homeless shelter helped him get admitted: “the reason that I came is because of the suicidal thoughts, telling you know [adult shelter] that I was suicidal. And they, they held me in the office and called this lady came and picked me up and she dropped me off here.”

On the other hand, mental health symptoms could create a barrier to successfully accessing shelter services that drove the young people to get mental health treatment. One young man described being unable to get help at the shelter due to a mental health diagnosis:

“Basically me being homeless I would try getting to, into [Adult Shelter] and they said they couldn’t accept me, they wouldn’t accept me because of my Bipolar and I needed treatment for my Bipolar. So, as, they wouldn’t accept me in as, if I didn’t have any kind of medication because they didn’t want to take any risks for people who were Bipolar and Schizophrenic and such.”

This eventually led to the young person seeking treatment through the crisis center to both control symptoms and remove barriers to getting housing services.

3.3.2. Homelessness as a barrier to mental health service use

Most young people had prior experiences with mental health services but had not remained successfully connected to services. Homelessness was one factor that contributed to this disconnection. Young people talked about the barriers to accessing the system including both financial and logistical challenges. One participant described the financial barriers for medications: “that’s stupid to expect someone to be able to afford an eight-hundred dollar medication, that might not even be generic. How are they going to afford it if they, if they can’t even afford to eat? You know, I mean that’s crazy.” She went on to describe the challenges of trying to get public funds to help with medical costs: “When I tried to get it (Public Medical Card), it was like they needed an ID. Okay, well what do I need to get an ID? Well you need a voter’s registration card. Okay, how do I get that? Well, you need proof of residence. Okay well if I am homeless, I don’t have a proof of residence, cause I’m living on the streets. Um, all I mean, all the documents that they require is just a catch twenty-two, you can’t have one if you don’t have the other...” The phrase “catch 22” was used by several young people to describe the circular barriers that they encountered in trying to access mental health treatment.

Beyond costs, the process of accessing services was also a barrier. At the time of the interviews, to get non-emergent care, participants had to seek an assessment and then be placed on a wait list where they were responsible to call periodically to check on their status. One young man described navigating this process: “…I don’t think about, uh, (calling to check on mental health waitlist) when I wake up homeless, I think about when am I going to eat, where am I going to sleep. You know, I like, and am I going to be able to shower today?”

3.3.3. Developmental aspects

In addition to the intersection of homelessness and mental health services, we also identified how seeking services was experienced in unique ways in the transitional period from adolescence to adulthood. Across the narratives, young people reflected on what it was like specifically to experience mental health challenges as they were becoming adults and to get help for those challenges. A few participants, particularly those who reported abusive situations at home or foster homes, noted that turning 18 gave them control over their own care and the ability to seek help for themselves. But, others noted that services were
more difficult to access as an adult and that there were more resources for adolescents: “if you’re under eighteen then...like you’re a kid, you know, everybody is more sympathetic for a kid on the street than they are a grown ass man.”

Beyond the process of seeking services, some young people talked more generally about their desire to get help in relation to their status as young adults. Several talked about wanting to address problems now so that they do not end up like older homeless people they have seen in service settings. One young man described his reasons for coming to get help: “I’m right here struggling, you got 100 more people out there homeless, just like me struggling, and they just crazy. I don’t want to be like this my whole life. Them people out there, they been doing this for years, homeless... I’m 22, I don’t want to be 35, 40 years old, in a wheelchair, one leg or with a cane and still in the streets.”

These comments illustrated the specific challenges experienced by young people when housing problems and mental health intersect during the transition to adulthood and the specific factors that motivated them to seek services.

4. Discussion/conclusion

This study explored the intersection of homelessness and mental health symptoms among a group of young people with recent, demonstrated need for mental health services. It is unique in its focus specifically on young people with a recent mental health service seeking experience. Notably, almost half of the participants recruited in this psychiatric crisis setting reported an experience of homelessness within the past year, highlighting the strong associations between intense psychiatric symptoms and housing instability. And, these young people were different from young people without homelessness in significant ways. Our findings revealed important factors that were linked to both mental health and homelessness that are worthy of further discussion – disrupted support networks, foster care, substance use, and trauma. In addition, the role of service systems – both homeless services and mental health services - merits further discussion as young people encountered barriers as well as some facilitators in their attempts to get help. We discuss these findings and provide recommendations for service providers to more effectively support this extremely vulnerable population.

The narratives of our study participants revealed the essential interconnections of disrupted social support networks, exposure to traumatic events, involvement with the foster care system, and substance use. In our quantitative data we found that foster care history, juvenile justice history, and problematic drinking were all significantly higher in the sample of youth that had experienced homelessness compared to those with stable housing. These relationships are in line with findings from prior studies that have examined these factors individually, though, our study provides unique data about how these factors may link together. While we did not have quantitative measures of trauma, the qualitative narratives revealed extensive histories of trauma among the homeless young adults in the sample, often in conjunction with experiences of homelessness. Exposure to traumatic events, both before and after becoming homeless, have been clearly connected to mental health in homeless youth in prior work (Coates & McKenzie-Mohr, 2010; Martijn & Sharpe, 2006). As we saw in the stories of our participants, the circumstances that result in homelessness are often traumatic in and of themselves. We saw evidence of traumatic experiences that led to homelessness as well as trauma that occurred during homeless episodes. And in many cases, youth talked about multiple traumatic events that piled up over time. It is worth highlighting the need to view all homeless youth, but particularly those with psychiatric problems, as people with complex trauma exposure and to ensure that all providers in both the homeless service system and the mental health system are trained to take a trauma-informed approach.

The role of the foster care system in our sample was also notable. The data illustrated how experiences of homelessness led to involvement in the foster care system specifically, then how leaving these systems without solid discharge plans led to homelessness. Prior empirical work has documented high rates of mental health problems (McMillen et al., 2005) and high rates of homelessness (Courtney, Dworsky, Lee, & Raap, 2010) among youth aging out of foster care. In one study that used latent class analysis to group young people after exiting care, Courtney, Hook and Lee (2010) identified a group that aged out of foster care who they described as “Troubled and Troubling.” This group had high rates of homelessness, high rates of substance use and mental health problems, and high rates of criminal justice involvement. The characteristics of this group appear to mirror some of the characteristics of homeless youth in our study and indicate that psychiatric crisis settings may be a point of intervention to connect these troubled and troubling young people with supportive interventions. The narratives of these young people, however, illustrated the challenges to providing appropriate housing supports for this group and underscores the need to have housing supports that are prepared to manage significant behavioral symptoms as well as co-morbid mental health and substance use problems.

The data from our participants highlighted examples where transition planning at the time youth exited foster care had been ineffective. But, we also saw illustrations of some of the barriers to effectively planning for housing stability at the time youth exit the foster care system, particularly for those with psychiatric diagnoses. First, many former foster youth wanted to reconnect with estranged family members and sought out housing situations that were inherently unstable. Open conversations about the desire to reconnect with family prior to system exit and active supports from the foster care system in helping youth safely make connections with family are needed to ensure that youth do not end up becoming homeless after they exit. In addition, some youth described extremely challenging behaviors such as setting fires and assaulting people. It is very difficult to find appropriate housing for youth with these types of behaviors after system exit and they may end up aging out of care without any plan. Foster care systems across the country face significant challenges in keeping younger children safe and the housing needs of those exiting care with significant psychiatric problems may be overlooked. In the stories of young adults who ended up using psychiatric crisis services in young adulthood, we saw one of the negative outcomes associated with the limited supports available to support successful transitions for this challenging group.

Another prominent thread that ran throughout many of the themes identified in this study was substance use. Substance use rates were high across all the youth in the study, not just those who had been homeless, however, indicators of problem drinking, our only measures of functional problems related to substance use, were higher. Prior research has consistently documented high rates of substance abuse and dependence among homeless youth and this has been correlated with mental health problems (Merscham, Leeuwen, & M.J. & McGuire, M., 2009; Narendorf, Cross, Santa Maria, Swank, & Bordinick, 2017). Other research with homeless youth has found experiences of victimization and trauma to be associated with greater odds of substance abuse and dependence (Bender, Brown, Thompson, Ferguson, & Langenderfer, 2015). These findings further support the interrelationships we identified in the narratives of our sample between trauma, substance use, homelessness and mental health. Service settings working with homeless youth who experience serious psychiatric problems need to be prepared to address co-morbid substance use problems and traumatic experiences that potentially contribute to both.

The young people in our sample had all successfully accessed psychiatric crisis services and their stories contained some evidence of homelessness as a facilitator to service use. But, they also provided some evidence of missed opportunities to intervene. While all young people in the sample had a diagnosis of a serious mental illness, identification with their challenges as a mental disorder requiring extended treatment varied across the sample. In some cases, young people
described homelessness as part of a phenomenon of hitting rock bottom where they finally realized it was time to get help. The situation of homelessness and the providers it connected young people with, also assisted them in moving closer toward insight about the need to manage these problems. Seeking homeless services led to connections with providers that screened for mental health problems and connected them with mental health services. Some young people, however, noted barriers to accessing mental health services when they did recognize the need in that managing waiting lists and getting prescriptions filled were simply logistically too challenging when the focus needed to be on day to day survival. These findings highlight the need for homeless service providers to assist young adults in understanding symptoms as a mental health problem and for mental health services to be readily available when a need is identified. Free and easily accessible prescribed pharmaceuticals were clearly needed as well as immediate connection to outpatient services when a non-emergent mental health need was involved. In spite of the clear evidence of overlapping needs, the service systems largely operated separately. The constellation of needs illustrated in this sample supports the need for closer coordination between providers in homeless service and mental health service systems to ensure that all identified needs can be addressed in a comprehensive, coordinated fashion.

5. Limitations

While our study provides new information from a unique sample, it does have some limitations that should be considered. First, the sample came from one service setting that was available to uninsured patients whose symptoms were not acute enough to warrant longer hospitalizations. Thus, the sample may not capture young adults with extremely serious psychotic symptom presentations and will likely not reflect the experiences of young adults with private insurance or more resources for accessing care. The setting was the primary crisis setting for a large urban county, however, so the sample did contain a range of experiences typical of those that access the public mental health system in this large urban area. It should also be noted that the current study is based on findings that emerged organically and were not primary research questions for the original study. Questions about homelessness were not asked directly in the qualitative interview, hence this analysis is not exhaustive of all the experiences of homelessness and may have missed some important experiences. And, our classification of youth as homeless was based on self-report so may exclude some participants who had been couch-surfing or other unstable situations but did not consider themselves to be homeless. Given the nature of these data and analyses, we identified themes but did not report definitively on the nature of their relationships. Further exploration in future work is warranted to better understand specifically how our identified factors interact with one another to produce homelessness and psychiatric crisis.

6. Conclusion

Our findings illustrate the complex relationship between mental health problems and homelessness. We found that disrupted support networks, traumatic experiences, substance use, and system involvement were all contributing factors that need to be considered and addressed in providing care for this group. Interventions should ideally include stable housing along with co-morbid substance abuse and mental health treatments that address the impacts of traumatic experiences. In addition, ongoing supports to assist youth in repairing and building supportive relationships are indicated since this was often at the heart of homeless experiences.

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