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Mental Health, Suicidal Behaviour, and Primary Healthcare among Homeless Youth

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ABSTRACT

Youth homelessness is a complex psychosocial problem. It refers to the experience of young people who live without their parents or legal guardians and who do not have the means or the capacity to reside in a stable, secure, and permanent place. This exploratory study sought to examine the mental health and suicidal behaviour of 76 homeless Québec adolescents as part of a reflection on the mission of primary healthcare. Note that these adolescents are mostly in the first segment of the homelessness continuum and have voluntarily left their homes because of personal and family difficulties. These 43 girls and 33 boys aged 12 to 19 living temporarily in shelters completed a semi-structured interview and self-administered questionnaires regarding stressful events, psychosocial stress, and mental health. Of these, 38 reported suicidal behaviour, including attempted suicide in 19 cases. The results show that these young people exemplify a high degree of suffering and multiple problems. Evidence indicates that lost relationships and academic problems rooted in attention deficit/hyperactivity disorder are linked to suicidal behaviour. Finally, non-productive coping strategies centred on somatization and little reassurance of worth provided by the social support network are associated with suicidal behaviour. Caregivers in temporary shelters should look out for these factors and refer vulnerable youth to primarycare mental health professionals.

Keywords: homeless youth, mental health, suicidal behaviour, primary health care

RÉSUMÉ

L'itinérance chez les jeunes est un problème psychosocial complexe. Il renvoie à l'expérience que connaissent des jeunes qui vivent sans leurs parents ou gardiens et qui n'ont pas les moyens ni la capacité de résider dans un lieu stable, sécuritaire et permanent. Cette recherche exploratoire vise à étudier la santé mentale et les conduites suicidaires de 76 adolescents itinérants temporaires québécois dans le cadre d'une réflexion sur la prise en charge en soins de santé primaires. Notons que ces adolescents s'inscrivent majoritairement au premier segment du continuum de l'itinérance et qu'ils ont quitté volontairement leur domicile pour des difficultés personnelles et familiales. Ces jeunes (43 filles et 33 garçons) âgés de 12 à 19 ans, hébergés temporairement dans un refuge, ont été rencontrés afin de participer à une entrevue semi-structurée avec passation de questionnaires autoadministrés portant sur les événements stressants et le stress psychosocial ainsi que leur santé mentale. Parmi eux, 38 présentaient des conduites suicidaires, dont 19 avaient fait une tentative de suicide. Les résultats montrent que ces jeunes présentent une souffrance élevée avec des problèmes multiples. Les données indiquent que les ruptures affectives et les problèmes scolaires enracinés dans un trouble d'attention/hyperactivité sont liés aux conduites suicidaires. Enfin, les stratégies non productives de somatisation et le peu de soutien quant à la réassurance en sa valeur sont associés aux conduites suicidaires. Les intervenants des refuges temporaires sont invités à bien repérer ces éléments afin de les référer à des professionnels en soins primaires de santé mentale.

Mots clés : jeune sans-abri, santé mentale, suicidalité, soins de santé primaire

PROBLEM

Statistics show that about 235,000 Canadian citizens experience homelessness each year, of which 20% are reportedly under the age of 25 (Gaetz, Dej, Richter, & Redman, 2016). In Québec, 2,124 stays were spent by 1,863 youths in 2012–2013 in one of the 30 temporary shelters that are part of the Regroupement des Auberges du Cœur du Québec collective (Regroupement des Auberges du Coeur du Québec, 2018). The risk

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of ending up homeless or living on the street is a very real possibility for adolescents. Some authors, such as Karabanow (2004), have shown how this problem severs the natural support youths receive from parents or legal guardians and compromises the possibility of a safe and planned transition into adulthood. Studies indicate, also, that homeless youths are more likely than the general population to have mental health problems (Farrow, Deisher, Brown, Kulig, & Kipke, 1992) and suicidal behaviour (Auerswald, Lin, & Parriott, 2016; Roy, Haley, Leclerc, Sochanski, Boudreau, & Boivin, 2004). Yet, the primary care mental health services trajectory still does too little to meet the needs of homeless youths (Karabanow & Naylor, 2013).

We undertook a study to describe the clinical characteristics of homeless youths, with or without suicidal behaviour, who were staying in temporary shelters, and from a set of variables, identify the best predictors of the presence of suicidal behaviour. Ultimately, this exploratory study aims to generate new avenues of research and intervention for future studies and treatment for homeless youth. Aside from the introduction and the conclusion, this article deals with youth homelessness, research on this population, and primary mental health care.

Homelessness in Youth

The homeless youth population is difficult to characterize on account of the diversity in the types of housing instability that they face. In this regard, Greenblatt and Robertson (1993) defined these youth as adolescents 17 or younger who spent the previous night in a shelter or on the streets. This definition contrasts with that used by Kipke, O'Connor, Palmer, and MacKenzie (1995), which included homeless youth "surviving on the streets" (e.g., from begging, theft, prostitution). For the Canadian Observatory on Homelessness (Gaetz et al., 2016), youth homelessness refers to "the situation and experience of young people between the ages of 13 and 24 who are living independently of parents and/or caregivers, but do not have the means or ability to acquire a stable, safe or consistent residence." Moreover, the heterogeneousness of the homeless youth population led the National Alliance to End Homelessness (2012) in the United States to create a typology based on three homelessness trajectories:

- *Temporarily disconnected*: Youth in this category are often younger, have a shorter history of homelessness, and are still in school. They have more interactions with their family and are on more stable terms with it. Most homeless youth fall under this category.
- *Unstably disconnected:* These youth are characterized by a more complex housing history and are more likely to experience longer and repeated episodes of homelessness. They are generally drop-outs and have difficulty finding and holding a job. Most maintain ties with their family, and they are less likely than their chronically disconnected counterparts to have serious mental health or substance use problems.
- *Chronically disconnected*: These youth are defined by long-term homelessness and a high recurrence of homelessness episodes. They are more likely to have mental and addiction problems or a disability. Their family ties are generally highly unstable or completely severed. Less than 10% of homeless youth fall under this category.

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Homelessness, Youth and Suicidality

The existing literature estimates the prevalence of attempted suicide in this population at 20% to 42% (Gonzalez et al., 2018; Kidd, 2004; Kidd, Gaetz, & O'Grady, 2017; Rotheram-Borus, 1993; Yoder, 1999), compared with about 9% in an adolescent population living at home (Grunbaum et al., 2002). The number of suicide attempts is three times as high among homeless youth as among youth living at home. Suicidal ideation, too, is common among homeless youth (Yoder, 1999). In Canada, a survey conducted in 2006 among British Columbia youth revealed that 15% of boys and 30% of girls on the streets stated having attempted suicide at least once in the past year, compared with 4% of boys and 10% of girls in school (Smith, Saewyc, Albert, MacKay, & Northcott, 2007). Along the same lines, 43% of homeless male youth reported having contemplated suicide, compared with 34% of youth living at home (Votta & Manion, 2004). In Richmond Hill, Ontario, 20% of homeless youth reported having attempted suicide at least once in their lifetime and 25% reported having contemplated suicide (Cameron, Racine, Offord, & Cairney, 2004). Among homeless youth surveyed in Toronto and Vancouver, 46% reported having attempted suicide at least once (Kidd, 2004). Recent studies have identified four main sources of factors associated with suicidal behaviour in homeless youth:

- Sociodemographic factors, such as female sex (Eynan et al., 2002), First Nation status, and sexual minority status (Gattis & Larson, 2016; Kidd et al., 2017; Moskowitz, Stein, & Lightfoot, 2013; Rhoades et al., 2018).
- Stressful events and psychosocial stress related to neglect (Kidd et al., 2017), physical and sexual violence (Hadland et al., 2015; Molnar, Shade, Kral, Booth, & Watters, 1998), intimidation (Kidd, 2004), familial substance abuse (Greene & Ringwalt, 1996; Moskowitz et al., 2013), familial psychopathology (Stiffman, 1989; Yoder, 1999), a friend's suicide, and broken relationships with family and peers (Rew, 2001; Yoder, 1999; Yoder, Hoyt, & Whitbeck, 1998).
- Mental health problems such as depression, psychosis, and alcohol/drug use disorders (Eynan et al., 2002; Greene & Ringwalt, 1996; Hadland, Marshall, Kerr, Qi, Montaner, & Wood, 2012; Hadland et al., 2015; Kidd & Carroll, 2007; Rotheram-Borus, 1993; Sibthorpe, Drinkwater, Gardner, & Bammer, 1995; Yoder, 1999).
- Vulnerability variables such as social disengagement or withdrawal (Votta & Manion, 2004), loss of hope for the future (Kidd & Carroll, 2007), poor social support network (Rew, Taylor-Seehafer, Thomas, & Yockey, 2001), and isolation or solitude experiences (Falardeau, 2002; Kidd et al., 2017; Kidd & Shahar, 2008).

Primary Healthcare and Research Questions

In 2014, the Québec government (Gouvernement du Québec, 2014) adopted its first province-wide policy to fight homelessness. This policy came with an inter-ministerial homelessness action plan for the 2015–2020 period. There was no mention in it of the overall health of youth; that is, of how their health also entails a state of well-being and not simply the absence of disorders and disease, nor was there any mention of the key principle of integrating youth mental health in primary or frontline healthcare, as recommended by the WHO (World Health Organization & World Organization of Family Doctors, 2008). Yet, it has been

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demonstrated that managing mental health in primary care is a crucial means to help these young people in particular (Funk, Benradia, & Roelandt, 2014).

Against this background, we undertook a study to gain a better understanding of the lived experience and mental health of 76 homeless adolescents 12 to 19 years old, with and without suicidal behaviour. Two research questions were asked: (1) Who are these youth in general and how do they differ depending on whether they are suicidal or not? (2) Which variables from among those selected best predict suicidal behaviour in these youth?

METHOD

Participants

Seventy-six homeless adolescents (43 girls and 33 boys) 12 to 19 years old living in temporary shelters participated in a semi-structured interview and completed self-administered questionnaires regarding their personal experiences and their mental health. Among them, 38 had suicidal behaviour and, of these, 19 had attempted suicide in the past year.

Procedure

Participants were recruited through the caregivers of the partner shelters. The caregivers were asked to offer each new youth on arrival the chance to participate in the research. If the youth agreed to participate, a research professional contacted them by telephone to describe the project and explain what their participation would entail. If they expressed interest, an appointment was set up at the shelter to complete a semi-structured interview and self-administered questionnaires. Each youth had to have understood and signed a consent form prior to beginning the interview. Data collection took place over a period of 18 months. The research protocol was approved by the Research Ethics Board of the Université du Québec à Montréal.

Measures

Basic data. Sociodemographic data was collected through an inventory covering sex, age, family, school, and housing. Suicidal behaviour was assessed through three questions drawn from the questionnaire used in the National Longitudinal Survey of Children and Youth (Statistics Canada, 2009): In the past 12 months, did you seriously consider attempting suicide? In the past 12 months, did you work out a plan how to commit suicide? In your lifetime, have you ever tried to commit suicide? An affirmative answer to any of these questions placed the respondent in the suicidal group.

Stressful events and psychosocial stress. The Life Events Questionnaire for Adolescents (LEQ-A) developed by Newcomb, Huba, and Bentler (1981) was used to determine the number of stressful events experienced by the youth in the past year. This 39-item questionnaire has been shown to possess good psychometric properties with French-speaking adolescents (Baron, Joubert, & Mercier 1991). In addition, the youth were asked two questions on physical/sexual abuse, drawn from a Québec survey of homeless people (Fournier, 2001).

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Mental health and vulnerability. Mental health was assessed with the predictive scale of the Diagnostic Interview Schedule for Children (DISC-IV). This 98-item instrument serves to identify youth who likely meet the DSM-IV criteria for various mental disorders. It has demonstrated satisfactory test-retest reliability and good-to-excellent sensitivity (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). Also, the Adolescent Coping Scale by Frydenberg and Lewis (1993) was used to assess how youths dealt with stressful life events. This instrument comprises 79 items and one open-ended question. It covers use of 18 coping strategies grouped into three styles: productive (centred on problem solving), non-productive (dysfunctional means of dealing with problems), and reference to others (geared to seeking natural or professional help). A French version of this instrument was previously validated in French (Labelle et al., 2015) in a clinical and community sample of Québec adolescents. Perception of support received was evaluated with the Social Provisions Scale (SPS) developed by Cutrona and Russell (1987). This 24-item instrument explores six dimensions of support: attachment, social integration, reassurance of worth, reliable alliance, guidance, and opportunity for nurturance. The SPS was validated in Québec by Caron (1996).

Statistical Analyses

First, bivariate analyses (chi squared and t-test-t at .05 significance level) were carried out on the participants' sociodemographic and clinical characteristics for the overall sample ($N = 76$) and to compare the suicidal and non-suicidal groups ($n = 38$ for each). Then, a backward multivariate logistic regression analysis was run to predict presence or absence of suicidal behaviour, with a significance cut-off of .05. The variables that were found to be significantly associated with suicidal behaviour were entered into a multiple regression model. These 10 variables are sex, sexual abuse, friend's suicide, death in family, romantic break-up, simple phobia, attention deficit/hyperactivity disorder (ADHD), conduct disorder, non-productive coping style, and little reassurance of worth. Analyses were run on the SPSS 16.0 application. Finally, a sample-size calculation showed that a minimal of 65 participants was sufficient to detect an $OR \geq 5$ (or $OR \leq 1/5$) with an 80% power using a 5% type I error. Our sample size of 76 participants was enough for this task (Cohen, 1988; Faul, Erdfelder, Lang, & Buchner, 2007).

RESULTS

General description of youth. All the youth were born in Québec. As indicated in Table 1, 57% were girls and 78% lived with one biological parent only. Also, 32% no longer went to school, 61% repeated a grade, 42% had been suspended from school at least once, and 58% were out of their home for at least a second time. As indicated in Table 2, these youth experienced numerous stressful events or psychosocial stress: 68% reported romantic break-up, 31% reported death in family, 25% reported physical abuse, 15% reported a friend's suicide, and 13% reported sexual abuse. Regarding mental health, 87% presented conduct disorder, 83% presented simple phobia, 76% presented alcohol use disorder, and 65% presented ADHD.

Differences between suicidal and non-suicidal youth. Compared with non-suicidal youth, suicidal youth reported significantly more stressful events related to affective loss (romantic break-up, friend's suicide and death in family), more psychosocial stress related to sexual abuse, and more mental health problems related to externalizing disorders. Suicidal youth were also less good at coping with stress: They were more likely to adopt a non-productive coping style and they received less social support (see Table 2).

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Table 1

Sociodemographic Characteristics of Participants by Overall Sample, Suicidal and Non-Suicidal Subgroups, and Difference in Percentages between Subgroups

Variables	Total (n = 76)	Non-suicidal (n = 38)	Suicidal (n = 38)	Significance test		
	n (%)	*n* (%)	*n* (%)	X^2/t	df	p
Sex						
Boy	33 (43.4)	23 (60.5)	10 (26.3)	9.05	1	.005*
Girl	43 (56.6)	15 (39.5)	28 (73.7)			
Age (years)						
12–15	42 (55.3)	18 (47.4)	24 (63.2)	1.92	1	.166
16–19	34 (44.7)	20 (52.6)	14 (36.8)			
Sexual orientation						
Heterosexual	73 (96.0)	37 (97,3)	36 (94.7)	3.13	1	.240
Bisexual/homosexual	3 (4.0)	1 (2,7)	2 (5.3)			
Family structure						
Two-parent	17 (22.4)	11 (28.9)	6 (15.8)	2.96	1	.398
Single-parent	59 (77.6)	27 (71.1)	32 (84.2)			
School attendance						
Yes	52 (68.4)	23 (60.5)	29 (76.3)	2.19	1	.139
No	24 (31.6)	15 (39.5)	9 (23.7)			
Repeated grade						
Yes	46 (60.5)	27 (71.1)	19 (50.0)	3.53	1	.060
No	30 (39.5)	11 (28.9)	19 (50.0)			
Suspended from school						
Yes	32 (42.1)	18 (47.4)	14 (36.8)	1.517	1	.280
No	44 (57.9)	20 (52.6)	24 (63.2)			
First out-of-home episode						
Yes	32 (42.1)	18 (47.4)	14 (36.8)	0.86	1	.353
No	44 (57.9)	20 (52.6)	24 (63.2)			

Note. * $p \leq .05$

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Table 2

Clinical Characteristic of Participants by Overall Sample, Suicidal and Non-Suicidal Subgroups, and Difference in Percentages and Means between Subgroups

Variables	Total	Non-suicidal	Suicidal	Significance test		
	(*n* = 76)	(*n* = 38)	(*n* = 38)	X^2/ t	df	p
Stressful events and psychosocial stress	*n* (%)	*n* (%)	*n* (%)			
Physical abuse[1]	19 (25.0)	6 (15.8)	13 (34.2)	3.44	1	.064
Sexual abuse[1]	10 (13.2)	2 (5.3)	8 (21.1)	4.14	1	.042*
Friend's suicide[2]	11 (14.5)	2 (5.3)	9 (23.7)	5.21	1	.022*
Death in family[2]	21 (31.3)	6 (19.4)	15 (41.7)	3.85	1	.050*
Romantic break-up[2]	49 (68.1)	19 (55.9)	30 (78.9)	4.39	1	.036*
Mental health and vulnerability variables						
Internalizing disorders						
Depressive disorder	13 (17.1)	5 (13.2)	8 (21.1)	8.35	1	.361
Generalized anxiety disorder	31 (40.8)	17 (44.7)	14 (36.8)	0.49	1	.484
Separation anxiety disorder	10 (13.2)	3 (7.9)	7 (18.4)	1.84	1	.175
Obsessive-compulsive disorder	8 (10.5)	3 (7.9)	5 (13.2)	0.56	1	.455
Agoraphobia	27 (35.5)	13 (34.2)	14 (36.8)	0.06	1	.811
Panic disorder	9 (11.8)	4 (10.5)	5 (13.2)	0.13	1	.723
Simple phobia	63 (82.9)	27 (71.1)	36 (94.7)	7.51	1	.006*
Social phobia	21 (27.6)	11 (28.9)	10 (26.3)	0.07	1	.798
Externalizing disorders						
Attention deficit/hyperactivity disorder	49 (64.5)	15 (39.5)	34 (89.5)	20.74	1	.000*
Oppositional defiant disorder	26 (34.2)	11 (28.9)	15 (39.5)	0.935	1	.333
Conduct disorder	66 (86.8)	29 (76.3)	37 (97.4)	7.37	1	.007*
Alcohol use disorder	58 (76.3)	25 (65.8)	33 (86.8)	4.66	1	.050
Substance use disorder	39 (51.3)	22 (57.9)	17 (44.7)	1.32	1	.251
	M (SD)	M (SD)	M (SD)			
Non-productive coping style[3]	2.7 (0.5)	2.6 (0.6)	2.9 (0.5)	2.34	74	.022*
Worry	2.9 (1.7)	2.7 (0.9)	3.2 (0.9)	2.20	73	.031*
Not coping	2.1 (0.9)	1.8 (1.9)	2.3 (0.9)	2.19	72	.032*
Tension reduction	2.8 (0.8)	2.5 (0.9)	3.1 (0.7)	2.68	73	.032*
Self-blame	2.6 (1.1)	2.3 (1.1)	2.8 (1.1)	2.15	73	.035*
Lack of social support	59.5 (4.7)	59.9 (4.9)	59.1 (4.4)	0.77	73	.442
Little reassurance of worth	12.3 (1.2)	12.6 (1.4)	11.9 (2.3)	10.9	73	.001*

Note. [1] Lifetime. [2] Past 12 months. [3] All scores out of 5 to reflect five-point scale.

* $p \leq .05$

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Table 3

Variables Associated with Presence of Suicidal Behaviour, Excluding Depression Based on a Multivariate Logistic Regression Analysis

Variables	*OR* [1]	*CI* [2]	*P* [3]
Presence of friend's suicide (past 12 months) yes vs. no	28.79	[1.48–559.23]	.010
Attention deficit/hyperactivity disorder presence vs. absence	11.84	[2.35–59.60]	.001
Presence of death in family (past 12 months) yes vs. no	8.52	[1.67–43.45]	.005
Presence of romantic break-up (past 12 months) yes vs. no	7.90	[1.69–36.89]	.004
Lack of social support – no reassurance of worth low score vs. medium score	5.86	[2.02–17.00]	.000
Non-productive coping – high somatization high score vs. medium score	2.79	[1.20–6.51]	.009

Note. [1] Odds ratio based on difference of one standard deviation on continuous variable's scale.
[2] Confidence interval of about 95%.
[3] Likelihood ratio test.

Variables associated with presence of suicidal behaviour. Based on a logistic regression, the best predictors of suicidal behaviour, in decreasing order of importance, were the following: (1) friend's suicide, (2) presence of ADHD, (3) presence of death in family, (4) presence of romantic break-up, (5) poor support regarding reassurance of worth, and (6) use of non-productive coping strategies centred on somatization (see Table 3).

DISCUSSION

This exploratory study does shed light on a few points. First, our results show that these youth come from essentially broken homes; for two-thirds of participants, parents were separated. In other words, most youths did not have a stable family nest so important in adolescence for constructing a basic sense of security. An extensive body of adolescent literature has highlighted this relationship between attachment style and mental health in this group (Paradise & Cauce, 2002). In addition, these youth had serious academic and housing problems. In this regard, about one-third were no longer in school and more than half were staying in a temporary shelter for at least the second time. This finding is concerning in that 55% of the sample comprised early adolescents 12 to 15 years old. These results are consistent with those reported by Karabanow (2004; Karabanow & Naylor, 2013). Moreover, the youths had had to deal with numerous difficult situations, particularly regarding physical/sexual abuse and romantic break-ups in the past year. These elements of personal histories are well documented in the literature (Hadland et al., 2015; Molnar et al., 1998).

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Where mental health is concerned, these youth presented an assortment of problems. Their mental suffering seemed to take the form of externalizing disorders, such as conduct disorder (87%), alcohol use disorder (76%) and ADHD (65%). This suggests that special attention should be paid to screening for these overt problems in these youth. Furthermore, participants tended not to cope well with stress, resorting primarily to non-productive strategies. These findings with homeless youth are comparable to those reported by Votta and Manion (2004) and Kidd and Carroll (2007). Where social support is concerned, the youth in our study obtained lower total scores than did students in the general population (Caron, 1996). They felt more isolated than others, which is line with findings reported by Kidd and Shahar (2008).

What's more, our bivariate analyses showed that the suicidal youth were much more burdened in terms of stressful events and psychosocial stress, mental health disorders, and problems related to coping and social support. These findings are consistent with those reported in the studies covered in the literature review (Kidd et al., 2017; Kidd & Carroll, 2007; Molnar et al., 1998; Votta & Manion, 2004; Yoder, 1999).

As for our multivariate analysis, the results underscore the importance of lost relationships, such as following a friend's suicide, a death in the family, and a romantic break-up, as major events to be considered when examining the suffering of these youth. Previous work has highlighted that broken relationships are a key aspect of emotional distress among homeless youth (Rew, 2001; Yoder, 1999). Moreover, only ADHD proved predictive of suicidal behaviour. To date, there is little scientific literature on this topic. Recently, two systematic reviews and meta-analyses found a positive correlation between ADHD and suicidality (Garas & Balazs, 2020; Septier et al. 2019). Based on these studies, the authors suggest some overlap between ADHD and particularly with mood disorders, which are strongly associated with suicidal behaviour. More research is needed in this regard. Finally, the fact that the youth in our study used coping strategies centred on somatization and received little reassurance on their worth tips the scales toward mental suffering that could lead to suicidal behaviour.

In closing, our study gives pause to reflect upon the sort of intervention to offer these homeless youth. Our results show that these boys and girls tend to experience numerous difficult situations and to present multiple mental health problems. As it happens, however, these youth all too often do not receive mental health services in primary care, thereby undermining their chances of getting out of their predicament. In Montréal and throughout Canada, an exceptional effort is being made to establish a protocol for referring homeless youth to frontline mental health services. This novel initiative, the ACCESS Open Minds program developed by Abdel-Baki et al. (2019), essentially applies the WHO's approach to using the different levels of care within health systems, whereby primary care is considered the entry level of care. This program includes day centers, shelters, housing resources, medical and psychiatric institutions and specialized services like psychotherapeutic intervention. The philosophy behind this program states that there is no "wrong door" or "bad timing" for seeking help. The structure of the ACCESS Open Minds represents an innovative approach to cross-sectoral and inter-services integration whereby diverse services align around a common objective. However, for it to be fully effective, primary mental health care must coincides with the availability of other levels of care, such as general and specialized hospital services and informal care in the community and from one's social network, including self-care, which implies possessing the knowledge and skills required to manage one's mental health problems with or without help from family and friends.

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In addition, this study leads us to consider a new avenue of research. Indeed, the present study is innovative. It is one of the first exploratory research to present ADHD adolescents with various family and school problems who may be more likely to develop suicidal behaviours. Furthermore, this exploratory study also has the merit of offering to the scientific community data that can be used in meta-analysis to quantify the weight of our results with more larger samples.

Limitations

This study presents several limitations. First a cross-sectional design was used, which does not allow for a definitive conclusion regarding the direction of the relationships between variables. We need longitidunal work to examine the various path of risk and protective factors in this population. Second participants were not randomly assigned to one condition or the other and the variables considered were attribute variables. Third, as data were collected at one time point only, no causal relationship could be established between variables. Fourth, participants were recruited on a voluntary basis, which might have introduced a selection bias, thereby limiting the degree to which results might be generalized. Fifth, the small sample size ($N = 76$) limited the statistical power of analyses. Because of this, we could not consider a larger number of variables to include in the regression analyses. Sixth, the large reference period measuring suicidal ideations/plans (over 12 months) and attempts (whole life) call for caution in interpreting results. Lastly, nearly all of the youth in the study were temporarily disconnected. Consequently, results cannot be transposed to unstably or chronically disconnected youth.

CONCLUSION

Homeless youth who resort to temporary shelters, such as those in our study, confirm that lost relationships and academic problems rooted in ADHD are associated with suicidal behaviour. Studies indicate, also, that non-productive coping strategies centred on somatization and little support in terms of reassurance of worth are linked to suicidal behaviour. Based on these findings, caregivers in temporary shelters should screen for these elements so that youth with this profile can be referred to mental health professionals in primary care.

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