Youth Homelessness in Canada, Germany, and the United States: A Cross Cultural Comparison and Exploration of Health Literacy as a Means of Prevention

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ABSTRACT

Because of its multiple pre-disposing factors and statistical potential for adverse outcomes, youth homelessness is a significant problem which transcends national borders. An overview and comparison of youth homelessness in Canada, Germany, and the United States (U.S.) illustrates that the problem of youth homelessness is not confined to any one country. An examination of the prevalence of youth homelessness indicates that statistics gathered are vague and widely ranged for all three countries. The definitions of homeless youth are numerous; however, the underlying theme is consistent. Common predisposing factors and socio-environmental influences on youth homelessness are identified. The impact of support and prevention programs within each country is discussed. Health literacy, within the school setting, is considered as a strategy to address youth homelessness.
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Introduction

Statistics gathered in Canada, the United States, and elsewhere internationally in the last 20 years indicate that young people are making up the fastest growing subgroup of the homeless population [UNCHF, 2002 (cited in Dachner & Tarasuk, 2002)]. There is a common thread among Canadian, German, and the United States societies with respect to youth homelessness and the definitions that attempt to classify it. In Canada, street youth are *"youth who spend lengthy amounts of time on the street, who reside in marginal or precarious living quarters, and who are involved extensively in the street lifestyle"* (Kelly & Caputo, 2007, p. 728). In the United States, the Runaway and Homeless Youth Act provides an overarching definition of a homeless youth as one who is "*not more than 21 years of age…for whom it is not possible to live in a safe environment with a relative and who has no other safe alternative living arrangement"* (Moore, 2005, p. 3). In Germany, *street kids* are defined as "*living and surviving on the streets with unsupportive family and school networks, and changing sleeping places"* (Off Road Kids, 2008; Rohman, 2000). Limited research and lack of a universal definition for homeless youth contribute to the challenge of comprehending the scope of the problem and developing policies and programs that effectively target this population in need (Frankish, Hwang, & Quantz, 2005; Moore, 2005; Smith et al., 2007).

Numerous pre-disposing factors contribute to the phenomenon of youth homelessness - a population that is high-risk for numerous and compounding adverse socio-environmental influences. Youth turn to the street lifestyle or are forced out of the home due to family breakdown, economic problems, physical and/or mental health issues, lack of education and job training, and/or because of residential instability (Frankish et al., 2005; Kelly & Caputo, 2007; McCreary Centre Society [MCS], 2002; Moore, 2005; Rutman, Hubberstey, Barlow, & Brown, 2005; Smith et al., 2007). The social and/or health consequences associated with street involvement and homelessness are multifold and include the following elements: depression, suicidal or self-destructive behavior; poor nutrition, health and illness; substance abuse; sexually transmitted infection; survival sex; pregnancy and delinquency (MCS, 2002; Moore, 2005) Homeless youth have limited job skills; many have dropped out of school, and; lack transportation and a supportive social network (Moore, 2005). All three countries have supportive-prevention programs in place for homeless youth offering counseling, housing, health care services and/or job-skill training. Unfortunately, programs that provide support are often not capable of meeting the demand because of the overwhelming number of vulnerable youth, limited funding, and restrictive policies (Smith et al., 2007). The concept of *health literacy* within school-based approaches will be discussed as a potential method for addressing prevention of youth homelessness in Canada, Germany, and the United States.

Youth Homelessness in Canada

In Canada, it is estimated that one-third of the homeless population includes youth between 16 and 24 years of age, and that on any given night, 65,000 youth are without a place to call home (Raising the Roof**,** 2008). A comprehensive definition of *street involved youth* encompasses youth who lack housing stability and engage in street life activities; i.e. "being homeless, panhandling, involvement in sex trade, selling or using drugs, or engaging in criminal activity" (Smith et al., 2007, p. 12). This definition allows researchers to illustrate a realistic portrayal of the situation street involved youth face, allowing them to influence the creation of effective policies, strategies and programs aiming to reduce or prevent youth homelessness.

In Canada, provincial and territorial governments have jurisdictional accountability over child welfare up to the age of 18 (Tweddle, 2005). Currently, local, province-wide, and nation-wide initiatives are being implemented by organizations and governments in an effort to reduce the prevalence of youth homelessness. Through the implementation of outreach programs, needs assessments, innovative strategy and program development, and appeals to policy makers, organizations are working to decrease youth homelessness. For example, Canada's *Raising the Roof* (www.raisingtheroof.org), launched a three-year funded project entitled Youthworks. This project's mission is to develop strategies and programs aimed at breaking the cycle of homelessness among Canada's youth.

Covenant House is a privately funded organization in Vancouver that offers support to street involved youth (www.convenanthousebc.org). *Covenant House Vancouver* opened in 1997 in response to the imminent need for youth short term transitional shelter and long term residential support. *Covenant House* provides services along a continuum of care including basic needs and support for transition into independent living for youth ages 16 to 24. Basic needs are met through the provision of shelter, medical assistance, obtaining identification, street outreach, counseling, and help obtaining employment and housing. A comprehensive Rights of Passage program exists to help street involved youth progress to stabilized independent living. This transitional living program consists of residential support and individual case support in vocational, educational, counseling, and after care support services. Evaluations of support programs offered at *Covenant House* indicate positive outcomes for some youth who utilize the services. A study that evaluated a Rights of Passage program indicated that up to 70% of youth who graduated from the program had a job and a place to live one year after leaving the program (Covenant House, 2008). Despite these encouraging results, existing policies and practices that impact this population must undergo ongoing evaluation and revision to ensure their beneficial effectiveness.

Youth Homelessness in Germany

There are no statistics for youth homelessness in Germany, as the only numbers captured are youth declared missing. However, estimates of the prevalence of youth homelessness in Germany vary from between 1,500 to 50,000 (Rohman, 2000, p. 14). This variation depends on: the definition used for the term *homelessness*; how long the juvenile has been living on the street; and, if the youth has an adequate place to reside. In 1996, the President of the German Child Protection Agency, Heinze Hilger, announced that there were 50,000 children in Germany who could be considered homeless (Rohman, 2000, p. 14). A major German newspaper, the *Frankfurter Rundschau*, defined homeless youth as, *those who have left their homes* (Rohman, 2000, p. 14). The organization, Off Road Kids (www.offroadkids.de), assumes that approximately 2,500 youth live on the streets annually, of which 300 are *street youth* (Seidel, 2008). Youth begin life on the street as early as 8 years old, however, the majority enter the street life around the age of 13 (Seidel, 2008). Explanations for the large range in estimates of street youth include: lack of residential stability; and their transient nature. The main centres for homeless street kids include the following venues: Berlin; Hamburg; Cologne; Frankfurt; and the Ruhrgebiet. Cities such as Munich, Leipzig, and Stuttgart are only stopovers.

To address youth homelessness in Cologne, a project entitled Beratung und Orientierung für Jugendliche und junge Erwachsene (B.O.J.E) was introduced to provide support services to homeless youth. The B.O.J.E. project began in 1993 to help vulnerable teenagers and young adults who are involved in street life (http://boje-koeln.de/). The project is financed by the Health Office of Cologne and the organization Auf Achse GmbH and is situated in a public bus at the back of the central train station. The crew consists of four social workers, a social pedagogue, a psychologist, and a doctor offering services in the areas of consultation and orientation. Themes of consultation include: youth welfare service advice; health; drugs/addiction; safer sex; pregnancy; judiciary advices; and, issues specific to youth, such as: relationships, conflicts with family or school, and apprenticeships. The provision of health promoting materials include: free vitamin juice; free condoms; and the exchange of disposable syringes. A relaxation room where youth can play parlour games, read magazines; and/or surf the

internet also exists. The B.O.J.E. utilizes a low threshold approach, offering anonymous services to youth without consequences involving police or social services (Schubert, 2006).

According to Schubert (2006), of the underage visitors who utilized B.O.J.E. services in 2006, 12% stayed in the milieu for over a year, 60% were female, 40% male, 10% were under 14 years old, 90% were age 14 to 17 years, and 351 visitors were between 18 and 25 years old. Prevention services were utilized by 77% for condoms, vitamin juice, exchange disposable syringes, or relaxation. Psychosocial consultation was utilized by 22% for health; drug addiction, pregnancy, safer sex, and/or conflict resolution with family or partners. Bedding was procured by 1%. B.O.J.E. was open for 239 days in 2006 and 10 visitors came during each hour that the bus was open. An average of 36 youth and maximum of 57 youth per operating hour visit B.O.J.E. (Schubert, 2006).

Youth Homelessness in the United States

Homelessness among youth in the United States dates back as far as the country's earliest history (Moore, 2005). From the early 20th Century through the 1960s, the needs of a generally unspecified problem of runaway and homeless youth were handled locally through the child welfare agencies and juvenile courts (Congressional Research Service, 2007). In the 1970s, there was a shift towards federal oversight of programs and in 1974, the Runaway Youth Act was legislated by Congress. In 1977, the Act was expanded to include homeless youth and was renamed, the Runaway and Homeless Youth Act (RHYA) (Congressional Research Service, 2007). Programs within the RHYA that receive federal funds are the Basic Center Program; Transitional Living Program; Street Outreach Program; National Runaway Switchboard, and; Maternity Group Homes (U.S. Dept. of Health and Human Services, 2008). Youth in this population are classified as: *street youth*; *thrown away youth*; *runaway youth*; and *homeless youth*. The programs provide an overview definition of homeless youth as: ages ranging from 12 to 21 years old; runaway, left or forced out of the home; with or without parental/guardian consent; without an adequate alternate living arrangement, and; for more than 24 hours (Moore, 2005).

The exact number of homeless youth in the United States is not known. In 2006, it was estimated that at any given time, there were between 500,000 and 2.8 million youth that were homeless (National Coalition for the Homeless, 2007). Youth homelessness is prevalent in urban, suburban and rural areas, but is most visible in major cities. More than 50% of runaways are girls, while the majority of youth living on the streets are boys, and 40% of homeless youth do not return home (Moore, 2005). A 2008 report to Congress stated that 3% of the homeless shelter population was unaccompanied youth, and that 3.4% were age 13 to 17 years old (N=1,150,866). The 3.4% included unaccompanied youth and youth in families (U.S. Dept. of Housing and Urban Development, 2008).

An example of a program that supports homeless youth is a Transitional Living Program (TLP) that is located in San Francisco This TLP offers long-term residence and vocational services for homeless youth ages 18–24 years old. In 2005, an evaluation study (n=23) of the program demonstrated that 100% of the homeless youth that initiated a comprehensive employment training program and stayed in the program for 2+ months, were discharged to stable housing. At 6 months post-discharge, 87% could be located, and of that percentage, 90% were still stably housed (Winston-Salem Plan to End Homelessness, 2005).

Information on the effectiveness of the programs is limited due to the lack of peer-reviewed literature (Moore, 2005; Winston-Salem Plan to End Homelessness, 2005). Studies on youth homelessness are further limited due to the ethical considerations of research on minors without parental/guardian consent. It has also been found that homeless youth will avoid shelters and other services where assistance is offered and where data can be collected because they may mistake help for victimizers, police, or social services (Moore, 2005).

Future Recommendations: Health Literacy and the School Setting

Research conducted internationally examining the outcomes of youth transitioning out of government care, a population at risk for street involvement, has illustrated common adverse health outcomes and poor quality of life (Rutman et al., 2005; Tweddle, 2005). Programs that provide support for vulnerable street youth exist in all three countries, yet, the problem persists. Literature on building resilience and protective factors for vulnerable youth indicates the negative outcomes associated with growing up in unstable or abusive living situations can be buffered or avoided if youth possess resiliency and develop self-protective behaviors [MCS, 2002; Silva-Wayne, 1995; Stein, 2005 (as cited in Tweddle, 2005)]. School-based primary prevention programs that use health literacy and the Health Promoting School (HPS)/ Coordinated School Health Program (CSHP) frameworks are considered for the prevention of youth homelessness.

Health Literacy

The internationally understood concept of health literacy is broadly defined as *"the extent to which people have the ability to obtain, understand, and communicate health information and to assess it"* (Rootman & Ronson, 2005, p. S63) – and can be used as a tool to empower youth to create their own positive health outcomes. As shown in Figure 1, Nutbeam (2000) outlines a three-level hierarchy of health literacy: 1) *basic/functional health literacy*; 2) *communicative/interactive health literacy*; and 3) *critical health literacy*. The highest level, *critical health literacy*, will be discussed as a prevention tool. *Critical health literacy* is defined as *"the cognitive and skills development outcomes which are oriented towards supporting effective social and political action"* (Nutbeam, p. 265). This level requires the collaboration of key stakeholders in the promotion of individual and population benefits through the improvement of personal and community/population capacities to act on social and environmental determinants of health. As critical health literacy emphasizes social issues at a population level as well as amendments to policies and practices, it is recommended that it be used to address the international problem of youth homelessness.

Figure 1. Strategy to Address Youth Homelessness through the Lens of Health Education.

Source: Hayos (2008). Unpublished.

Health Promoting School/Coordinated School Health Program

In the past, school health education and promotion has been based on the premise that schools can be utilized as an effective setting to target adolescents and at-risk groups. [World Health Organization [WHO], 1996b (cited in St Leger, 2000)]. More recently, schools have begun to take on the role of building protective factors and resilience in young people (Nutbeam, Smith, Moore, & Bauman, 1993; Resnick, Harris, & Blum, 1993). It is recommended that the school setting be utilized as an environment to reach vulnerable youth prior to street involvement to allow the development of capacities, skills, and resiliency needed to overcome adverse experiences and enable positive outcomes.

Achieving critical health literacy appears to be beyond the capacity of many schools (St Leger, 2001). Critical health literacy works to promote health at individual, community and population levels. Therefore, strategies and programs working to reduce youth homelessness must connect all levels of influence to create sustainable changes. Research indicates the HPS/CSHP approach provides the framework necessary to meet the challenges associated with achieving critical health literacy (St Leger, 2001). It is recommended that the HPS/CSHP approach be utilized as a potential framework in the development of school-based primary prevention programs aimed at achieving critical health literacy in vulnerable youth and their communities.

Outcome objectives

The proposed health literacy outcome objectives (Figure 1) aimed to promote youth's acquisition of knowledge and the development of skills (Table 1) can only be achieved if the recommended components are included in strategy and program development. The HPS/CSHP framework promotes the connection between youth, communities, and key stakeholders, serving to bridge the gap between research and practice, enabling youth and communities to take an active role in shaping the policies and programs that influence their health and quality of life.

Conclusion

The negative socio-environmental consequences of youth homelessness in Canada, Germany and the United States have had a profound impact on this vulnerable population. Determining the scope of the problem in the three countries has remained a challenge at the local and national levels. The definitions of youth homelessness are vague and/ or inconsistent. Canada, Germany and the United States have programs that provide supportive services and that aim to reduce the prevalence of youth homelessness. Unfortunately, the grave situation persists. The concept of health literacy in school-based programs has been identified as an approach to

preventing youth homelessness. The Ottawa Charter for Health Promotion defines health promotion as the process of enabling people to develop control over their own health (WHO, 1986). The key concept of health promotion is empowerment (Rootman & Ronson, 2005). It is essential that the concept of empowerment be integrated into the policies and practices which influence the outcomes of vulnerable youth. Further research on youth homelessness and examining prevention outcomes of health literacy/health promotion is critical. Integrating the concepts of health literacy and empowerment into existing support programs may be the key to promoting sustainable life changes that reduce or eliminate youth homelessness.

Table 1. Knowledge and Skills Needed to Make Successful Transitions into Adulthood.

Health Literacy Domains	**Knowledge and Skills**
Access	*Access* existing support services
Comprehend	*Comprehend* consequences associated with street involvement
Evaluate	*Problem solve* and *critically evaluate* challenging situations
Communicate	*Advocate* for improved services and *communicate* personal needs

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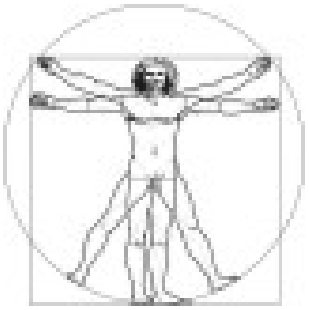

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