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Improving youth mental health through family-based prevention in family homeless shelters ☆

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ABSTRACT

This exploratory study examines changes in suicidal ideation among a sample ($N = 28$) of homeless youth, ages 11–14, residing within family shelters in a large metropolitan area. Changes in suicidal ideation from pretest to posttest are compared across two group approaches to delivering HIV prevention. Youth and their families participating in the HOPE Family Program, incorporating a family strengthening approach, are compared to those receiving a traditional health education-only approach. Multivariate analyses reveal that youth in the HOPE Family Program were 13 times more likely to report a decrease of suicidal ideation. These findings indicate that health education programs integrating a family strengthening approach hold promise for positively impacting mental health outcomes for vulnerable youth.

1. Introduction

While there has been an increased focus upon suicidal risk among homeless youth (Rew, Taylor-Seehafer, & Fitzgerald, 2001; Yoder, Longley, Whitbeck, & Hoyt, 2008; Yoder, Whitbeck, & Hoyt, 2008), research focusing on self-harm among youth living in family shelters is rare. Further, little is known about effective interventions to decrease thoughts of self-harm among this subpopulation of homeless youth. The purpose of this exploratory study is to investigate the prevalence of suicidal ideation, the relationship between various risk factors, and the impact of participation in family-based HIV prevention programs upon self-harm among a sample of adolescents residing in urban homeless shelters with their families. Two family-based approaches are compared. Guided by Social Action Theory (Ewart, 1991) it is expected that the program, including a family-strengthening approach aimed at bolstering key family and youth processes including communication, family decision-making, parent leadership and supervision, and youth problem-solving, will have a beneficial impact on youth suicidal ideation.

1.1. Family homelessness

Families with children make up 38% (239,403) of the total homeless population (633,782) across the United States (National Alliance to End Homelessness, 2013). This number is on the rise, despite that the population of other subgroups has remained relatively stable. In fact from 2011 to 2012, families with children were the only subgroup of homeless persons to experience an increase, resulting in 162,246 homeless children in 2012 (National Alliance to End Homelessness, 2013). Homeless families face multiple adversities. They experience the longest stays in temporary housing (e.g., emergency shelters, transitional housing, and permanent supportive housing) comparative to single adults (U.S. Conference of Mayors, 2008), and are at risk for significant levels of poverty, domestic violence, and increased involvement with the child welfare system (Cutuli, Wiik, Herbers, Gunnar, & Masten, 2010; HUD, 2009; Stainbrook & Hornik, 2006).

Further, studies consistently find that homeless parents, who are most likely to be single women (Gewirtz, 2007), have high rates of mental health and substance abuse difficulties (Gewirtz, 2007; Zima, Wells, Benjamin, & Duan, 1996). And two decades of research show that their offspring have increased likelihood of evidencing developmental delays, mental health problems, substance abuse, academic and peer-related difficulties, and involvement in the juvenile justice system (Bassuk & Rubin, 1987; Buckner, 2008; Busen & Engebretson, 2007; Haldenby, Berman, & Forchuk, 2007; Obradovic, 2010; Rhode, Noell, Ochs, &

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Seeley, 2001; Rhule-Louie, Baer, & Peterson, 2008; Rotheram-Borus & Futterman, 2000).

1.2. Adolescent suicide risk

Recently, there has been an increased focus upon suicidal risk among homeless adolescents. Thoughts of self-harm and suicidal acts are highly associated with mental health disorders, including major depressive disorder, posttraumatic stress disorder, and substance abuse (Yoder, Longley, et al., 2008), and are the third cause of death among youth 12 to 18 years of age (Borse & Sleet, 2009). In fact, exposure to violence and victimization has been linked to an increased risk for suicidal ideation among adolescents (Chemtob, Madan, Berger, & Abramovitz, 2011; Turner, Finkelhor, Shattuck, & Hamby, 2012; Wolitzky-Taylor et al., 2010), as has youth substance abuse (Gould et al., 1998; Vermeiren et al., 2003, Wolitzky-Taylor et al., 2010).

Homeless adolescents are at significant risk for suicide. One recent study found that over two-thirds of youth endorsed one or more indicators of intent to self-harm (Yoder, Longley, et al., 2008; Yoder, Whitbeck, et al., 2008), and a second study found that approximately 35% of adolescents had thought seriously about suicide, with 12% attempting suicide on one or more occasions (Rew et al., 2001). However, there is little knowledge about suicide risk among sheltered youth living with their families, as the samples in these studies tend to be runaways, youth who were forced out of their homes, or who live on the streets. The current study extends upon this knowledge base by investigating prevalence, as well as child and family-level correlates of suicidal ideation among family shelter-dwelling youth.

1.3. Family-level variables

Additionally, we studied the impact of a family strengthening and HIV prevention program upon suicide risk. Evidence suggests parenting factors, including lack of parental support, poor parenting practices (e.g., low monitoring, lax rules, poor problem solving), and a discordant parent/child relationship are associated with suicide risk among youth (Brausch & Gutierrez, 2010; Garber, Little, Hilsman, & Weaver, 1998; King, Segal, Naylor, & Evans, 1993), yet there is little information about this relationship among shelter-dwelling families. Homeless families living in the shelter system are at particular risk for disruptive parenting practices and impairments in the parent/child relationship. Evidence suggests that the stressors that accompany homelessness interfere with important parenting processes, including monitoring and supervision, provision of support, and discipline (Howard, Cartwright, & Barajas, 2009). Families living in shelters also contend with lack of privacy, relinquishing control to shelter rules and regulations, and concerns that their parenting skills are being assessed by staff, which further impairs parenting and stresses the family unit (Fraenkel, Hameline, & Shannon, 2009; Howard et al., 2009; Paquette & Bassuk, 2009). This literature, coupled with the lack of knowledge about the relationship between these processes among homeless families, led to the second aim of the study; to determine whether participation in a family-focused prevention program that aimed to enhance parenting processes and the parent/child relationship would also impact suicidal ideation among these youth.

2. Methods

2.1. Description of the intervention

Data used in the current study were gathered from participants in the HOPE (HIV Outreach for Parents and Early Adolescents) Program, a study that involved a sample of young adolescents (11–14 years of age) residing within family housing shelters in New York City. All necessary institutional review board approvals were obtained before undertaking the larger study. Further, in regards to mental health safeguards, it should be noted that when a youth was identified as having suicidal ideation, she/he was clinically assessed by a master's-prepared professional, parents were involved in supporting the child, and active attempts were made to secure clinical care as indicated.

The HOPE Program study contrasts two prevention strategies. The first is the HOPE Family Program, which offers an intensive family strengthening intervention meant to build communication, parental monitoring, and supervision skills, as well as assist parents to manage stressful situations both inside and outside of the shelter. Through strengthening family functioning and promoting youth mental health, subsequent youth risk-taking behaviors (e.g., suicide risk and HIV risk) are hoped to decrease. The HOPE Family Program consists of an eight-session, weekly one-hour intervention that includes both separate and conjoined sessions for parents and youth to engage together and separately with the content material. This is done in order to allow for both caregivers and youth to be able to discuss issues freely among their peers before coming together to discuss them as a family.

In contrast, the HOPE Health Educational Program provides informational sessions pertaining to methods of prevention of HIV/AIDS and sexually transmitted infections, the effects of the use of illicit substances, and normative adolescent changes (i.e., puberty). HOPE Health consists of three 2-hour generationally separate group sessions for caregivers and youth. A social worker is present for both the HOPE Family Program and HOPE Health Program to provide clinical support to youth and parents as needed. The primary facilitators for both programs are community members with five years or more experience in HIV prevention services.

2.2. Setting and sample

The sample of the current study ($N = 28$) was drawn from a larger study of 204 urban parents and their school aged children residing in NYC family homeless shelters. Unlike traditional shelters, family shelters offer multiple services including case management services, housing assistance, employment services, childcare, and other resources to facilitate returning to permanent housing (Barnes, 2004). Of these 204 families residing in the shelter, 48.5% ($n = 99$) were assigned to the HOPE Family Program, and 51.5% ($n = 105$) were assigned to HOPE Health within randomly assigned shelters with one program offered in each shelter.

In terms of racial/ethnic background, 42% ($n = 86$) of adult caregivers described themselves as Hispanic/Latino, 47% ($n = 96$) described themselves as Black, and 11% ($n = 22$) described themselves as a Black/Hispanic racial/ethnic mix or other. Over ninety percent (92%, $n = 188$) of the sample of adult caregivers was female. The average age of adult caregivers was 38.4 ($SD = 6.8$) years old. Eighteen percent ($n = 37$) of adult caregivers reported having an 8th grade education or less, 27% ($n = 56$) had some high school, 26% ($n = 54$) had a high school/GED diploma, 18% ($n = 37$) had some college, and 5% ($n = 11$) reported that they had completed college. The remaining caregivers reported either completing post college courses (2%, $n = 4$) or did not respond (4%, $n = 8$). Adult caregivers reported their marital status as being 57% ($n = 116$) single, 25% ($n = 51$) married/common law marriage, and 18% ($n = 37$) divorced/separated/widowed. Fifty-seven percent ($n = 116$) of adult caregivers reported that this was their first time staying in a shelter.

Children described their racial/ethnic background as 40% ($n = 81$) Hispanic/Latino, 43% ($n = 88$) Black, and 17% ($n = 35$) described themselves as a Black/Hispanic racial/ethnic mix or other. Fifty-five percent ($n = 112$) of the sample of children was male and 45% ($n = 92$) female. The average age of children was 12.8 ($SD = 1.2$) years old.

Of the 204 youth that provided data at baseline, 198 provided data regarding suicidal ideation. Of the 204 youth at baseline, 68% ($n = 139$) completed a posttest survey, of these 139, 135 provided posttest data regarding suicidal ideation. Among these groups, there were 131 youth that provided overlapping pretest and posttest scores describing