Mental Health in College Students Who Are Experiencing Homelessness or Housing Insecurity

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Key words: homelessness or housing insecurity, mental health, treatment adaptations, treatment barriers, college students

Abstract

College students experiencing homelessness or housing insecurity present with higher rates of mental health problems relative to the general college population. Despite this elevated risk and increasing rates of homelessness and housing insecurity, published studies on the prevalence and severity of these students' mental health problems are scarce. We will review relevant population trends, factors related to increases in mental health issues, barriers to engaging in treatment, and potential solutions including treatment adaptations. We will discuss findings on the effects of stigma and social support on mental health. Although students experiencing homelessness or housing insecurity encounter significant barriers to treatment, recent and ongoing efforts aim to increase equity and access to care, including digital mental health interventions, drop-in centers, and treatments adapted specifically for individuals' backgrounds and identities.

Introduction

Over the past decade, college students in the United States have experienced almost an 80% increase in rates of mental health service utilization, from a 19% rate of treatment in 2007 to 34% in 2017 (Lipson, Lattie, Eisenberg 2018). Bruffaerts and colleagues (2017) found that one in three college freshmen reported experiencing mental health problems in the past year. Another 2017 study of around 3,600 students from seven California community colleges found

that approximately one-third of students experienced housing insecurity (Wood, Harris, & Delgado 2017).

The 1987 McKinley Housing Assistance Act defines homelessness as lacking an adequate permanent or consistent nighttime residence (U.S. Congress, House, 2007). Housing insecurity encompasses a broader set of challenges such as the inability to pay rent or utilities, or a frequent need to move (Goldrick-Rab, Richardson, Hernandez, & Wisconsin HOPE Lab 2017). This paper will use the term *homelessness* while citing papers that specifically encompass the formerly mentioned population. When citing papers that address both populations, we will use the term *housing insecurity*. While better ways to describe the population are "unhoused" or "houseless," we will follow the definition of 'homelessness" and "housing insecure" as per the 1987 McKinley Housing Assistance Act in the paper. In addition, we want to specify the population as not defined by their housing-related challenges, but as moving through or experiencing them.

College students experiencing housing insecurity face additional challenges that put them at elevated risk for mental health problems (Silva et. al 2015). College students experiencing housing insecurity also have lower treatment utilization rates; a study by Eisenberg and colleagues (2011) found that students living on campus received more psychotherapy than those not living on campus. Multiple studies have confirmed the association between housing insecurity and lower academic performance, which may arise due to higher rates of mental health issues and lower class completion rates for these students relative to their non-housing insecure peers (Silva et. al 2015).

Homelessness, Housing Insecurity, and Food Insecurity — Demographic Breakdowns

Both homelessness and housing insecurity present unique sets of obstacles for college students. Studies in these populations are made complicated by the lack of documentation and reporting on these issues by colleges, as well as individuals' fears of possible consequences and the temporary nature of their living arrangements and associated difficulties with contact and follow-up (Ringer 2015). Although the Department of Education and Free Application for Federal Student Aid (FAFSA) reported more than 56,000 college students experiencing homelessness in the United States for 2013-2014 (Department of Education, 2014), there are likely many more students who haven't self-disclosed an insecure housing status due to the negative stigma associated with housing insecurity and other factors (Ringer 2015). By 2018, the recorded number of college students experiencing homelessness had increased to more than 68,000 (Freedom of Information Act, 2018). The Los Angeles Continuum of Care reported that the rates of homelessness among transition-age youth households (those moving from state custody to foster environments) and minors without legal guardians increased by 19% from 2019 to 2020, corresponding to the onset of the COVID-19 pandemic (LAHSA, 2020).

In Los Angeles County's 2020 survey of youth aged 18-24 who were homeless at the time, 38% were African American and 43% were Hispanic or Latino (LAHSA, 2020). Across the age spectrum, African Americans were four times as likely to experience homelessness than Caucasians; the report cited structural racism as a contributing factor to these disparities (LAHSA, 2020). While racial minorities report overall lower rates of mental health disorders in what has been dubbed the "minority mental health paradox" (Schnittker & Do 2020), in which racial minorities who present with mental health problems are less likely to receive treatment and prescribed pharmaceutical medicine (AHRQ, 2018).

In the general population of those experiencing homelessness, males are overrepresented — two-thirds of people experiencing homeless in Los Angeles identify as male (LAHSA, 2020). However, this gender imbalance is reverse in college students who are housing insecure, in which females are overrepresented. A 2017 survey conducted by the Wisconsin Hope Lab found that 75% of all undergraduates moving through housing insecurity were female (Goldrick-Rab, Richardson, Hernandez, & Wisconsin HOPE Lab 2017). The authors speculated that this trend reflects the majority of those in higher education who overall identify as female. Those over the age of 25 are also overrepresented in college students moving through homelessness — 45% were over the age of 25, while 27% were under the age of 21 (Goldrick-Rab, Richardson, Hernandez, & Wisconsin HOPE Lab 2017). Youth in guardian or parental custody, unaccompanied youth who aren't under guardian custody, and non-traditional students over the age of 25 who may already be parents and have delayed enrollment are also disproportionately represented (Ringer 2015), with the last of the three groups making up the largest percentage. While some college students have experienced chronic housing instability, others may be facing housing insecurity for the first time in college, likely due to rising tuition costs (Geis 2015).

Food insecurity, which has often been linked with housing insecurity, is defined as lacking access to sufficient food due to monetary or other limitations (Gundersen & Ziliak 2015). The general trends of housing insecurity and food insecurity in California reflect broader patterns across the United States (University of California Global Foods Initiative 2017, Goldrick-Rab, Richardson, Hernandez, & Wisconsin HOPE Lab 2017). Recent estimates indicate that 42% of students in the University of California college system experience food insecurity yearly, with transfer students being more likely to experience food insecurity than freshmen — 52% versus 42%, respectively (University of California Global Foods Initiative 2017). The same study found

that students at California State Universities (CSUs) experienced food insecurity at half the rate (around 21%) of students at UC schools. Although a systematic study of California community college students has yet to be conducted, country-wide studies of food insecurity at community colleges indicate that the percentage may be much higher than those of UCs and CSUs (Goldrick-Rab, Richardson, Hernandez, & Wisconsin HOPE Lab 2017).

For the youth and young adult populations, homelessness or housing insecurity have been associated with higher levels of mental health issues. More than two-thirds of youth and young adults who are homeless meet the criteria for having a mental health disorder (Cauce et al., 2000, Hodgson et al., 2014, Whitbeck et al., 2004). According to the Los Angeles Homeless Security Authority, 18% of youth aged 18-24 who are homeless reported having serious mental illness (LAHSA, 2020), which was more than twice the 8% prevalence of serious mental illness in 18-25-year-olds overall (NIMH 2019). From 2019 to 2020, 18-24-year-old youths experiencing homelessness evidenced a 14% decrease in the prevalence of serious mental illness and a 163% increase in substance use disorders (LAHSA, 2020).

Barriers to Seeking Treatment

A significant barrier to accessing care is students' awareness of mental health problems and corresponding resources. Only one-third of students suffering from mental health disorders receive treatment, while less than 25% of students who are homeless or housing-insecure are even aware of needing treatment (Eisenberg et. al 2011). A lack of awareness of either having mental health problems or of the existence of services could explain the lack of reported need for treatment (Homelessness Policy Research Institute 2019). In a 2018 study of youth experiencing

homelessness, despite more than half of respondents meeting criteria for having mental health problems, less than half reported a need for accessing treatment services (Pedersen et. al 2018).

Although most universities have designated departments or offices to support students struggling with mental health issues, few have similar resources for students experiencing housing insecurity. Students face the common barrier of not even knowing how to access such services, even if the resources are available (Geis 2015). For instance, the FAFSA form for financial assistance asks for certain information that they may have difficulty accessing (Geis 2015).

In a 2014 study of the overall college student population at Midwestern universities, the most commonly cited reasons for college students overall not seeking treatment included "embarrassment," "denial," and "not wanting to seem crazy" (Vidourek et. al 2014), all of which indicated stigma. In another study across multiple college campuses, students mainly reported that there was "no need" for treatment and that they may have had competing priorities, such as academics (Castillo & Schwartz, 2013). Students who are housing insecure face amplified stigma due to their housing status (Vidourek et. al 2014), in addition to stigma-related barriers already commonly cited in the general college population. These include, but are not limited to, perceived ineffectiveness of treatment and inconveniences related to receiving treatment (Sareen et. al 2007).

Further barriers may arise for college students experiencing housing insecurity depending on their socioeconomic status and race. Among college students, the "minority mental health paradox" persists, where white youths are more likely to receive mental health treatment and prescription medicine than Asians, non-white Hispanics, and African Americans, yet more likely to experience distress or depression (Schnittker & Do 2020). Lower rates of treatment for racial

minorities may be associated with the lower retention and graduation rates and the higher frequency of African Americans and Hispanics currently experiencing homeless (Eisenberg et. al 2011, Moore 2018). Poorer families, which constitute a majority of those experiencing housing insecurity, also have lower treatment rates (Eisenberg et. al 2011).

Underserved minority youth and young adults specifically have high rates of disengagement with treatment (Moore 2018). With traditional mental health services, the minority youth and young adult population has to manage responsibilities including but not limited to managing costs, finding transportation, and committing to scheduled appointment times in addition to already existing stressors (Schueller et. al, 2019; Glover et. al, 2019). In addition to logistical barriers, youth who are homeless have reported individual barriers, such as low motivation, lack of support, and poor therapeutic relationships (Kozloff et. al 2013). As disengagement with services presents a major challenge to providing effective mental health treatment, the heightened risk of poorer outcomes from treatment poses further concerns for homeless students from racial minorities or lower socioeconomic backgrounds (Moore 2018).

Potential Areas of Treatment Adaptations

Due to the treatment barriers mentioned earlier and other barriers not explicitly named, engaging college students experiencing housing insecurity in traditional mental health treatments may be difficult. To better address these barriers, different treatment adaptations provide possible solutions for increasing engagement and effectiveness of mental health treatments.

1. *Social Support*

Social support, consistently defined as a key determinant of mental wellbeing for college students, plays an even larger role in the mental health of students who are housing insecure

(Hefner and Eisenberg 2009, Geis 2015, Burleson 2009, etc.). Social support has been associated with fewer negative emotions (Burleson 2009) and better academic achievement in college students (de la Iglesia, Freiberg Hoffmann, & Liporace 2014), but students moving through homelessness may be lacking in several support systems (Geis 2015). Having a lack of social support in college students has been associated with higher rates of mental health problems such as "depression, anxiety, and somatic complaints" (Brown, Brady, Lent, Wolfert & Hall, 1987, p. 342). Due to the unstable nature of homelessness, students struggling with homelessness also struggle with having proper social support (Geis 2015). For youth experiencing homelessness that do have social support, namely from their teachers and peers, Griffin and colleagues (2019) suggest that the aforementioned sources of support can promote positive affect and resilience.

Although social support interventions have not been specifically developed for college students experiencing housing insecurity, promising adaptations based on social support have been studied in similar populations (Homelessness Policy Research Institute, 2019). A 2018 survey conducted in Los Angeles of 18-25 year olds in supportive housing buildings led to better social relationships and better health outcomes (Henwood et. al 2018). While another 2018 study found social connectedness to be an effective buffer to mental health problems in youth in Los Angeles and two other major cities (Austin, TX and Denver, CO), it warned of certain adverse social networks that may lead to substance use issues (Begun et. al 2018).

2. Digital Mental Health Interventions

Recent research on adapting online or smartphone-based mental health services aims at increasing accessibility (Schueller et. al 2019). Although exact rates of phone ownership and usage vary across studies, they remain consistently high. A 2019 Pew Research Center study found that 96% of Americans own a cellphone of some kind, a 2017 study of 421 homeless

adults cited that 96% owned a cell phone (Rhoades et. al, 2017), and 62% of 169 homeless youth in a study by Rice, Lee & Taitt owned a cell phone (Rice, Lee & Taitt, 2011).

Technology comes with its own usage and knowledge barriers, however. For instance, youth and adults who are homeless have high turnover rates with phones and phone numbers and lower rates of Internet access (Rhoades et. al, 2017). Participants using mobile health applications from low-income and racially diverse populations reported a lack of confidence, frustration with mobile application design navigation, and overall difficulty in technology use (Sarkar et. al 2016). In addition, many low-income families rely only on shared smartphones for Internet access (Pew Research Center, 2019), which could raise issues of privacy and confidentiality. With limited Internet access, issues with data-intensive mental health apps may also arise.

Despite having potential usage-related complications, online-based mental health services allow for easier access to treatment for homeless populations and less major barriers overall. A pilot study in Chicago recruited 35 participants, all homeless and aged between 18 and 24, and supplied them with a mobile phone, data plan, and three mental health apps preinstalled. Participants also had access to one month of phone support from a therapist trained in treatment for homeless populations. Both the apps and coaching services based their treatment approaches on cognitive behavioral therapy (CBT) principles (Schueller et. al 2019). At the end of the one-month intervention trial, participants reported high satisfaction rates with the program; 100% of participants noting that they would recommend the treatment to someone else. A majority of participants (20/35) completed all three coaching sessions, and participants tended to engage in either none or all phone sessions (Schueller et. al 2019). Schueller and colleagues suggest that

even with a lack of incentives to continue engaging the program, participants found the treatment services valuable.

Since the study's small sample size ended up inconclusive on improvements in clinical outcomes, a follow-up study tracked the progress of 100 youth volunteers experiencing housing instability over the course of up to six months (Glover et. al 2019). Despite only 48% of participants completing the three-month midpoint survey, the engagement rate was still higher than those enrolled in the control group receiving traditional mental health services. The remaining participants reported high satisfaction rates with the study; 84% of the 19 youth who completed the entire six-month program said that they would recommend it to someone else (Glover et. al 2019). Although Glover and colleagues found that participants preferred automated services over those involving direct human interaction, clinical effectiveness needs to be further explored. Glover and colleagues propose that digital mental health interventions can serve complementary to traditional mental health treatments. Albeit not directly replacing in-person services, digital interventions can improve traditional treatments' low rates of satisfaction and engagement (Glover et. al 2019).

Digital mental health interventions as supplementary services to traditional mental health services have also shown potential for those from racial minority populations (Aguilera et. al 2017; Schueller et. al 2019; Ramirez et. al 2016; Torous et. al 2020). A study of low-income Latino patients experiencing depression demonstrated lower dropout rates and higher engagement levels when providing text messaging as an adjunct to CBT treatment (Aguilera et. al 2017). Text messages included daily mood monitoring, summaries of the week's content, and medication and appointment reminders. Like those from homeless or housing unstable populations, the patients enrolled in the study were similarly less technologically savvy and more

difficult to engage than their counterparts of higher socioeconomic status (Aguilera et. al 2017). Another study following a similar population of Hispanics/Latinos with alcohol, drug, and/or mental health disorders also found high engagement rates with digital treatment — 58 of 73 patients stayed engaged in a supplementary smartphone recovery app after residential treatment (Muroff et. al 2017). To meet the high demand for mobile health tools for Spanish speakers, the app was specifically adapted linguistically and culturally for Spanish speakers (Muroff et. al 2017). App features included text messaging adjuncts, as well as educational and social support resources and daily survey reminders to take medication. Resources embedded in the app related to participants' experiences with alcohol or drug abuse (Muroff et. al 2017). While the study has limitations in small sample size and bias, as most patients were Latino males, it further supports the narrative that digital mental health technology can narrow the disparities in minority healthcare and mental health treatment (Muroff et. al 2017). Therefore, for both homeless and historically disadvantaged populations, which often overlap, technology offers a bridge to address the gaps and disparities in mental health services (Schueller et. al 2019).

3. Drop-In Centers

For those who may have difficulties accessing digital mental health interventions, drop-in centers may also provide a safe space for youth experiencing homelessness looking for mental health and other services. They are the most widely used services for this population — more than a majority of 83 youth surveyed in Chicago, IL, and Los Angeles, CA, used drop-in centers (58%), compared to less than half going to shelters (36%) or counseling centers (40%) (Pedersen et. al 2016). In Canada, focus groups demonstrated the positive influence of social support in the mental health of youth who are homeless, attributing family and peer support in initiating youth's visiting drop-in centers (Pedersen et. al 2016). A myriad of additional factors contribute

to drop-in centers' popularity over other service venues. DeRosa et. al 1999 cites some factors as greater flexibility, less paperwork, greater confidentiality, and less restrictions. Those using drop-in centers over other traditional services also noted that the high costs and difficulty finding transportation acted as barriers to seeking out the latter (Pedersen et. al 2016). Drop-in centers ease the need for scheduled appointment times and may lessen the stigma associated with asking for help. Because drop-in centers also typically provide other basic services such as food and clothing, they can serve as convenient places for homeless youth to access mental health services as well. Nevertheless, independent motivation on the patient's part and difficulty locating a drop-in center itself still pose substantial barriers to accessing drop-in mental health care (Pedersen et. al 2016).

4. Other Interventions

Other less commonly studied potential interventions include but are not limited to finding housing for college students experiencing housing insecurity first, prioritizing trauma when treating mental health, and providing students with pets to reduce loneliness (Homelessness Policy Research Institute, 2019) . The short-term efficacy of these interventions looks promising, but long-term effectiveness has yet to be sufficiently studied. While they address barriers such as housing itself, they may be difficult to execute for the majority of students experiencing housing insecurity due to costs and other factors.

Discussion and Future Directions

With the growing population of college students struggling with housing insecurity will come increased demand for mental health services. The treatment adaptations mentioned in the paper provide avenues to improve engagement, efficiency and effectiveness. Rather than

implementing a one-size-fits-all approach to treatment, what is called for is a shift toward a more personalized approach that can overcome obstacles and barriers associated with traditional mental health treatment. Digital or hybrid services and drop-in centers lessen the need for reliable transportation and scheduling, while tailoring care to participants' cultural and ethnic backgrounds can improve engagement and outcomes. Digital mental health interventions offer have the potential to increase access to care and engage in young adults' lives where traditional treatments have lacked. Despite this promise, further study should be conducted in the long-term effectiveness of treatment adaptations, as the published evaluations of such interventions has focused on the progress of participants over the course of less than a year. Additional research should focus specifically on the population of college students who are housing insecure, as opposed to the more general populations to which the students belong (i.e. homeless youth or college students). Nevertheless, with the promising direction that treatment adaptations and interventions are moving, one day college students struggling with housing insecurity may finally get the specialized mental health care they need.

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