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

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A B S T R A C T

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.

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 individ-uals 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 run-aways, 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.

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). More-over, 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 psychiat-ric disorder (Ginzler, Garrett, Baer, & Peterson, 2007), which is astound-ingly 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). Fur-ther, another study found that more than half (53%) of homeless youth meet criteria for a disruptive behavior disorder (e.g., Conduct Dis-order, Oppositional Defiant Disorder), 32% for Attention-Deficit/Hyperactivity Disorder (AD/HD), 21% for a mood disorders (e.g., Depres-sion, 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 psycho-active 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 regular-ly experienced suicidal thoughts and, in addition to drug overdose, re-search 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 home-less students are extreme and contribute substantial risks for experienc-ing 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 de-velopment 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 home-less 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 hetero-sexual peers to display clinically elevated levels of depression and at-tempt 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 psycho-social 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 trans-portation and not having health insurance. Results from one study indi-cate 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 cer-tificate, photo identification card).

Lastly, personal qualities of homeless youth also reduce their like-lihood to receive mental health services. Lack of knowledge about ser-vice 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

fear of being reported to child welfare services prevent some homeless youth from seeking mental health treatment (Edidin et al., 2012; Kidd, Miner, Walker, & Davidson, 2007). However, it is important to note that the aforementioned barriers are not insurmountable and research indicates that homeless youth are more likely to utilize services when they are made more accessible. In support of this notion, a study by Carlson, Sugano, Millstein, and Auserwald (2006) found that 99% of homeless youth used some form of mental health or healthcare service when these services were made readily available to them. Thus, as sug-gested by Edidin et al. (2012), minimizing barriers to service provision and increasing access to services may lead to improved mental and physical health outcomes for homeless youth.

5. School-based service delivery to reduce access barriers

Through reducing barriers to service delivery, schools can be an optimal environment to address the unmet mental health needs of homeless youth (Aviles de Bradley, 2011). Most youth spend at least 40 h a week in school (Resnicow, 1993) and more than three-fourths (77%) of youth from homeless families attend school regularly (NCFH, 2009). Therefore, providing mental health services to homeless youth at school may reduce some major logistical, financial, and personal bar-riers to mental health service utilization (Bryant, Shdaimah, Sander, & Cornelius, 2013). Schools exist in all communities across the U.S. and they are required to employ a range of professionals such as school psychologists, counselors, and social workers to help students who are experiencing mental health problems and research indicates that various disparities in the provision of supportive services are reduced in school versus in community settings (Cummings, Ponce, & Mays, 2010). Furthermore, schools often are viewed as trusted social institu-tions and homeless youth already are familiar with members of school communities (e.g., teachers, administrators, peers) so they may be more open to receiving mental health services in these settings (Julianelle, 2008).

6. School mental health

The past twenty years have witnessed a growth in the school mental health movement in the U.S. and in other countries because of a number of factors. First, even though about 20% of all students display mental health problems, less than a third of these youth receive services in any setting to address these problems according to the President's New Freedom Commission on Mental Health (2003). Second, consider-able variability exists in the type and quality of services that youth receive to address their mental health problems. Unfortunately, despite the establishment of evidence-based treatments for various forms of psychopathology, research indicates that youth generally do not receive these treatments, especially as first-line interventions (Jordan, De Nadai, Sulkowski, & Storch, 2013; Weist et al., 2009). Third, youth often receive and are more amenable to receiving mental health ser-vices in natural settings including schools and in home environments as opposed to clinical or medical settings, which is where adults are more likely to receive these services (Clauss-Ehlers, Serpell, & Weist, 2013). Fourth, even though schools often are overcrowded with stu-dents and understaffed with mental health service providers, immense potential exists for school professionals to address the mental health needs of students collectively through providing a full continuum of universal, selective, and indicated services (Sulkowski, Joyce, & Storch, 2013; Sulkowski, Wingfield, Jones, & Coulter, 2011). In support of the school mental health movement, it is noteworthy that the New Freedom Commission on Mental Health (2003), which aimed to trans-form the nation's mental health system, supported expanding school mental health programs as one of its 16 specific recommendations (Recommendation 4.2).

6.1. School mental health service delivery

Following a public health model of prevention and intervention service-delivery, which involves addressing a range of mental health problems in youth, schools can support the mental health needs of homeless youth through employing a Multi-Tiered System of Support (MTSS) framework that involves universal, selective, and indicated service provision levels (Christner & Mennuti, 2008; Hess, Short, & Hazel, 2012). Within this framework, universal assessment and inter-vention services are implemented population-wide and they aim to influence all students in a school environment. These services might involve universal screening for academic, emotional, or behavioral problems and school-wide intervention programs (e.g., Positive Behav-ioral Intervention Supports [PBIS], bullying prevention programs).

In contrast to universal services, selective services purport to address the needs of youth who already are displaying problems or are at risk to do so in the near future. Assessment practices with these youth might involve employing a more systematic evaluation approach to identify the functions of problematic behaviors or using a multi-trait, multi-setting, and multi-informant assessment approach to triangulate data on what might be contributing to a youth's mental health problem. Regarding intervention efforts for youth displaying a need for selective service provision, small group interventions such as group counseling or non-highly invasive intervention practices may be warranted.

Lastly, within a public health model, indicated services aim to address the needs of youth who display significant mental health prob-lems. These youth likely have already been identified, have received intervention services that did not effectively meet their needs, and they may need more intensive and individualized intervention services such as individualized evidence-based therapy (Sulkowski et al., 2013). Depending on the availability of resources and the nature of the school, indicated services may be provided by school-based practitioners or by practitioners in the community.

7. A multi-tiered framework for meeting the mental health needs of homeless youth

To date, a school-based MTSS framework has not been employed that specifically addresses the needs of homeless youth. However, ele-ments of different tiers of school mental health service delivery have been tested with highly vulnerable populations of students that display many of the same risk and problems that homeless youth experience. For example, a recent study by Albright et al. (2013) evaluated the effi-cacy of a school mental health program that is based in a high school that is located in rural western North Carolina. Results of this evaluation support the efficacy of mental health service delivery in the schools for at-risk youth as 63% of youth who were treated during the 2011–2012 school year recovered or improved based on their scores on the Youth Outcome Questionnaire (Burlingame et al., 2005), a measure of mental health treatment response. Therefore, in light of these results, school-based mental health service providers also could provide similar supportive services to more directly address the needs of homeless youth. In addition, they could build the provision of these services into a MTSS service-delivery model that addresses the myriad needs of homeless youth across a spectrum of needs and service delivery efforts. With this aim in mind, a conceptual model that describes different as-sessment and intervention practices that members of school communi-ties can employ at each MTSS service delivery level is presented below.

7.1. Universal assessment and intervention

No universal assessment or screening practices exist for identifying homeless youth. However, every Local Education Agency (LEA) is required to employ a homeless liaison under the McKinney–Vento Act (McK–VA; 42 U.S.C. §11431 et seq.), which was re-authorized under No Child Left Behind (NCLB; P.L. 107-110, 2001). Among other duties,

homeless liaisons are required to proactively identify all homeless youth who reside within the LEA in which they work, facilitate the immediate enrollment of these youth, and connect them with appropriate supports and service providers to help facilitate their placement in stable housing situations, access to basic necessities (e.g., food, clothing), and appropriate educational services. Therefore, it is critically important for school-based mental health professionals to know and reach out to the homeless liaisons in their LEAs who have the onus of identifying homeless students. Jozefowicz-Simbeni and Israel (2006) report that the roles and functions of homeless liaisons under McK–VA and school-based mental health professionals—especially social workers—overlap significantly. Thus, through establishing a collaborative relationship, homeless liaisons and school-based mental health professionals can share information on procedures that are in place to identify homeless students as well as data that have been collected as part of universal emotional and behavioral health screening efforts. As an example of this, a school psychologist who is involved with universal efforts to assess students' academic and emotional and behavioral functioning can meet regularly with a homeless liaison to assess the progress of homeless students on these indicators as well as to review other meaningful data related to student success and wellbeing (e.g., attendance records, disciplinary referrals, suspensions). Collectively, through collaborating to review these data, homeless liaisons would be better able to fulfill their duty as a "stabilizing force in homeless students' and families' lives" (Jozefowicz-Simbeni & Israel, 2006, p. 41) and school-based mental health practitioners would be better able to under-stand the psycho-educational needs of the homeless students they serve (Sulkowski & Kaczor, in press).

Universal interventions focus on the whole school population and often involve efforts to prevent problems from occurring or to improve the school climate. In a report on meeting the educational needs of homeless youth, Julianelle (2008) emphasizes the importance of home-less youth feeling safe and supported in schools because they often feel disenfranchised from school environments and experience academic failure, difficulty adjusting to school environments, poor peer relation-ships, and they frequently dropout. Therefore, universal interventions that increase students' attendance rates, feelings of being engaged at school, socially supported, and connected to members of school com-munities may help support homeless youth. Stemming the tide of ex-cessive absences can serve the dual purpose of preventing students from getting even farther behind academically and becoming even more estranged from the school environment, especially for older homeless students who have fewer caregiver supports and are more likely to have fragmented school attendance, experience academic problems, and to dropout altogether (Obradović et al., 2009). Indeed, Shochet, Dadds, and Montague (2006) reported that "school connected-ness" as measured by the Psychological Sense of School Membership (PSSM; Goodenow, 1993) was significantly and inversely related to depressive symptoms, both concurrently and after one year. Thus, pro-moting school attendance and engagement broadly, especially for those most likely to feel disenfranchised, could have important benefits for homeless youth and their psychological well-being.

Furthermore, along with this effort, it is important for educators to reach out to family members and caregivers of homeless students to facilitate positive home–school relationships and remove barriers to school attendance, success, and access to mental health services. Research by Epstein and Sheldon (2002) indicates that family/caregiver–school partnership practices predict an increase in daily attendance and a decrease in chronic absenteeism, even among chronically absent students such as homeless youth. More specifically, these practices involve providing awards to students for meeting academic and behav-ioral goals, regularly communicating and establishing social contacts with families (e.g., giving caregivers the name and telephone number of at least one person who is officially designated to discuss attendance issues), holding workshops to help caregivers problem–solve issues re-lated to attendance barriers, providing afterschool programs, providing

referrals to counselors and truancy officers, and having school-based personnel conduct home visits.

7.2. Targeted assessment and interventions

Students in need of targeted assessment or intervention services display risks or problems that negatively impact their educational performance. Therefore, they may benefit from services that extend beyond what is usually universally provided in schools and they may need additional services that are adjunctive to the services they receive as part of their general educational programming. However, because of laws that govern service delivery, privacy, and informed consent in schools, homeless youth may not be assessed or provided with these services. For example, the Individuals with Disabilities Educational Improvement Act (IDEIA; P.L. 101-476) and the Family Educational Rights & Privacy Act of 1974, 1232g (1974) both include language about obtaining informed consent from a legal guardian prior to assessing a student for or actually providing targeted intervention services. Therefore, school-based mental health professionals or other members of student support teams may fail to assess or intervene with homeless youth who do not have a caregiver who can consent on their behalf (Julianelle, 2008; Zima, Wells, & Freeman, 1994).

However, in contrast with the former, a failure to assess or provide services to homeless students with suspected disabilities or needs that warrant the provision of targeted interventions, actually violates their right to a free and appropriate education under No Child Left Behind and the McK–VA. Therefore, as mandated by McK–VA, it is important for schools to immediately enroll homeless students and begin pro-viding them with the services they need as soon as it is feasible, even if consent cannot be obtained from a legal guardian (Jozefowicz-Simbeni & Israel, 2006). In lieu of obtaining parental consent to initiate the provision of assessment or intervention services, according to McK–VA, a custodial guardian can be a "appropriate staff of emergency shelters, transitional shelters, independent living programs, and street outreach programs that are involved in the education and care of the child … until a surrogate parent is appointed who is not an employee of an agency that is involved with the education of the child" (34 CFR §300.519f). Furthermore, members of LEAs such as McK–VA homeless liaisons also can serve and do serve in the role of temporary surrogate according to the National Association for the Education of Homeless Children and Youth (NAEHCY, 2008). Therefore, schools must respect homeless students' right to a free and appropriate education and access to services that support their success at school through providing targeted services to these youth as soon as such a need is identified.

Targeted assessments for homeless youth might involve the use of a multi-trait, multi-setting, and multi-informant assessment approach to evaluate a students' emotional and behavioral functioning (Saklofske, Joyce, Sulkowski, & Climie, 2013). This assessment approach would involve collecting data from several different individuals who have fre-quent contact with the student in question (e.g., teachers, relatives, members of community agencies), use different sources of data, and assess the students' functioning across different settings (e.g., school, shelter, community). Measures and sources of data that commonly are utilized as part of a multi-trait, multi-setting, and multi-informant assessment approach include clinical interviews, observations, omnibus behavior rating scales (i.e., measures of multiple constructs or domains of functioning), single-construct measures (i.e., measures of unitary or narrow constructs such as depression or self-esteem), and personality measures. The overall goal for this assessment approach is to integrate and triangulate convergent data sources so that a clear picture emerges of a child's emotional and behavioral functioning.

Targeted interventions generally are provided to youth who have been identified as having problems that do not warrant immediate or intensive intervention. These intervention services often are group-based or are delivered individually in a manner that does not consume substantial time or resources. For example, with consent from a custodial

guardian or a recognized caregiver, a school psychologist or counselor can identify homeless students who have elevated levels of anxiety and recruit them in a therapy group that follows an evidence-based cognitive–behavioral therapy (CBT) treatment protocol. The efficacy of group-based CBT interventions for treating childhood anxiety is supported by several studies (e.g., Flannery-Schroeder & Kendall, 2000; Masia Warner, Fisher, Shrout, Rathor, & Klein, 2007). Similarly, a study by Kataoka et al. (2003) found that group-delivered CBT was effective at reducing PTSD symptoms and depression in Latino immigrant students who have been exposed to community violence. In general, group-based interventions may be particularly effective for homeless youth because group members can identify with each other, receive social support and support others, and help to facilitate therapeutic engagement and consistent attendance (Masia-Warner et al., 2005).

Targeted interventions can also be individually administered. As an example, check in/check-out (CICO) often is used as a targeted intervention for youth who display problematic behavior at school and might benefit from receiving additional attention and opportunities for positive reinforcement (Hulac, Terrell, Vining, & Bernstein, 2011). In gener-al, this intervention approach involves meeting with the student at the beginning and end of each day to check if the student is meeting his or her behavioral expectations or goals. Depending on the student's goals and their attainment throughout the day or segments of the day, the student can be provided with desirable reinforcers. For homeless youth, CICO might be an especially potent intervention because it links to the provision of desired resources and it allows an educator valuable time to assess a child on a daily basis. For example, in addition to reviewing behavioral goals and progress, an educator can check to see if the student had breakfast, needs clean clothes, got enough sleep the night before, and has a safe place to go after school.

7.3. Intensive assessments and interventions

Intensive assessment and intervention services are provided to help students who either did not respond well to universal or selective interventions or to students who display extensive needs. These services tend to be individually administered and they often are time consuming. Therefore, intensive services must be tailored to the specific student and they should consider a multitude of environmental influences on his or her behavior.

As an intensive assessment, a functional behavioral assessment (FBA) may be conducted to determine the functions of a student's problematic behavior. This process involves using multiple data sources (e.g., interviews, observations, behavior rating scales) to develop an operational definition that describes the antecedents and consequences of a child's problematic behavior. Although an in depth discussion on the procedures associated with conducting FBAs and interpreting data that are collected during this process is beyond the scope of this article (for more information, see Steege & Watson, 2008), it is important to note that the FBA process must consider both proximal and distal influ-ences on the behavior of homeless students. In other words, even if a student's problematic behavior can be understood in functional terms (e.g., "when Matthew is expected to do independent seatwork for more than four minutes, he will begin to make inappropriate vocaliza-tions [grunting, whining, talking to other peers] until his teacher repri-mands him verbally or imposes a negative consequence"), a functional understanding of a problematic behavior still may be devoid of informa-tion about the etiology of the behavior. In the previous example, even if it seems as if the student's disruptive behavior is being reinforced by teacher attention, it is still not known why teacher attention is a rein-forcer. Thus, the FBA process may generate additional questions in addi-tion to answering them: Is the student receiving attention from supportive adults in other settings besides in school? Can the student ask for and receive teacher attention in a prosocial way? Often children with histories of abuse and neglect, which is common among homeless

youth, display attention-seeking behaviors, especially to receive atten-tion from adults at school (Campbell & Keeshin, 2011).

Indicated interventions to address mental health problems in the schools often involve proving individual counseling of therapy. Because of the wide range of psychiatric and mental health problems that homeless youth display, a large percentage of these youth likely could benefit from receiving indicated intervention services. Furthermore, it is important for these services to be calibrated to the specific needs displayed by each individual (Kidd et al., 2007). For example, a homeless student with a trauma history may benefit from receiving an evidence-based form of psychotherapy called trauma-focused CBT, which has been shown to be effective with youth in schools (Jaycox et al., 2010; Kataoka et al., 2003; McKenzie-Mohr, Coates, & McLeod, 2012). Although research is needed on the implementation of indicated inter-ventions to address student mental health problems in schools, a growing corpus of research supports the use of various forms of psycho-therapy to address mental health problems in youth that can be applied to school settings (Weist et al., 2009). One can argue that these studies do not address service delivery to homeless youth; however, if various barriers to receiving intervention services and staying engaged in the therapeutic process are addressed that impact homeless students, their results will likely generalize to homeless youth (Jozefowicz-Simbeni & Israel, 2006).

8. Integrated service-delivery for homeless youth across tiers

All homeless youth can benefit from universal service delivery at schools and many also could benefit from more intensive assessments and interventions. Usually, MTSS frameworks suggest that about 85% of service delivery efforts should be universal, 10% should be targeted, and 5% should be indicated or delivered to students manifesting clinically significant problems. However, because the majority of homeless youth display mental health problems or have been subjected to trauma, MTSS service delivery for this population likely is skewed toward needing more intensive assessment and intervention services. Therefore, it is important for school-based mental health service providers to be cognizant of this issue and help to ensure that these students are provided with the services they need on an individual basis (Kidd et al., 2007).

In addition, it is important to note that homeless youth may need supportive services that enable them to then prioritize their mental health issues and actively seek help. In other words, homeless students may need assistance with getting their basic needs met, feeling safe and secure, and learning to trust others before they can address their mental health problems. Therefore, school-based mental health providers will need to work closely with homeless liaisons in their respective LEAs who are charged with the task of ensuring that homeless students have access to stable housing arraignments, food and clothing, transpor-tation to and from school, and community-based healthcare and mental health providers (Markward & Biros, 2001). Lastly, to find local community-based service providers who can provide the aforemen-tioned services, school-based mental health professionals should con-tact their McK–VA State Coordinators. Contact information for all current McK–VA State Coordinators is available at the following link: http://center.serve.org/nche/downloads/sccontact.pdf.

9. Conclusion

The number of homeless youth in America is a growing problem with significant implications. First, the notable increase in homeless youth in this country speaks to a number of unfortunate realities of our time, including economic decline, family estrangement, a grossly in-sufficient health care infrastructure, high rates of substance abuse, and of course, mental health treatment needs outpacing our capacity to serve those in need, especially among children and adolescents. Because being homeless at a young age portends dire outcomes and prognoses

across most health variables, an effective response to this problem is needed.

Efforts to serve homeless students through MTSS might help a substantial number of these youth. Even if the problems contributing to their distress cannot be eradicated, the provision of more relief and support to homeless students—regardless of the amount—may make a meaningful difference in these students' lives (Jozefowicz-Simbeni & Israel, 2006). Instead of feeling overwhelmed from the prospect of serving a highly at-risk population that often experiences negative life outcomes, school-based mental health professionals should feel empowered by their effort to make a difference. Homeless students need all the support they can get and school-based mental health pro-viders are well-positioned to meet the mental health needs of homeless students through using MTSS and through utilizing critical laws that govern school-based service delivery.

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