



# Meeting the mental health needs of homeless students in schools: A Multi-Tiered System of Support framework



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## ARTICLE INFO

### Article history:

Received 4 June 2014

Received in revised form 12 June 2014

Accepted 16 June 2014

Available online 20 June 2014

### Keywords:

Homelessness

Homeless students

School mental health

Multi-Tiered Systems of Support

## ABSTRACT

The number of homeless youth in the U.S. has reached an all-time high and this represents a growing social problem. Research indicates that homeless youth are significantly at-risk for experiencing a range of negative life-outcomes such as school dropout, the development of mental health problems, use/abuse of illicit substances, suicidality, and even early mortality. Thus, effective interventions and mental health supports are needed to help address their complex mental health needs. Fortunately, however, many homeless youth regularly attend school, especially younger youth (i.e., under 13 years old) and youth who are members of homeless families. Therefore, as important members of school communities, school-based mental health professionals can help support these students. With this aim in mind, this paper discusses the use of a Multi-Tiered System of Support (MTSS) framework to meet the mental health needs of homeless students in schools. More specifically, following a public health service delivery model, service delivery is discussed at universal, selective, and indicated levels. Lastly, to address the diverse needs of homeless students, integrated service-delivery across various systems of care is discussed.

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## 1. Introduction

According to a report by the U.S. Department of Education, a record number of homeless students—1.1 million—are now enrolled in public schools (National Association for the Education of Homeless Children and Youth [NAEHCY], 2014). Moreover, according to the same report, rates of homeless students have increased 72% since the beginning of the 2008 economic recession and approximately 10% since the beginning of the 2011–2012 school year. Collectively, these findings indicate that student homelessness is a growing problem in the U.S.

Student homelessness is a major social problem that impacts society as a whole. Experiencing episodes of homelessness in childhood is associated with being homeless in adulthood as well as with being socially maladjusted and economically disadvantaged (Simons & Whitbeck, 1991). One study that was conducted with homeless individuals ( $N = 10,193$ ) in the greater Los Angeles area found that the typical cost for services for each homeless individual was approximately \$35,000 per

year (Flaming, Matsunaga, & Burns, 2009). However, homeless individuals with mental health problems are even more costly to society. A study that included homeless individuals with mental health problems ( $N = 4679$ ) in New York City found that it cost taxpayers an average of \$57,561 (inflation adjusted) per person per year in services to support each homeless individual (Culhane, Metraux, & Hadley, 2002). Thus, although the exact cost of each homeless individual to society is not known, estimates obtained from major metropolitan regions suggest that this cost is substantial.

Because student homelessness is a significant problem that exerts a considerable burden on affected individuals and society, effective assessment and intervention practices are needed to help mitigate this problem and help those who are in need of support. Furthermore, because student homelessness is a complicated phenomenon that includes different subtypes of homeless youth (e.g., situational runaways, throwaways, systems-youths) that display different needs (Milburn et al., 2009), integrated and comprehensive assessment and intervention practices are needed to help address this problem. With this aim in mind, this paper discusses the use of a Multi-Tiered System of Support (MTSS) framework to meet the mental health needs of homeless students in schools that often go unrecognized and untreated. Consistent with this aim, service-delivery practices are discussed at universal, selective, and indicated levels following a public health service delivery model.

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## 2. Mental health needs of homeless students

### 2.1. Psychiatric disorders

Homeless students display extensive mental health needs. High levels of psychiatric disorders such as anxiety, depression, posttraumatic stress disorder (PTSD), substance abuse, and psychosis have been identified in populations of homeless youth (Kamieniecki, 2001). Moreover, the lifetime prevalence of having a psychiatric disorder is almost as twice as high for homeless youth than it is in their non-homeless peers (Kamieniecki, 2001; Slesnick & Prestopnik, 2005). In one study, 86% of homeless youth ( $N = 176$ ) met diagnostic criteria for a psychiatric disorder (Ginzler, Garrett, Baer, & Peterson, 2007), which is astoundingly high because research indicates that only about 10% of non-homeless U.S. youth meet criteria for a psychiatric disorder during their school years (National Center for Education Statistics, 2006). Further, another study found that more than half (53%) of homeless youth meet criteria for a disruptive behavior disorder (e.g., Conduct Disorder, Oppositional Defiant Disorder), 32% for Attention-Deficit/Hyperactivity Disorder (AD/HD), 21% for mood disorders (e.g., Depression, Bipolar Disorder), 12% for PTSD, and 10% for Schizophrenia (Cauce et al., 2000). It is important to note, however, that these estimates need to be validated further as other studies have found different rates of psychiatric disorders among homeless youth. For example, PTSD has been identified in 25–33% of homeless youth (Busen & Engerbretson, 2008; Yoder, Longley, Whitbeck, & Hoyt, 2008) and mood disorders (e.g., depression, bipolar disorder) have been diagnosed in almost half these same youth in other studies (Busen & Engerbretson, 2008).

### 2.2. Substance use/abuse disorders

In addition to psychiatric disorders, homeless youth are at-risk for experiencing a range of general mental health problems and challenges to their emotional wellbeing. Research indicates that homeless youth are much more likely to use, abuse, and become dependent on psychoactive drugs than their non-homeless peers (Ginzler et al., 2007; Tyler & Melander, 2013). Although estimates of the percentage of homeless youth who abuse substances vary, research indicates that between 70 and 90% of these youth use illicit substances (Edidin, Ganim, Hunter, & Karnik, 2012; Hudson et al., 2010) and one study found that 86% of participants met the diagnostic criteria for substance dependence or abuse for at least one substance (Ginzler et al., 2007). Further, both episodic substance use and heavy substance use are common as well as poly-substance use among homeless youth (Ginzler et al., 2007).

In addition to being at risk for PTSD, a substantial percentage of homeless youth experiences the adverse effects of trauma. One recent study found that 84% of homeless youth screened positive for childhood physical and/or sexual abuse and that 72% of these youth reported that they were still affected by maltreatment (Campbell & Keeshin, 2011). Although other studies have found lower rates of physical or sexual abuse, usually in the 33% range (Busen & Engerbretson, 2008; Kral, Molnar, Booth, & Watters, 1997; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000), these rates are still markedly higher than the rates in non-homeless youth (Maikovich-Fong & Jaffee, 2010).

### 2.3. Suicidality and mortality

Among an alarmingly high number of cases, the mental health problems experienced by homeless students can culminate in death. Research indicates that between 20 and 40% of homeless youth attempt suicide (Greene & Ringwalt, 1996; Yoder, 1999), which is remarkable because only about 3% of non-homeless youth attempt suicide (King et al., 2001). Moreover, a study by Yoder, Hoyt, and Whitbeck (1998) found that more than half of homeless youth reported that they regularly experienced suicidal thoughts and, in addition to drug overdose, research indicates that suicide is the leading cause of death among

homeless youth (Roy et al., 2004). Overall, although a stable estimate has not yet been established, mortality rates for homeless youth have been reported to be between eleven to forty times higher than for non-homeless youth (Frankish, Hwang, & Quantz, 2005; Roy et al., 2004; Shaw & Dorling, 1998). Thus, in light of these estimates and the previous findings, it is clear that the mental health problems in homeless students are extreme and contribute substantial risks for experiencing markedly negative life outcomes.

## 3. Homelessness as a risk factor for mental health problems

Speculation exists over whether mental health problems tend to predate homeless episodes or to occur thereafter (Edidin et al., 2012). Although research on this phenomenon is limited, some external factors have been identified that predate homelessness such as being exposed to poor parental caregiving; a history of sexual, physical, and emotional abuse; the existence of mental illness in caregivers; and the presence of severe parental conflict (Wrate & Blair, 1999). In addition, factors that occur after a first episode of homelessness that contribute to the development of mental health problems have also been established. These include poor social support, family estrangement, economic strife, substance abuse, and the chronicity and duration of subsequent homeless episodes (Cleverly & Kidd, 2010; Edidin et al., 2012).

Certain subsets of homeless youth may be at an even higher risk to develop mental health problems than others. For example, a study by Gangamma, Slesnick, Toviessi, and Serovich (2008) found that gay, lesbian, and bisexual homeless youth are more likely than their heterosexual peers to display clinically elevated levels of depression and attempt suicide. In addition, independent of factors related to sexual orientation or preference, certain extremely risky sexual behaviors are highly specific to homeless youth and negatively impact their psychosocial functioning. For example, having previously engaged in survival sex (i.e., performing sexual acts for money, food, shelter, or other resources) has been found to increase the likelihood of developing depression and poor adjustment in homeless adolescents (Tyler, 2009).

## 4. Barriers to supporting the mental health of homeless youth

Homeless youth rarely receive adequate support from mental healthcare providers to address their complex needs (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). This is because of significant logistical, financial, and personal barriers to service provision (Jozefowicz-Simbeni & Israel, 2006). Common logistical barriers often relate to difficulties with transportation and stable housing or lodging. Mental health clinics may be located in regions of a community that are difficult for homeless youth to reach on a regular basis. In addition, because homeless youth are a highly mobile population that often moves around and between different communities, going to the same clinic on a regular basis to receive services may not be feasible for many of these youth.

Financial barriers include having difficulty with paying for transportation and not having health insurance. Results from one study indicate that the majority of homeless youth (65%) do not have health insurance (Busen & Engerbretson, 2008), even though almost all of these youth are eligible for Medicaid (English, Scott, & Park, 2014). Unfortunately, meeting eligibility requirements for health insurance often is a challenge for homeless youth who may not have a permanent address, which is often requested and they may not have copies of important documents that are needed for enrollment (e.g., birth certificate, photo identification card).

Lastly, personal qualities of homeless youth also reduce their likelihood to receive mental health services. Lack of knowledge about service availability along with confusion with navigating the healthcare system may prevent homeless youth from seeking services. In addition, distrust of adults, embarrassment associated with being homeless, worry about being judged negatively by mental health providers, and

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