HOMELESS & HOUSING RESOURCE CENTER

Youth Experiencing Homelessness and Serious Emotional Disturbance

August 11, 2025

SAMHSA
Substance Abuse and Mental Health Services Administration

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Mental Health in Youth and Young Adults Experiencing Homelessness

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Agenda

- Youth and young adult homelessness – scope and key drivers
- Youth and young adult homelessness mental health
  - Prevalence
  - Risk and protective factors
  - Related behavioral health outcomes
- Intervention approaches
- Key take-aways

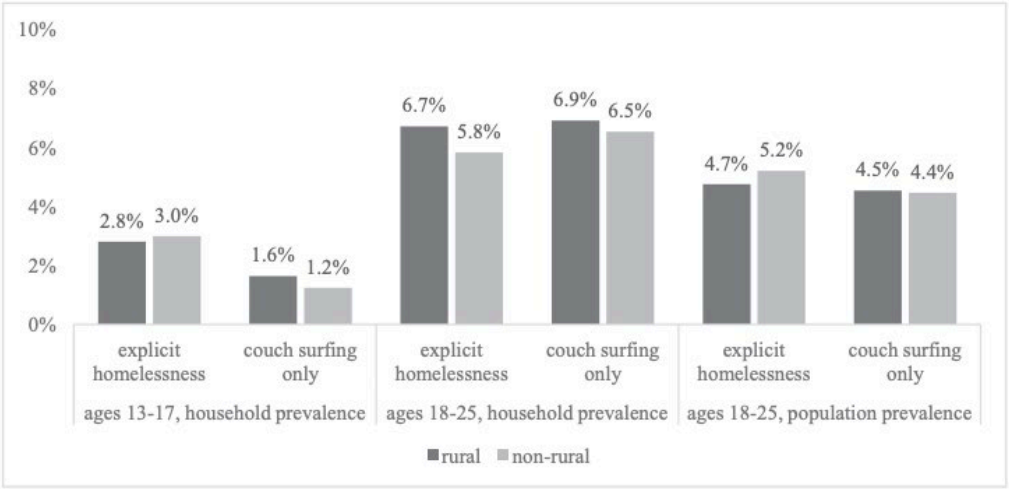
Youth and Young Adult Homelessness - Assessment

Primary means of assessment

- Youth Point in time (PIT) counts –specialized effort within larger PIT count by local Continuums of Care on behalf of HUD
  - Narrower definition, e.g. literal homelessness
- Mckinney-Vento Act reporting for school age youth
  - Broader definition which includes “doubled up” situations
- Youth Risk Behavior Survey
  - Nationally representative survey included a housing stability item in 2021
- Voices of Youth survey conducted by Chapin Hall from 2015-2017

Likely all undercounts

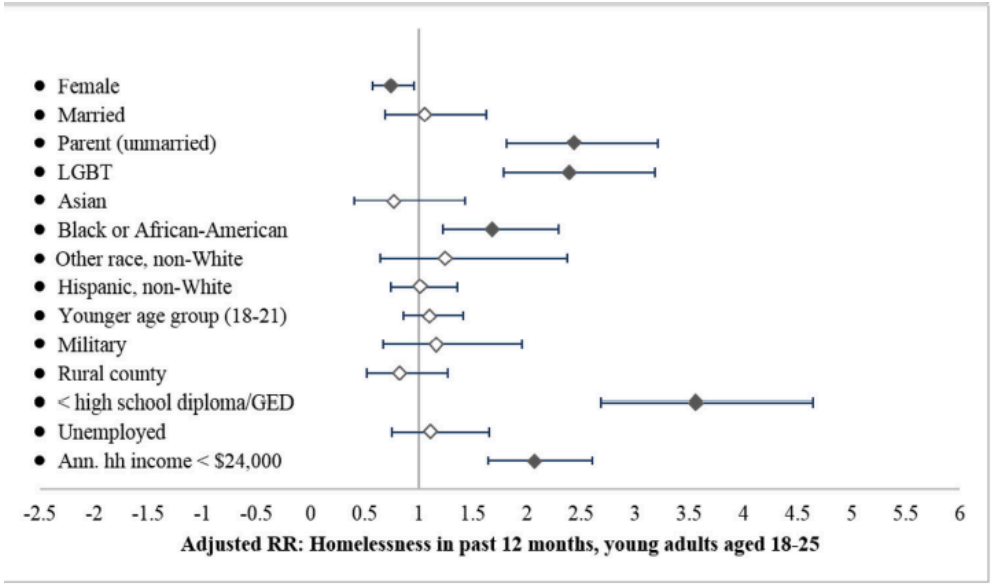
Youth and Young Adult Homelessness - Scope



2025 prevalence estimates from the National Council of State Legislators

- 4.2 million youth and young adults will experience homelessness at some point
- 700,000 are or will be unaccompanied minors
- 1 in 10 young people 18-25 will experience or are experiencing homelessness
- 1 in 30 youth 12-17 will experience or are experiencing homelessness

Youth and Young Adult Homelessness – Key Drivers



- **Poverty and lack of affordable housing**
  - Federal poverty rate for an individual is $15,650 for an individual and family of four is $32,150
- **Family conflict**
  - Multidimensional – poverty, parental mental health challenges, sexual / physical / emotional abuse
  - Caregiver substance use and depression predict housing insecurity
- **Foster care and juvenile justice system exits**
  - Up to 1/3 homeless young adults are former foster youth
- **Sexual minority / LGBTQ+ status**
  - LGBTQ+ have a 120% higher risk of homelessness relative to non-LGBTQ+ youth in some studies
  - 22% of homeless youth are LGBTQ

Mental Health in Youth and Young Adults Experiencing Homelessness

- **Disproportionately high rates of trauma prior to and during homelessness**
  - Prior to becoming homelessness between 25% and 66% report experiencing physical or sexual abuse (Tyler & Schmitz, 2018)
  - While homeless 77% reported physical abuse, sexual abuse, or both (Sharpe, 2006)
  - Increased risk for victimization, violence, and abuse after becoming homeless
- **Disproportionately high rates of mental health symptomology compared to housed peers**
- **Individual and family mental health challenges are both risk factors for becoming homeless and exacerbated by homelessness.**
- **Prolonged experiences of homelessness are casually related to mental health symptom severity**

Mental Health in Youth and Young Adults Experiencing Homelessness - Prevalence

- **Lifetime prevalence of mental health disorder between 2x and 4x higher than housed peers**
- **Most common mental health disorders lifetime prevalence – 2025 global meta analysis**
  - Depression (43%)
  - Posttraumatic stress disorder (33%)
  - Anxiety (22%)
  - ADHD (25%)
  - 70% comorbid diagnoses
  - High rates of bipolar disorder, behavioral disorders, psychotic disorders*

Mental Health Related Outcomes – Substance Use

- **Prevalence**

Youth experiencing homelessness use more substances than housed peers – studies show 70-90% use substances

- **Variability**

Rates & types of substance use vary by gender and length of time homeless: those homeless for longer tend to use more and use more “hard” drugs

- **Network Effects**

Studies show that connections to more substance using peers raises risk of substance use, as with other risky behaviors

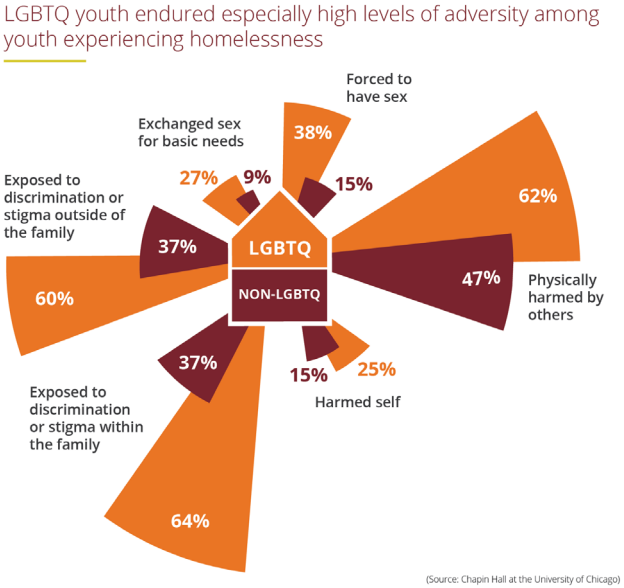
- **Current substance use**
  - Current alcohol use 37%
  - Current cigarette 28%
  - Current vape 45%
  - Current marijuana 32%
- **Lifetime substance use**
  - Cocaine 32%
  - Methamphetamine 36%
  - Heroin 28%
  - Ecstasy /MDMA 33%
  - Injection drug 28%
  - Rx opioid misuse 31%

Compared to single digit percentages for housed youth (except for opioid misuse – 13%)

Mental Health Related Outcomes – Suicidality

Suicide is the leading cause of death in homeless youth and young adults

- Risk factors
  - Sexual minority status
    - LGBTQ youth 2x more likely to attempt suicide compared to heterosexual youth
  - Gender
    - Mirrors the general population
  - Trauma history / mental health challenges
  - Maladaptive emotion regulation strategies
  - Duration of homelessness
  - Survival sex



Mental Health Related Outcomes – Suicidality, cont.

Estimates from YBRS data

- 44% suicide ideation
- 42% suicide plan
- 28% suicide attempt

Estimates from other studies

- 40%-80% suicide ideation
- 23-67% suicide attempt

Protective Factors

Internal factors

- Self-esteem
- Emotion regulation
- Positive peers / connection to caring adult
- Subjective wellbeing

External factors

- High quality housing availability and affordability
- Material needs met
- Educational attainment
- Strong social support network

Intervention

Evidenced-based therapeutic approaches

- CBT
  - Improvements in depression and substance use
- Family therapy approaches
  - Improvements in substance use
- Other approaches fitting diagnostic needs
  - Trauma treatment (e.g. PE, EMDR, CPT) *

Housing first approaches

- Housing supports are essential but insufficient and do not show the same multidimensional improvements on mental health and substance use outcomes as housing first approaches for adults

Life skills support

- Basic living skills, assistance to obtain and maintain housing, financial literacy, shopping for food, education support, employment and job training

Flexibility is essential

- Nonlinear, overlapping application of these approaches depending on evolving needs

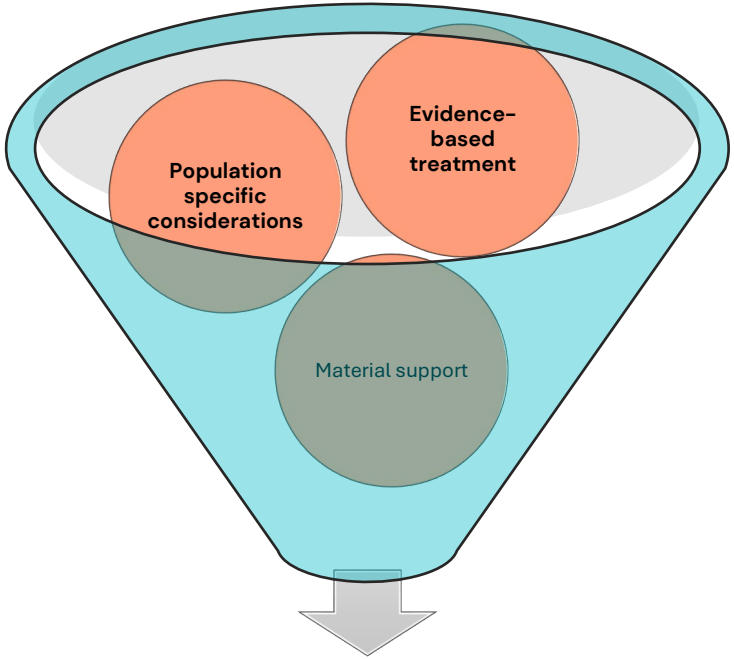
Intervention Characteristics

Must address population-specific issues

- Psychosocial impacts of housing instability
- Physical and psychological safety
- Collaboration and mutuality

Additional Considerations

- Holistic
- Long-term
- Multidimensional (+ material) supports



Sustainment

Clinical Anecdote

Client history

- 18 year old female
- Childhood history of sexual, physical, and emotional abuse
- Chaotic and unstable housing and family history
- Moved out approximately 1 year ago
- Couching surfing / staying with friends who are also financially and housing insecure – creates relationship strain

Mental health

- DSM-V dx: MDD + BPD diagnosis (ICD-11: complex trauma)
- History of self-harm and suicidality
- Relational instability and challenges with trust and appropriate boundaries

Strengths

- Hard worker - working two jobs 😑
- Full time CC student – 4.0 GPA
- Committed to therapy and skill building

Clinical approach

- DBT informed skills training – validation and change dialectic
- Psychological safety, physical relaxation exercises
- Case management
  - Housing support
  - Financial literacy (e.g. credit building, predatory financials avoidance)
  - Medicaid enrollment support (mother removed her from Medicaid when she moved out)

Key Take Aways

- Youth experiencing homelessness come from already socially marginalized groups
- Mental health often vulnerabilities predate homelessness.
- These vulnerabilities are exacerbated when youth are unsheltered or unstably housed
- Homelessness is an inherently stressful experience:
  - prevents healthy sleep & nutrition
  - exposure to perpetrators and maladaptive coping strategies (e.g. substance use)
  - difficult to establish and maintain MH treatment
- Effective treatment requires
  - Addressing material conditions
  - Appropriate diagnosis and evidence-based treatment
  - Sustainment over a longer time horizon than is required with stably housed individuals
  - Life skills training
  - Flexibility in moving between these domains

COVID-19 Impact?

- **Direct family impact**
  - Over 140,000 U.S. children are estimated to have lost a caregiver due to COVID-19
  - Hispanic and Black children account for 32% and 26% of all children losing a primary caregiver but are 19% and 13% of the total population
- **Indirect impacts**
  - School
    - Missed school days & interaction with teachers & peers
  - Social development
    - Interruption of social and emotional skill development during critical developmental periods
  - Health
    - Interruption / loss of access to health and mental health care, social services, food, income, housing

SAMHSA Virtual Webinar on Young Adults Experiencing Homelessness and Serious Emotional Disturbance

Presented by Katie Power, LCSW

Common Mental Health Diagnoses by youth facing homelessness

What does it look like and how do we help?

Depression & Anxiety

What does it look like?

- Persistent sadness or irritability
- Loss of interest in activities
- Social Withdrawal
- Changes in appetite or weight
- Sleep disturbance
- Fatigue/low energy
- Feeling worthless and/or excessive guilt/ hopelessness
- Difficulty thinking, concentrating, and making decisions
- Recurrent thoughts of death and suicide

What does it look like?

- Excessive anxiety and worry
- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Unexplained physical complaints (headaches or stomach aches)
- Sleep disturbance

PTSD and Complex Trauma & Co-Occurring Disorders

- **What does it look like?**
  - **Emotional regulation.** May include persistent sadness, suicidal thoughts, explosive anger, or inhibited anger.
  - **Consciousness.** Includes forgetting traumatic events, reliving traumatic events, or having episodes in which one feels detached from one's mental processes or body (dissociation).
  - **Self-perception.** May include helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings.
  - **Relations with others.** Examples include isolation, distrust, or a repeated search for a rescuer.
  - **One's system of meanings.** May include a loss of faith or a sense of hopelessness and despair.

What does it look like?

- Someone who is using substances to manage mental health symptoms or mask them or alleviate them
- Someone who presents with mental health symptoms and also uses substances
- Someone who uses substances that eventually leads to or triggers mental health symptoms
- Signs of substance use vary by the substance the person is using

Symptoms of Psychosis

Many young people are impacted by symptoms of psychosis which can be a barrier to housing and access to mental health treatment as well as ability to engage in consistent services.

Symptoms of psychosis can be present with severe depression, due to substance use or a young person may be experiencing their “first break” that may lead to a diagnosis of schizophrenia.

Basics of psychosis include:

- Hallucinations - auditory, visual, olfactory; the hallucinations are very real to the person experiencing it. Can be commanding, critical or threatening. Voices may belong to someone known or unknown to the person.
- Delusions - false beliefs that don’t change even when presented with new ideas or facts. Can coincide w/ problems concentrating, distorted perceptions, confused thinking, or thought blocking.

Early Signs to Watch For:

- Unusual thoughts or perceptions, confusion about reality
- Isolation from social connections or other connections
- Decline in personal hygiene (wearing the same clothes, pulling their hoodie over their head)
- Disorganized behavior and thoughts
- Increased or new sensitivity to light and sound

Early Experiences with Mental Health

Often a youth's first experience with mental health symptoms or treatment was not trauma informed

- Treatment or support was forced and punitive
- Disregarded principles of recovery & trauma
- Diagnosis was used to stigmatize, wasn't explained and and only treated with medication
- Developed negative and incomplete self-concept based on a diagnosis that limited potential
- Made young people feel defective, rather than empowered
- Multiple diagnoses given throughout their lives making it confusing to understand
- Labeling and assumptions based on diagnoses when seeking out help in the future
- Intervention was not sustainable or did not offer a clear path forward depending on resources and support

How we engage for a repair experience

Trauma Informed Response

- Focus on psychoeducation about the root causes of symptoms and behaviors through a trauma-informed lens.
- Remove the stigma by explaining how behaviors and symptoms are a normal response to traumatic experiences, systems of oppression and intergenerational trauma.
- Empower young people to make choices about their mental health care and employ harm reduction & motivational interviewing along the way.
- Promote the idea that our mental health is multidimensional and will experience periods of wellness and periods of unwellness and that this is most often influenced by the world around us.
- Provide daily support that reinforces coping skills to help young people get through a moment of struggle.
- Reinforces help-seeking behavior as a sign of personal strength, not weakness, and promote community healing.

How do we best support?

- Connection!
  - Building rapport and attachment with young people offers them a relationship with a provider where they can have healing and repair through trust and clear boundaries (ARC model- Attachment Regulation Competency)
- Community
  - Groups and spaces where young people can be around other youth helps to reduce isolation and feelings that they are alone in their struggle, also spaces that uphold healthy boundaries but are also flexible and open to mistakes
- Support with a referral for psychiatric medication if symptoms are severe
  - In some cases psychiatric medication can offer stabilization that allows for a young person to differently engage in resources and goals
- Supporting with safety planning, harm reduction and open conversation
  - Helping the young person identify areas of risk and how to create safety with limited resources or connections, being open and honest about risks and concerns and impact
- Starting where they are at and offering psychoeducation to build awareness
  - Building a young person's awareness around coping skills and risks and maladaptive behaviors so that they can identify areas where making a different choice might be possible to disrupt cycles

Reminders for Engagement with Youth

- The young person is the expert of their life. We can support and guide but they will ultimately make their own choice and developmentally this where they are at (establishing their own identity and challenging societal norms)
- We recognize that as service providers we are only present for a small portion of a young person's life and that we often don't know or won't know the full extent of their day and everything they are facing. What we do know is that young people are resilient and we can help them build their knowledge and skills for navigating challenges and keep presenting opportunities and options for growth and change.
- It's helpful to lead with learning and understanding the youth and how they utilize resources and how they have gotten through challenges in the past. Do not lead with advice or taking the stance that you know better.
- Take high risk behavior seriously and name it so it can be talked about and harm reduction or safety planning can happen in a real way.

Risk Assessments and Safety Planning

Some of the challenges with risk assessments and safety planning with youth experiencing homelessness include

- Higher chance of interaction with police when street based, risk for “suicide by cop” or negative interaction with police rather than therapeutic intervention
- When attempting to self hospitalize if it’s shared that the youth is homeless their SI can be seen as a way to “get a bed” making it harder to get care
- Lack of social system and support to create safety making
- Lack of access to technology, often having a phone that only works with wifi or no phone at all, limiting safety planning and use of crisis hotlines
- Isolation and lack of community depending mental health and other circumstances

Minor Consent Law (in California- please check your state)

In California, minors 12 and older can consent to mental health treatment or counseling without a parent or guardian's consent if they meet certain requirements:

- The minor is mature enough to participate intelligently in the treatment
- The treatment is outpatient or residential shelter services
- The minor is not on Medi-Cal, or they are in serious danger of physical or mental harm, or are the alleged victim of incest or child abuse

The goal of this law is to break down barriers to care and ensure the youth's safety and well-being. It's important to note that the minor's access to care from a trusted professional may help build a healthy connection between the minor and their parent or guardian

Third presenter:
Arc Telos Saint Amour

Youth MOVE National

Panel Discussion

Evaluation and Certificate of Participation

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