

The Unique Needs of Homeless Youths With Mental Illness: Baseline Findings From a Housing First Trial

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Objective: Although youth homelessness presents a significant public health problem, the needs of homeless youths with mental illness, as distinct from adults, are not well understood. This study examined the unique demographic, clinical, and service use characteristics of homeless youths.

Methods: At Home/Chez Soi was a large randomized controlled trial of the Housing First model in five cities in Canada. Of 2,255 participants, 7% (N=164) were youths ages 18 to 24. Youths were compared with older participants on baseline demographic, clinical, and service use characteristics.

Results: More youths than adults had not finished high school (76% versus 54%), had a drug use disorder (66% versus

52%), and had been assaulted in the past six months (44% versus 36%) (all $p < .05$). Fewer than half the youths (49%) had a regular medical doctor, 50% reported unmet need for health care, and 61% visited an emergency department in the past six months.

Conclusions: This sample of homeless youths with mental illness had low education, high rates of substance use disorders and victimization, and problems accessing services. These findings suggest that youths have trajectories to homelessness and service needs that are distinct from adults and may guide future planning for this vulnerable population.

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Youths age 24 years and younger represent a significant and growing segment of the homeless population. In the United States, an estimated 4% to 8% of youths have experienced homelessness (1,2). The problem of youth homelessness is increasingly being recognized. The National Alliance to End Homelessness captured point-in-time data on unaccompanied youths for the first time in 2013, finding that almost 47,000 American youths were homeless (3). In Canada, approximately 30,000 youths ages 16 to 24 access shelters annually, representing 20% of shelter users (4).

Homeless youths are known to have multiple challenges. Between 48% and 98% meet criteria for a psychiatric disorder (5); common disorders measured with the Mini International Neuropsychiatric Interview (MINI) (6) in a group of 18- to 24-year-old homeless youths included depression (28%), hypomania (30%), posttraumatic stress disorder (24%), alcohol abuse or dependence (28%), and drug abuse or dependence (36%) (7). Homeless youths also have high rates of trauma (8); general medical illnesses, including hepatitis and HIV (9); and traumatic brain injury (TBI) (10). The burden of mental and general medical illness on homeless youths confers an 11-times increased mortality rate, accounted for mainly by suicide and drug overdose (11). Rates of health service use vary depending on diagnostic group, service type, and time period; for example, in a group of homeless

youths in the United Kingdom, most of whom had a psychiatric disorder, 24% had used the emergency department, 31% had accessed mental health services in the past six months, and 60% had seen a general practitioner in the past three months. Homeless youths tend to have high perceived unmet need for health care (12).

Data for homeless youths are limited by the use of inconsistent definitions and measures and by challenges to recruiting representative samples (13). Furthermore, most data for homeless youths come from studies specifically of young people, rather than broader studies that allow comparisons with older homeless adults. Governments are increasingly recognizing the need for improved understanding of and services for homeless populations, including youths (14). In 2008, the Canadian government allocated \$110 million to the Mental Health Commission of Canada for a demonstration project on mental health and homelessness. The result, At Home/Chez Soi, is the largest trial to date of Housing First, which provides homeless individuals with immediate access to housing and mental health support services. At Home/Chez Soi presented a rare opportunity to examine a well-characterized sample of homeless youths. Using baseline data collected for At Home/Chez Soi, we compared demographic and clinical characteristics and service use among homeless youths with mental illness and older

adults and explored factors associated with use of services by youths.

METHODS

At Home/Chez Soi was a randomized controlled trial of Housing First in five cities in Canada. The study protocol has been described in detail elsewhere (15). Briefly, the trial tested Housing First, which provides access to housing of the individual's choice and support services without mandating sobriety or psychiatric treatment beyond a weekly visit by the support team. Participants were individuals age 18 or older in Moncton, Montreal, Toronto, and Winnipeg and 19 or older in Vancouver who were currently homeless or precariously housed and had a mental disorder on the basis of *DSM-IV* criteria determined by the MINI at study entry (6). Individuals were excluded if they were clients of other assertive community treatment or intensive case management teams, had illegal immigration status, or did not meet a strict definition of homelessness. [Additional details about recruitment are reported in an online supplement to this article.]

Participants were recruited from community agencies that serve homeless people; institutions such as health care facilities, prisons, and jails; and directly from the street. Participants provided verbal consent to be screened for eligibility; those who met inclusion criteria were assessed for capacity to consent before written informed consent was obtained. Recruitment occurred from October 2009 to July 2011. Participants were randomly assigned to Housing First or treatment as usual by computer using adaptive randomization procedures. The study was approved by research ethics boards in every jurisdiction (11 in total).

Participants self-reported demographic information (gender was reported as male, female, transgender, transsexual, other, or declined to answer), chronic general medical conditions, diagnosis of a learning problem or learning disability, involvement with health services, and arrests. MINI results obtained at screening were used to determine *DSM-IV* mental disorders and suicidality (6). The Adverse Childhood Experiences Study (ACE) questionnaire was used to measure childhood trauma (16). Community functioning was determined from the observer-rated Multnomah Community Ability Scale (MCAS) (17,18). Participants completed comprehensive face-to-face interviews at baseline and every six months and brief measures of housing and vocational status by telephone or in person approximately every three months, for a total of 21 to 24 months of follow-up. Data were entered remotely on laptops and stored in a central database. Participants received monetary incentives for attending interviews. The data set for this analysis was drawn from the interviews that occurred at baseline, except for the ACE questionnaire, which was completed at 18 months.

Descriptive statistics were calculated for each demographic, clinical, and service use variable. We defined a "youth" as an unaccompanied individual age 24 and under,

reflective of the definitions used by the United Nations and local governments. We compared participants age 24 and younger with those over age 24 by using two-tailed *t* tests for continuous variables and chi-square tests for binary and categorical variables.

Logistic regression models were used to examine the effect of demographic, clinical, and service use factors on having a regular medical doctor and reporting having had a need for health care and not having received it, which generated odds ratios that indicated the likelihood of the outcome. To model the number of visits to the emergency department, a negative binomial regression model was used to account for any overdispersion in our data. Incidence rate ratios were calculated by exponentiating the estimates, which provided ratios of events compared with the overall rate. To determine the effect of each covariate considered in the analysis, univariate tests were performed to obtain the unadjusted odds ratios or rate ratios. Variables significant at $p < .2$ were entered into the final multivariate model. All analyses were conducted with SAS, version 9.4.

Mean imputation was performed for the MCAS, an instrument with validated scale scores, for participants who refused or skipped a number of items by adding the mean of remaining items if they provided answers to at least half. Complete-case analysis was used for regression outcomes, because each had less than 4% missing.

RESULTS

In total, 2,255 participants recruited into At Home/Chez Soi completed baseline interviews; 7% ($N=164$) were age 24 or younger, and 93% ($N=2,091$) were over age 24.

Participant demographic characteristics are shown in Table 1. Younger participants had a mean age of 21.6 years; most were male, had less than a high school education, and were unemployed. Youths had been homeless for a mean of 26.1 months. Clinical and service use characteristics are shown in Table 2. Most youths had a current diagnosis of substance abuse or dependence and had a TBI. Nearly half had been assaulted in the preceding six months, had four or more adverse childhood experiences, and self-reported a learning disability. Less than half of the youths had a regular medical doctor, and 50% reported a perceived unmet need for health care in the past six months. Over 40% reported two or more psychiatric hospitalizations in the previous five years. Over 60% had visited an emergency department in the past six months. Almost 40% had been arrested in the past six months.

Compared with older participants, youths were more likely to be from an ethnoracial minority group, to have English as a first language, and to have not completed high school (all $p < .05$). Youths were less likely than the older participants to have a psychotic disorder, more likely to have mania or hypomania or a drug use disorder, and more likely to report having been identified as having a learning disability; youths had lower rates of hepatitis B and C and HIV/AIDS,

compared with the older participants (all $p < .05$). Younger participants were more likely than the older group to have been assaulted and arrested in the past six months. They were less likely to have a regular medical doctor. Youths and adults had similar MCAS scores and psychiatric hospitalization rates.

In logistic regression analysis, only birth outside Canada and moderate to high suicidality were associated with having a regular medical doctor in a univariate model at $p = .2$; however, these associations were not significant in the final multivariate model (Table 3). Being nonmale and not being from an ethnoracial minority group or Aboriginal were associated with perceived unmet need for health care in a multivariate model (Table 4). The mean \pm SD number of emergency department visits among youths was 1.7 ± 2.9 , indicating a highly skewed distribution. In a negative binomial regression analysis (Table 5), a learning disability and perceived unmet need for health care and absence of a drug use disorder were associated with having more emergency department visits.

DISCUSSION

Youths age 24 and younger enrolled in At Home/Chez Soi had a high degree of impairment, as measured by several indicators, including a mean MCAS score suggesting moderate disability, and a substantial rate of multiple psychiatric hospitalizations. Although some differences between youths and older participants are self-explanatory and related to age (for example, lifetime duration of homelessness), and others may be partly explained by an age effect (for example, drug use disorder) or a cohort effect (for example, self-reported learning disability), some of the findings may truly distinguish homeless youths from older homeless individuals, youths in general, and youths with mental illness. These findings may have particularly important implications for prevention and services directed to homeless youths with mental illness.

Youth were less likely than older participants to have completed high school and more likely to report a learning disability, which could represent age and cohort

TABLE 1. Demographic characteristics of At Home/Chez Soi youths and older participants (N=2,255)

Characteristic	≤ 24 years (N=164)		> 24 years (N=2,091)		p
	N	%	N	%	
Age (M \pm SD)	21.6 \pm 1.5		42.4 \pm 10.2		<.001
Nonmale gender ^a	64	39	666	32	.16
Racial, ethnic, or cultural identity					
Aboriginal	44	27	442	21	.088
Ethnoracial minority group	56	34	497	24	.003
White	64	39	1,152	55	<.001
Born outside Canada	25	15	392	19	.26
Native language					.001
English	123	75	1,255	60	
French	16	10	408	20	
Other	25	15	428	20	
Has children	28	17	656	32	.001
Current housing status					.15
Absolutely homeless	143	87	1,696	81	
Precariously housed	21	13	394	19	
Age first homeless (M \pm SD)	18.1 \pm 3.2		32.2 \pm 13.1		<.001
Lifetime duration of homelessness (months)					
M \pm SD	26.1 \pm 26.3		60.7 \pm 71.5		<.001
Median \pm interquartile range	18.0 \pm 29.0		36.0 \pm 72.0		<.001
Education					<.001
Did not complete high school	124	76	1,133	54	
Completed high school only	25	15	396	19	
Some postsecondary school	15	9	552	27	
Currently employed	6	4	67	3	.76
Monthly income (M \pm SD Canadian \$)	563.33 \pm 937.80		698.73 \pm 657.90		.073

^a Gender was self-reported as male, female, transgender, transsexual, other, or declined to answer. "Female" was combined with responses other than male for privacy reasons due to small numbers.

effects. However, rates of not completing high school and a self-reported learning disability in both groups were overwhelmingly higher than national averages (19,20). Given that a high school education has been shown to protect youths from homelessness and predict rehousing and residential stability among homeless youths (21), efforts should be directed to teenagers at risk of dropping out of high school, with the goal of preventing later homelessness. The high rate of self-reported learning disability in this sample, previously undescribed to our knowledge, also suggests that educational programs directed at homeless youths should include screening and corresponding evidence-based interventions for learning disability.

As in previous reports on homeless youths in Canada (22), many youths in our sample identified as being members of ethnoracial minority groups at rates significantly higher than adult participants, and many were Aboriginal. This may be partly explained by a cohort effect, but the ethnoracial differences are more extreme than among older and younger Canadians in the general population (23). Furthermore, although youths from ethnoracial minority groups in the general population tend to report better mental health than white youths, they appear to be overrepresented among homeless youths with mental illness (24). An At Home/Chez

TABLE 2. Clinical characteristics of and service use by At Home/Chez Soi youths and older participants (N=2,255)

Characteristic	≤24 years (N=164)		>24 years (N=2,091)		p
	N	%	N	%	
Current mental disorder ^a					
Major depressive episode	83	51	1,071	51	.88
Manic or hypomanic episode	35	21	262	13	.001
Panic disorder	30	18	494	24	.12
Posttraumatic stress disorder	58	35	598	29	.067
Mood disorder with psychotic features	27	16	345	17	.99
Psychotic disorder	48	29	782	37	.038
Drug use disorder	108	66	1,091	52	.001
Alcohol use disorder	84	51	908	43	.053
Any substance use disorder	121	74	1,398	67	.069
Moderate or higher suicidality	68	41	746	36	.14
Learning problem or disability	75	47	660	33	<.001
Traumatic brain injury (lifetime)	99	61	1,376	66	.14
Any chronic medical condition	146	89	1,975	94	.005
Infectious disease (hepatitis B or C or HIV)	8	5	501	24	<.001
Victim of assault in past 6 months					
Physically assaulted	70	44	725	36	.049
Forced into unwanted sexual activity	23	14	172	8	.010
Adverse childhood experiences ^b					
≥1	111	87	1,434	84	.48
≥4	56	44	757	45	.86
MCAS total score (M±SD) ^c	59.4±7.3		59.6±8.7		.79
Has a regular medical doctor	80	49	1,310	63	<.001
Perceived unmet need for health care in past 6 months	80	50	957	46	.41
≥2 psychiatric hospitalizations in past 5 years	67	41	789	39	.52
Recent service use					
Any health or social service use in past month	130	80	1,680	81	.73
≥1 emergency department (ED) visits in past 6 months	97	61	1,230	59	.78
M±SD	1.7±2.9		2.1±4.8		.17
Median± interquartile range	1.0±2.0		1.0±2.0		.95
Arrested in past six 6 months	60	37	558	27	.005

^a Diagnoses based on the Mini International Neuropsychiatric Interview^b Traumatic exposure in 10 categories. Values reflect number of categories endorsed.^c Multnomah Community Ability Scale. Possible scores range from 17 to 85, with higher scores indicating a higher level of community functioning.

Soi subtrial recently found that Housing First with intensive case management enhanced with antiracism and anti-oppression principles (25) was effective in improving housing stability in an ethnoracially diverse subgroup of participants (26). Further research is needed to guide culturally sensitive interventions for homeless youths. At the Winnipeg site, where over 70% of participants identified as Aboriginal, all active treatment was delivered with an Aboriginal holistic approach by staff who received ongoing cultural training. Practices such as these are likely to increase engagement and improve effectiveness of interventions delivered to Aboriginal homeless youths (27).

In our sample, youths were more likely than adults to have a drug use disorder and had rates of substance use

disorder much higher than young people in general (28). In the unadjusted logistic regression model, having a drug use disorder was associated with perceived unmet need for health care among youths. Homeless youths with co-occurring mental and substance use disorders are known to have significant barriers to care (29). More research into the complex interaction between homelessness, drug use, and access to health care among youths is warranted.

A majority of our sample reported a history of TBI, a rate much higher than prevalence estimates in the general population (30). Unfortunately, it was not possible to determine whether TBI preceded or followed homelessness, an important factor in guiding prevention efforts. The literature on homeless adults indicates similarly high rates of TBI and suggests that 70% to 90% of affected individuals experienced their first injury prior to becoming homeless (31). Given the cognitive, emotional, and behavioral sequelae associated with TBI, training of service providers and collaboration with specialized services is recommended.

The prevalence of infectious disease (hepatitis B or C or HIV) in our sample was almost five times as high among adults over age 24 compared with youths, an important finding given that these diseases can lead to chronic morbidity and death and are associated with high health care costs. Although the finding may represent an age or cohort effect, it points to an important opportunity to direct prevention efforts to youths—for example, education about transmission through sex and intravenous drug use, provision of condoms, and needle exchange programs.

Most of this sample of homeless youths reported one or more adverse childhood experiences, and almost half reported four or more adverse childhood experiences, the cutoff associated with an increased risk of poor mental health, behavioral, and general medical outcomes (16). This adds to the body of evidence from longitudinal studies that early victimization can predict homelessness in young adulthood and that preventive interventions should be targeted to child victims of abuse—for example, through child protective services (1). Our findings also suggest that homeless youths continue to be victimized at rates that exceed those of youths in the general population (32). The phenomenon of trauma both precipitating and resulting from homelessness among youths has been well described (13). Not surprisingly, over one-third of youths met criteria for current

posttraumatic stress disorder, underscoring the need for trauma-informed and trauma-specific services directed to homeless youths.

Over one-third of the youths in our sample had been arrested in the past six months, a rate significantly higher than among adult participants and youths in the general population but similar to rates among other youths with psychiatric diagnoses, such as drug use disorders (33). Given the established relationship between incarceration and homelessness (34), our findings lend further support for optimizing the criminal justice system as an entry point to housing and supports.

Less than half the youths in the sample reported having a regular medical doctor, a significantly lower proportion than among adult participants and Canadian youths in general (35), and most had visited an emergency department in the past six months (medical visits are covered by universal health care in the study setting). This finding suggests that homeless youths are receiving less preventive health care and more acute (and costlier) care. Half the youths reported unmet need for health care, which was associated with being nonmale and not being from an ethnoracial minority group or Aboriginal. The variable entails both the perception of having needed care and not having received it. Nonwhite homeless youths may be less likely than white homeless youths to perceive that they require care or may feel that their needs are better met.

The number of recent emergency department visits in this sample was associated with a self-reported learning disability and perceived unmet health care need. Because the reason for the visit was not assessed, it remains unclear whether these were

TABLE 3. Logistic regression analysis of variables associated with having a regular medical doctor in the past six months among youths in At Home/Chez Soi

Characteristic	Unadjusted			Adjusted ^a		
	OR	95% CI	p	OR	95% CI	p
Nonmale (reference: male) ^b	1.20	.64–2.25	.57			
Nonwhite (reference: white) ^c	.68	.36–1.27	.23			
Born outside Canada (reference: born in Canada)	.54	.22–1.30	.17	.57	.23–1.38	.21
Has children (reference: no children)	1.08	.48–2.44	.86			
Total months homeless	.99	.98–1.01	.33			
Income	1.00	1.00–1.00	.46			
Major depressive episode (reference: none)	.78	.43–1.45	.44			
Psychotic disorder (reference: none)	.75	.38–1.48	.41			
Drug use disorder (reference: none)	.67	.35–1.28	.23			
Alcohol use disorder (reference: none)	1.00	.54–1.85	.99			
Moderate or higher suicidality (reference: no or low suicidality)	1.80	.96–3.38	.066	1.76	.93–3.30	.081
Learning problem or disability (reference: none)	1.05	.56–1.95	.89			
N of adverse childhood experiences	.98	.86–1.11	.72			

^a In the adjusted analysis, blank cells indicate that the p value for the unadjusted analysis was <.2; these variables were not retained in the adjusted analysis.

^b Gender was self-reported as male, female, transgender, transsexual, other, or declined to answer. "Female" was combined with responses other than male for privacy reasons due to small numbers.

^c Self-identified as a member of an ethnoracial minority group or Aboriginal

true emergencies or whether the youths encountered barriers to using less acute services; the precise nature of the interaction between dissatisfaction with care, cognitive ability, and emergency department use also remains unclear. The association between perceived unmet need for health care and frequent emergency department use is

TABLE 4. Logistic regression analysis of variables associated with perceived unmet need for health care among youths in At Home/Chez Soi

Characteristic	Unadjusted			Adjusted ^a		
	OR	95% CI	p	OR	95% CI	p
Nonmale (reference: male) ^b	4.50	2.27–8.93	<.001	3.18	1.24–8.12	.016
Nonwhite (reference: white) ^c	.58	.30–1.10	.094	.36	.14–.93	.036
Born outside Canada (reference: born in Canada)	.63	.26–1.50	.29			
Has children (reference: no children)	2.54	1.07–6.03	.035	1.15	.34–3.92	.82
Total months homeless	1.01	.99–1.02	.35			
Income	1.00	1.00–1.00	.052	1.00	1.00–1.00	.29
Major depressive episode (reference: none)	1.46	.78–2.71	.24			
Psychotic disorder (reference: none)	.43	.21–.86	.018	.60	.23–1.49	.27
Drug use disorder (reference: none)	2.96	1.48–5.92	.002	2.42	.83–7.01	.10
Alcohol use disorder (reference: none)	2.07	1.11–3.89	.023	1.47	.54–4.02	.45
Moderate or higher suicidality (reference: no or low suicidality)	2.22	1.17–4.22	.014	1.05	.41–2.68	.92
Learning problem or disability (reference: none)	1.14	.61–2.12	.69			
N of adverse childhood experiences	1.15	1.01–1.31	.042	1.09	.92–1.29	.34
Has a regular medical doctor (reference: none)	1.19	.64–2.21	.58			

^a In the adjusted analysis, blank cells indicate that the p value for the unadjusted analysis was <.2; these variables were not retained in the adjusted analysis.

^b Gender was self-reported as male, female, transgender, transsexual, other, or declined to answer. "Female" was combined with responses other than male for privacy reasons due to small numbers.

^c Self-identified as a member of an ethnoracial minority group or Aboriginal

TABLE 5. Negative binomial regression analysis of variables associated with number of emergency department visits among youths in At Home/Chez Soi

Characteristic	Unadjusted			Adjusted ^a		
	RR	95% CI	p	RR	95% CI	p
Nonmale (reference: male) ^b	1.67	1.08–2.59	.022	1.32	.84–2.08	.22
Nonwhite (reference: white) ^c	.58	.38–.91	.016	.75	.49–1.15	.18
Born outside Canada (reference: born in Canada)	.52	.26–1.02	.058	.77	.40–1.48	.43
Has children (reference: no children)	1.00	.55–1.81	1.00			
Total months homeless	1.01	1.00–1.02	.19	1.00	1.00–1.01	.48
Income	1.00	1.00–1.00	.64			
Major depressive episode (reference: none)	.87	.56–1.36	.55			
Psychotic disorder (reference: none)	.71	.43–1.18	.19	.98	.60–1.63	.95
Drug use disorder (reference: none)	.72	.46–1.14	.16	.64	.41.98	.042
Alcohol use disorder (reference: none)	.83	.54–1.29	.41			
Moderate or higher suicidality (reference: no or low suicidality)	1.96	1.27–3.01	.002	1.17	.74–1.85	.50
Learning problem or disability (reference: none)	1.64	1.07–2.53	.024	1.73	1.14–2.63	.010
Adverse childhood experiences (count)	1.04	.96–1.13	.29			
Regular medical doctor	1.87	1.21–2.88	.005	1.34	.88–2.05	.17
Perceived unmet need for health care (reference: none)	1.80	1.16–2.78	.008	1.62	1.02–2.57	.043

^a In the adjusted analysis, blank cells indicate that the p value for the unadjusted analysis was < .2; these variables were not retained in the adjusted analysis.

^b Gender was self-reported as male, female, transgender, transsexual, other, or declined to answer. "Female" was combined with responses other than male for privacy reasons due to small numbers.

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consistent with findings from homeless adults (36). Having a drug use disorder was associated with fewer emergency department visits, a surprising finding that may indicate that youths with these disorders prefer receiving services elsewhere (for example, community withdrawal services) or that they may use fewer medical services in general, perhaps out of fear of criminal charges or discrimination (37). The mean number of emergency department visits was highly skewed in this sample, suggesting that a small number of individuals may have accounted for most of the visits. Studying the most frequent users of the emergency department among homeless youths may help identify those whose care and outcomes could be improved by interventions while reducing health care costs.

Several limitations must be considered in interpreting the results of our study. The primary purpose of the trial was to test Housing First among homeless adults with mental illness. Participants were recruited on the basis of study inclusion criteria and not necessarily to represent homeless youths. Our findings are similar to those from the general literature on homeless youths, which is based mostly on recruitment from local agencies (13). We were limited to analyzing data collected in the trial, which omitted some factors particularly important to youths, including sexual orientation. Furthermore, in our regression analyses, we chose to group nonwhite participants to determine the impact of race-ethnicity on service use, which may have obscured important differences between participants from

ethnoracial minority groups and Aboriginal participants. This study was not designed to identify differences between younger and older homeless adults; given the discrepancy in sample sizes between the group of participants ages 18 to 24 and the remaining participants, differences should be interpreted with caution. The instruments used in this study were mostly validated (and pretested for the trial) in the general adult population and not necessarily among young adults, which may have resulted in less than optimal precision. Finally, our analysis was cross-sectional, and we are unable to make conclusions about causative or even temporal effects of measured variables on homeless youths with mental illness. Forthcoming studies will examine

the longitudinal effects of Housing First and other factors on youths enrolled in this trial.

CONCLUSIONS

In this study of homeless individuals from five cities in Canada, homeless youths differed from homeless adults. Youths had higher rates of high school noncompletion and learning disabilities, and a larger proportion were from ethnoracial minority groups, had a drug use disorder, had been victimized or arrested recently, and did not have a regular medical doctor. Both youths and adults had similar rates of overall impairment, but the findings suggest that youths have unique needs. These differences may also reflect diverse root causes of homelessness for youths and adults and should be explored in future research to more effectively guide prevention efforts. Future At Home/Chez Soi analyses will focus on determining the effectiveness of Housing First for homeless youths with mental illness. Findings such as those described here may be used to guide the adaptation of future interventions to more effectively target youths in order to reduce the individual and societal costs associated with youth homelessness.

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Book Reviews Available Online With October Issue of *Psychiatric Services*

The October issue of *Psychiatric Services* reviews the following books online in its Book Reviews section, edited by Jeffrey L. Geller, M.D., M.P.H.:

- Faith Aimua, M.D., reviews *Miracles, Moons, and Madness*, by S. C. Ryder
- Jeffrey L. Geller, M.D., M.P.H., reviews *He Wanted the Moon: The Madness and Medical Genius of Dr. Perry Baird, and His Daughter's Quest to Know Him*, by Mimi Baird, with Eve Claxton
- Ann L. Hackman, M.D., reviews *Unhinged: A Memoir of Enduring, Surviving, and Overcoming Family Mental Illness*, by “Anna Berry”
- Amy Hoglund, R.N., reviews *Mermaid: A Memoir of Resilience*, by Eileen Cronin
- Velandy Manohar, M.D., reviews *Brave: A Painfully Shy Life*, by Helen Rivas-Rose
- M. M. Naveen, M.D., reviews *Bastards: A Memoir*, by Mary Anna King
- Roger Peele, M.D., and Mahrokh Shayanpour review *Bobby Wonderful: An Imperfect Son Buries His Parents*, by Bob Morris
- Carrie Sacco, R.N., reviews *No Map to This Country: One Family's Journey Through Autism*, by Jennifer Noonan
- Sandra Steingard, M.D., reviews *My Mysterious Son: A Life-Changing Passage Between Schizophrenia and Shamanism*, by Dick Russell